GHANA AIDS COMMISSION

Under the Office of the President

HIV AND SOCIAL PROTECTION ASSESSMENT IN GHANA

EVIDENCE FOR POLICY AND ACTION ON HIV AND SOCIAL PROTECTION

November 2021

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FOREWORD

This study assessed how sensitive social protection programmes are to HIV and AIDS to inform the Ghana AIDS Commission and partners about HIV-sensitive social protection programmes in Ghana. HIV-sensitive social protection programmes are designed specifically with and for people living with, at risk of or affected by HIV.

This report provides tailored analysis on HIV and social protection. The data collected and analysed suggest that there are myriad categories of social protection and health schemes with benefits in the country targeting various poor and vulnerable groups. The report also reveals that social protection interventions and health services in Ghana are somewhat HIV-sensitive. However, there are barriers that hinder persons living with and or affected by HIV access to such interventions.

Information gathered from the assessment tool will support decision-making in strengthening the HIV sensitivity of social protection schemes to better reach people living with HIV, adolescent girls and young women, key population and others.

To ensure the sustainability of social protection interventions in addressing the vulnerabilities in persons living with and or affected by HIV, the Ghana AIDS Commission, partners and stakeholders work together to strengthen social protection interventions in order to mitigate the impact of HIV and AIDS and improve the wellbeing of persons infected and affected by HIV.

Kyeremeh Atuahene (PhD)
Director General

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CSOs	Civil Society Organizations
DACF	District Assemblies Common Fund
DCD	Department of Community Development
DSW	Department of Social Welfare
FBOs	Faith-Based Organizations
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GAF	Ghana Armed Forces
GES	Ghana Education Service
GHS	Ghana Health Service
GNHR	Ghana National Household Registry
GNSPS	Ghana National Social Protection Strategy
GSFP	Ghana School Feeding Programme
HIV	Human Immunodeficiency Virus
IUDs	Injection Drug Users
KIIs	Key Informant Interviews
KPs	Key Populations
LEAP	Livelihood Empowerment Against Poverty
LIPW	Labour Intensive Public Works
MLGRD	Ministry of Local Government and Rural Development
MMDAs	Metropolitan, Municipal and District Assemblies
MOE	Ministry of Education
MoGCSP	Ministry of Gender, Children and Social Protection
MOH	Ministry of Health
MOT	Ministry of Transport
MPs	Members of Parliament
MSM	Men who have sex with men
NACP	National AIDS Control Programme
NADMO	National Disaster Management Organization
NAP+	Network of Association of Persons Living with HIV
NCCE	National Council on Civic Education
NGOs	Non-governmental Organizations

NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NSP	National HIV and AIDS Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PLHIV/PLs	Persons Living with HIV
PWD	People with Disabilities
PWID	People Who Inject Drugs
RM&E	Research, Monitoring and Evaluation
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SP	Social Protection
SSNIT	Social Security and National Insurance Trust
TSUs	Technical Support Units
UNAIDS	The Joint United Nations Programme on AIDS
WFP	World Food Programme
YPLHIV	Young Persons Living with HIV

EXECUTIVE SUMMARY

The fight against HIV and AIDS in Ghana like other countries in the sub-region has been pursued through interventions to stop the spread of the virus and prolong the lives of those infected mainly using antiretroviral therapy (ART) and a combination of prevention measures. Significant successes have been made in this regard and the Ghana HIV numbers suggest a down-trending of its prevalence. Despite the successes pertaining to access to treatment commodities which have also been shown to lead to a reduction in the number of AIDS-related deaths, a major challenge many HIV-affected individuals and households in sub-Saharan Africa grapple with is food insecurity. The impact of the HIV epidemic on household vulnerability is extensively documented with communities and households already living on the edge, being made more vulnerable by the complex consequences of HIV and AIDS.

Inclusive social protection systems contribute to holistic responses to the needs of beneficiaries and enable countries to better address the different dimensions of poverty and vulnerability across the life cycle, as well as offer beneficiaries a broad range of coordinated multi-sectoral interventions that aim at ultimately bringing greater wellbeing for individuals, their families and communities. Social protection contributes to advancing the AIDS response by contributing to the prevention of new HIV infections and reducing AIDS-related deaths and stigma and discrimination. Social protection can also help address the multiple social determinants of the epidemic – income inequalities, gender inequalities, social exclusion – and thus contribute to a reduction in new HIV infections.

Though investments in social protection have shown to have sustainable impacts on poverty reduction, as poor and vulnerable people become productive contributions to the development of society, many barriers exist that prevent people living with, at risk of or affected by HIV from accessing HIV-sensitive social protection services. This assessment which is the first-ever in the country was therefore carried out by the Ghana AIDS Commission (GAC), with funding from the World Food Programmes and in collaboration with stakeholders and partners in the AIDS response, to assess how the social protection schemes and health services in Ghana address the unique vulnerabilities and needs of households of persons living with, at risk of and affected by HIV. Thus by assessing the HIV sensitivity of these services the study also looked at the barriers that prevent the vulnerable groups from accessing these services and how the barriers can be mitigated.

The Approach for Conducting the Assessment

The methodology outlined for the UNAIDS HIV and Social Protection Assessment was used. This involved extensive stakeholder consultations to

secure their commitments in participating fully in the assessment as well as implementing the recommendations; review of literature of key national policy and programmes documents as well as global literature on the subjects of HIV and Social Protection schemes and services; primary data collection at the national and sub-national levels using the UNAIDS HIV and Social Protection Assessment Tool and key informant interviews to complement the information collected through the use of the assessment tool.

Participating in the completion of the Tool at the national and sub-national levels were respondents from government agencies that implement social protection interventions including the Ministry of Gender, Children and Social Protection, Ministry of Local Government and Rural Development and the National Health Insurance Authority; National Association of PLHIV (NAP+), UN agencies, NGOs implementing interventions for PLHIV and KPs, District Assemblies, as well as the government institutions leading the AIDS response i.e. the Ghana AIDS Commission (GAC) and the National AIDS Control Programme, Ghana Health Service (NACP, GHS).

Thematic issues extracted from the information collected using the HIV and Social Protection Assessment Tool as well as the KIIs (involving PLHIV and NGOs providing social services to PLHIV, KPs and other vulnerable groups) were analysed to inform the content of this assessment report. The key findings were shared with stakeholders for validation before finalizing the report.

A few limitations were encountered during the conduct of this assessment and these included, the non-availability of segregated data on the estimated sizes of the populations and groups that were identified as vulnerable and facing barriers in accessing social protection services. Another key challenge was the presence of the Covid-19 pandemic during the period within which the assessment was completed and the gathering restrictions imposed by the government making it impossible to conduct focused group discussions (FDGs) and difficult to conduct face-to-face stakeholders' workshops and key informant interviews. In view of this, no FGDs were conducted, two of the stakeholders' workshops were virtual and the KIIs that involved PLHIV and NGOs implementing social interventions for PLHIV and other vulnerable groups were also virtual.

Key Findings

There are myriad categories of social protection and health schemes with benefits in the country targeting various poor and vulnerable groups. These social protection and health services are somewhat HIV-sensitive, with about 50% level of HIV-sensitivity; and hence need to be improved by the removal of all the barriers that prevent or hinder persons living with, affected by or at risk of HIV who are also vulnerable from accessing these interventions.

The populations identified by the respondents at both the national and zonal levels as those that face the most barriers in accessing these social protection and health services are PLHIV who are very poor, PLHIV living in hard-to-reach communities, adolescent girls and young women, OVC, pregnant women and lactating mothers living with HIV, KPs (people who inject drugs, FSW and MSM), people with disabilities, and people aged 50 years and above who are poor and vulnerable. These barriers include the non-recognition of some groups as vulnerable in the national social protection policies and strategic plan; inadequate resources for the inclusion of all poor and vulnerable populations as beneficiaries of these services resulting in prioritizing; low level of awareness of the existence of these social protection services and how to access them; various forms of stigma and discrimination among others.

Recommendations

To remove the access barriers and improve the HIV-sensitivity of the social protection programmes and health schemes in Ghana the following recommendations were given:

- Recognition and inclusion of all populations who are living with, affected by or at risk of being infected by HIV, including key populations, as beneficiaries of the various social protection interventions and health schemes in the country

- Generation of data on the vulnerable and poor who are supposed to be included as beneficiaries for these interventions and services

- Improving the HIV-sensitivity of the social protection programmes through the removal of all the access barriers and meaningful involvement of some of the vulnerable groups and other stakeholders through the design, planning, implementation, monitoring and evaluation stages at all levels

- Extensive public education and awareness creation on the existence and benefits packages of the various social protection schemes, who is to benefit and how to benefit from such interventions

- Continuous anti-stigma campaigns among the general population

- Active and intensified resource mobilization to enable the programmes to be extended to cover as many vulnerable populations as possible.

1.0. INTRODUCTION

Social protection, an increasingly popular policy and programme option to address the vulnerabilities experienced by the poorest people in developing countries, including those affected by and living with HIV, aims to reduce risks, mitigate their impacts and increase the capacity of households to cope and respond to the risks[1]. Social protection systems should therefore have a preventive and sustainable effect; strengthening the resiliency of individuals, families and communities and enhancing the capability to react to risks of life.

Social protection mechanisms may include anti-discrimination legislation, contributory insurance schemes, pensions for the elderly and disabled, grants to caregivers of orphans, food stamp programmes, school feeding programmes, paid sick support, unemployment benefits, cash transfers, anti-stigma campaigns and a litany of other interventions.

A working paper [2], categorizes these social protection measures into four groups, which helps to reveal their purpose:

protective – providing relief from deprivation;
preventive – seeking to avert deprivation;
promotive – aimed at enhancing real incomes and capabilities;
and transformative – addressing social equity and exclusion

1.1. Global Initiatives on HIV and Social Protection

The relevance of social protection systems is also highlighted in global platforms and initiatives including the new Sustainable Development Goals. The Sustainable Development Goals (SDG) which are explicitly linked to the protection of the health and wellbeing of the poor and vulnerable in society are SDG 1 - No Poverty; SDG 2 - Zero Hunger; SDG 3 - Good Health and Well-being; SDG - 8 Decent Work and Economic Growth as well as SDG 10 Reduced Inequalities. Within these goals, there is a concrete target spelling out the commitment to ***"implement nationally appropriate social protection***

1 HIV-sensitive social protection: the case of Nigeria, Fiona Samuels and Carolyn Blake, Overseas Development Institute and UNICEF Project Briefing No 61, September 2011

2 Greenblott, Kara, "Social Protection in the Era of HIV and AIDS, Examining the Role of Food-Based Interventions", World Food Programme, 2007, Rome, Italy

systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable." This target reflects a global consensus on the need to strengthen social protection systems and expand their coverage.

The current Global AIDS Strategy 2021-2026 [3] which is a bold new approach that is to use an inequalities lens to close the gaps that are preventing progress towards ending AIDS aims to reduce these inequalities - that drive the AIDS epidemic and prioritize people who are not yet accessing life-saving HIV services. The Strategy sets out evidence-based priority actions and bold targets to get every country and every community on-track to end AIDS as a public health threat by 2030.

Among the strategic priorities and actions outlined to be implemented by global, regional, country and community partners to get on track to ending AIDS is:

Strategic Priority 3 - fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

In addition, among the 10 results areas proposed to accelerate progress towards realizing the vision of zero new infections, zero discrimination and zero AIDS-related deaths is the:

Results area 9 - Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.

1.2. Impact of HIV on Household vulnerability and food security

Like other countries in the sub-region, the fight against HIV and AIDS in Ghana has been pursued through interventions to stop the spread of the virus and prolong the lives of those infected mainly using antiretroviral therapy (ART) and combination prevention measures. Significant successes have been made in this regard and the statistics on HIV in Ghana suggest a down-trending of its prevalence. However recent scientific evidence and advancement in treatment coverage have brought about an increased understanding of the role of nutrition in the prevention, treatment and care of HIV [4].

Studies have shown that HIV exacerbates the vulnerability of affected families to food insecurity, leading to hunger and malnutrition. Indeed, scholars have previously provided elucidation on the relationship between HIV and food insecurity [5]. The relationship is complex and intertwined in a vicious cycle, with each worsening vulnerability and thus exacerbating the severity of the other. Food insecurity heightens susceptibility to HIV exposure and infection; HIV on the other hand, increases vulnerability to food insecurity, food insecurity can also impede adherence to ART.

3 End Inequalities, End AIDS, Global AIDS Strategy 2021-2026, Data corrected version, The Joint United Nations Programmes on HIV and AIDS, UNAIDS, March 2021

4 2019 Report on the Assessment of Food Security and Vulnerability of HIV-Affected Households in Selected Regions of Ghana, Ghana AIDS Commission (GAC) and World Food Programme (WFP) Country Office

5 Weiser SD, Tsai AC, Gupta R, et al. Food insecurity is associated with morbidity and patterns of healthcare utilization among HIV-infected individuals in a resource-poor setting. AIDS (London, England) 2012; 26(1): 67. AND Gillespie S, Kadiyala S. HIV/AIDS and food and nutrition security: From evidence to action: Intl Food Policy Res Inst; 2005 (as referenced in the 2019 Report on the Assessment of Food Security and Vulnerability of HIV-Affected Households in Selected Regions of Ghana, Ghana AIDS Commission (GAC) and World Food Programme (WFP) Country Office)

Some of the most cited impacts[6] of the HIV epidemic on household vulnerability among others are:

- reduced household labour capacity, affecting agricultural production at the household and community levels;
- household income diverted from investment, savings and spending on essentials and instead used to cover medical expenses, funerals and other illness-related costs;
- time and effort dedicated to care-taking instead of household production or income generation;
- children in HIV affected households bear the brunt if they have to be withdrawn from school to help with household chores and care-taking or discontinue schooling when there is the need to earn in order to augment family income;
- an increasing number of orphans and extra burden placed on the households that host them;
- increased demand on health systems because of the greater number of people who are chronically ill

The 2020 national estimated number of people living with HIV (PLHIV) was 346,120 comprising 229,755 (66%) females and 116,364 (34%) males. The HIV population for Adult (15+ years) and children (0-14 years) was 317,410 and 28,710 respectively [7]. The populations left behind by the HIV response who are more at risk, more vulnerable and more affected by HIV due to their exclusion and discrimination include people living with HIV, adolescent girls and young women, children, pregnant and lactating women living with HIV, people in prison, migrants, displaced people, people who inject drugs, sex workers, men who have sex with men, transgender people, people with disabilities, and people aged 50 years and older[8].

The need to strengthen programmes to reach these people and meet their multiple needs including health, education, social, economic, employment, housing, food and nutrition, psychosocial and legal needs cannot be overemphasized.

A 2018 Ghana national survey[9] assessed food insecurity and vulnerability status of HIV-affected households in four regions of Ghana (Greater Accra, Eastern, Northern and Brong Ahafo Regions) to enable WFP and other stakeholders to glean relevant information on the food security profile of PLHIV in Ghana and better tailor future strategies and interventions to address the problem. The study population included adults in households caring for an HIV-seropositive person in the indicated regions of Ghana. Food security and vulnerability to food insecurity were the key outcomes in the assessment.

The data suggest that food insecurity is a problem for thousands of HIV-affected households in the four focus regions of Ghana. About 21percent of the 1,666 households

6 2019 Report on the Assessment of Food Security and Vulnerability of HIV-Affected Households in Selected Regions of Ghana, Ghana AIDS Commission (GAC) and World Food Programme (WFP) Country Office

7 National and Sub-National HIV and AIDS Estimates and Projections, 2020 Report, Ghana AIDS Commission (GAC)

8 HIV and social protection assessment tool, Generating evidence for policy and action on HIV and social protection, UNAIDS 2017

9 Assessment of Food Security and Vulnerability of HIV-Affected Households in Selected Regions of Ghana, January 2019, Ghana AIDS Commission (GAC) and World Food Programme (WFP) Country Office

are food insecure (highest in Northern region – 24.0 per cent and lowest in Brong Ahafo region – 16.4 per cent). Also, 30 per cent of the 1,666 households are classified as being on the edge of food insecurity (the borderline group). Extrapolations based on the entire number of PLHIV on ART in the focus regions (36,586) take the numbers who are food insecure to 7,778 PLHIV. Based on an average household size of four members, this means that altogether 7,778 x 4 (31,112) persons infected or affected by HIV need to be targeted for assistance.

Considering the optimal and undisputed role of nutrition in the treatment success one of the recommendations from the study to contribute to the attainment of the 3rd of the 90-90-90 targets was that the Government of Ghana in line with their policy on LEAP may include food insecure PLHIV households as beneficiaries of LEAP or other social protection interventions.

1.3. HIV-sensitive Social Protection Programmes

There has been increasing recognition of the role of HIV-sensitive social protection in advancing the AIDS response to increase uptake and use of HIV prevention, treatment and care services[10]. HIV sensitive social protection seeks to accelerate actions that remove barriers to accessing social protection services for people living with, at risk of or affected by HIV.

The term "HIV-sensitive" also refers to the degree to which people living with, at risk of or affected by HIV are considered and included in the design and implementation of social protection schemes[11]. Thus social protection is HIV-sensitive when it is inclusive of people who are at risk of HIV infection or are susceptible to the consequences of HIV infection[12].

1.4. Barriers to accessing social protection interventions/programmes

Investments in social protection globally have shown to have sustainable impacts on poverty reduction as poor and vulnerable people become productive contributions to the development of society. However, many barriers exist that prevent people living with, at risk of or affected by HIV from accessing social protection services. These barriers may be policy or programmatic, or a combination of both yet they can be removed and opportunities for HIV and social protection co-programming exist that could be exploited.

Examples of barriers that prevent people living with, at risk of or affected by HIV from accessing HIV-sensitive social protection services[13]:

- non-existence of HIV-sensitive social protection programmes,
- limited coverage and benefits packages of existing schemes, lack of information on available social protection programmes,

10 HIV and social protection assessment tool, Generating evidence for policy and action on HIV and social protection, UNAIDS 201

11 HIV and Social Protection Guidance Note, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011

12 HIV - sensitive social protection: what does the evidence say by Mariam Temin, UNAIDS 2010

13 HIV and social protection assessment tool, Generating evidence for policy and action on HIV and social protection, UNAIDS 2017

- missing documents such as identity cards and birth certificates that confer
- eligibility and entitlement to services, cumbersome and complicated procedures,
- People living with, at risk of or affected by HIV may be discriminated against or may self-stigmatize and exclude themselves from accessing HIV-sensitive social protection schemes for a variety of reasons.

Although HIV-sensitive social protection services may be free at the point of use, the process of obtaining services may impose economic costs that may be unaffordable to some of the recipients; such costs include transportation to reach the service point, foregone wages and waiting times. For example, antiretroviral therapy may be free at the point of use, but recipients may have to pay for tests or buy drugs for opportunistic infections in private pharmacies due to stock-outs at public hospitals or because these services are not exempt from fees. Legal barriers also keep some groups of people living with HIV from treatment, such as people with illegal status[14].

1.5. Assessment of Social Protection Programmes Sensitive to HIV

The Joint United Nations Programme on AIDS (UNAIDS) and its partners (UNICEF and ILO) in 2017, developed the HIV and Social Protection Assessment Tool used for a quick scan of existing social protection programmes and their sensitivity (or lack of) to the HIV response in a given country and location[15]. The assessment provides countries and communities with tailored analysis on HIV and social protection by seeking to gather information on:

- the social protection schemes that exist in different countries and locations, and their purpose, eligibility criteria, coverage and HIV sensitivity;
- whether people living with HIV, adolescent girls and young women at high risk of HIV infection, key populations and others eligible to benefit from social protection benefits are accessing existing social protection schemes
- and, if not, the key barriers people face in accessing social protection benefits as well as what can be done to eliminate the barriers and include these populations in existing social protection programmes.

Information gathered using the assessment tool is intended to support decision-making in strengthening the HIV-sensitivity of social protection schemes to better reach people living with HIV, adolescent girls and young women, key populations and others, and inform the development of national HIV-sensitive social protection portals, revision of national AIDS strategies, HIV investment cases, concept notes for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other social welfare and poverty alleviation programmes.

The Ghana AIDS Commission therefore in collaboration with its partners and key stakeholders used the tool developed by the UNAIDS to carry out the HIV and Social Protection Assessment in Ghana to quickly scan existing social protection programmes and their HIV sensitivity, interface or lack of with the HIV response.

14 HIV and Social Protection Guidance Note, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011

15 HIV and social protection assessment tool, Generating evidence for policy and action on HIV and social protection, UNAIDS 2017

2.0. BACKGROUND - SOCIAL PROTECTION IN GHANA

In recent decades, social protection programmes have become an effective and efficient poverty reduction tool across the developing world. These programmes address the structural constraints that tend to perpetuate chronic poverty and transitory poverty by facilitating investment in human and physical assets in order to reduce the risk of future poverty. The 1992 Constitution of Ghana advocates social justice and equity and this has facilitated the passage of various pieces of legislation into law, which provides a broad regulatory framework for addressing the needs and interests of vulnerable and excluded groups in the Ghanaian society.

The Ministry of Gender, Children and Social Protection (MoGCSP) was created in 2013 with the mandate of ensuring the effective and efficient coordination of SP programmes in Ghana. Thus, in Ghana social protection has become an indispensable part of the government's responsibility toward its citizens and an essential element of the agenda for addressing vulnerability and poverty reduction[16]. The main objective for social protection in Ghana is to promote the integration and protection of the extremely poor, vulnerable, excluded and persons with disabilities. Examples of social protection programmes include social assistance programmes such as cash transfers, school feeding programmes, social insurance schemes such as national health insurance, social pensions etc.

According to the National Social Protection Policy, ***the definition of social protection for Ghana[17] is a range of actions carried out by the state and other parties in response to vulnerability and poverty, which seek to guarantee relief for those sections of the population who for any reason are not able to provide for themselves.*** The Child and Family Welfare Policy also define Social Protection[18] (SP) as a national system of policies and programmes that aim to prevent, reduce and mitigate vulnerability and persistent poverty. Ghana is also a signatory to various regional and international commitments on social protection.

More recently, as a signatory to the Sustainable Development Goals of 2015, under goal 1 on poverty, Ghana has committed to target 1.3: Implement nationally appropriate social protection systems and

16 Report on Ministry of Gender, Children and Social Protection's (MoGCSP) COVID-19 Response: Emergency Social Protection Assistance During Partial Lockdown, MoGCSP, April 2021

17 Ghana National Social Protection Policy, Ministry of Gender, Children and Social Protection, November 2015

18 The National Child and family Welfare Policy, 2014, Ministry of Gender, Children and Social Protection

measures for all, including floors, and by 2030 achieve substantial coverage of the poor and vulnerable. Specifically, the international legal and conceptual framework of Social Protection Floor advocates four basic social security guarantees at nationally defined minimum levels. Ghana's social protection floor, therefore, seeks to cater for the entire life-cycle, fill social protection gaps and strategically balance social assistance, social security and productive inclusion.

Ghana's social protection floor[19] consists of:

Access to basic essential healthcare for all,
Minimum income security to access the basic needs of life for children
Minimum income security for people of working age
Minimum income security for older person

2.1. The National Social Protection Policy and Strategy

The National Social Protection Policy provides a framework for delivering social protection coherently, effectively and efficiently in a way that is holistic and properly targeted. It provides an institutional framework for coordination and stakeholder collaboration in monitoring and ensuring accountability. It is linked to a range of legal instruments and policies that provide a framework within which the obligations to various target groups may be justified, implemented, regulated and advocated.

The policy embraces a strategic vision of an all-inclusive and socially empowered society through the provision of sustainable mechanisms for the protection of persons living in situations of extreme poverty and related vulnerability and exclusion. It supports the principle that every Ghanaian matter and is capable of contributing to national development. It, therefore, aspires to close the inequality gap and ensure total inclusion for all Ghanaians. It seeks to promote the well-being of Ghanaians through an integrated platform of effective social assistance, social and productive inclusion, social services and social insurance.

> The National Social Protection Policy defines social protection for Ghana as[20] ***"a range of actions carried out by the state and other parties in response to vulnerability and poverty, which seek to guarantee relief for those sections of the population who for any reason are not able to provide for themselves"***.

According to the Ghana National Social Protection Strategy (GNSPS) 2012[21], the vision of social protection in Ghana, is an inclusive equitable society in which ordinary and extremely poor and vulnerable citizens are protected from risks and shocks and are empowered with improved capability, to overcome social, economic and cultural challenges in order to realise their rights and responsibilities and to make meaningful contributions to society. The vision points to the fact that the Ghana National Social Protection Strategy (GNSPS) is a people-centred national intervention framework aimed at poverty alleviation. It seeks to spearhead the provision of livelihood support and empowerment for both the abject and chronically poor and categories of the working poor, who are vulnerable to transitions into poverty, as well as poor unemployed youth.

19 Ghana National Social Protection Policy, December 2015, Ministry of Gender, Children and Social Protection (MoGCSP)

20 Ghana National Social Protection Policy, December 2015, Ministry of Gender, Children and Social Protection (MoGCSP

21 Ghana National Social Protection Strategy (GNSPS), Investing in people for a better Ghana, Ministry of Employment and Social Welfare (MESW), Draft, January 2012

The 'poor' are categorised in the GNSPS as those who face a combination of risks under which they survive at minimum levels of well-being and cannot expand their assets. They experience seasonal or short-term hardships such as food insecurity and malnutrition.

The most vulnerable and excluded people are said to suffer from severe livelihood insecurity and are exposed to multiple life-cycle risks and shocks. They also tend to lack access to education, health, information and the opportunity to participate in social processes.

These citizens are further likely to endure denial of rights, the inability to demand accountability, lack of access to resources as well as other institutional barriers that contribute to poverty, vulnerability, and social exclusion.

2.2. The Five National Flagship Social Protection Programmes[22]

Ghana has a rich tradition of social protection efforts by communities and civil society entities which complements a range of pro-poor programmes undertaken by the state. This includes the implementation of five flagship programmes, namely, the Livelihood Empowerment Against Poverty (LEAP), the Labour Intensive Public Works (LIPW), the School Feeding Programme (SFP), the National Health Insurance (NHI) Exemptions and the Basic Education Capitation Grants. The objectives of these flagship programmes are described below as follows:

Livelihood Empowerment against Poverty Programme (LEAP): The LEAP Programme is the Government of Ghana's flagship Social Protection intervention which was designed in 2007 to empower the extremely poor and other vulnerable population with programme implementation commencing in 2008. LEAP is a Cash Transfer Programme to empower the extremely poor population to "leap" out of extreme poverty. The programme is designed to promote the use of Social Services as a catalyst to improve the welfare of the extreme poor and to foster long-term human capital development of the population. The LEAP Programme is managed by the Ministry of Gender, Children and Social Protection (MoGCSP), through the LEAP Management Secretariat (LMS) as the implementing agency[23]. The programme is also intended to support the MoGCSP's humanitarian cash transfers as and when the need arises.

The main objective of the programme is to reduce poverty by increasing consumption and promoting access to services and opportunities among the extremely poor and vulnerable. The eligibility criteria are poorest households and specific categories including orphans and vulnerable children (OVC), the aged who are above 65years without any support, persons living with HIV, persons with severe disability and the extremely poor pregnant women with children under one year.

22 Ghana National Social Protection Policy, December 2015, Ministry of Gender, Children and Social Protection (MoGCSP)

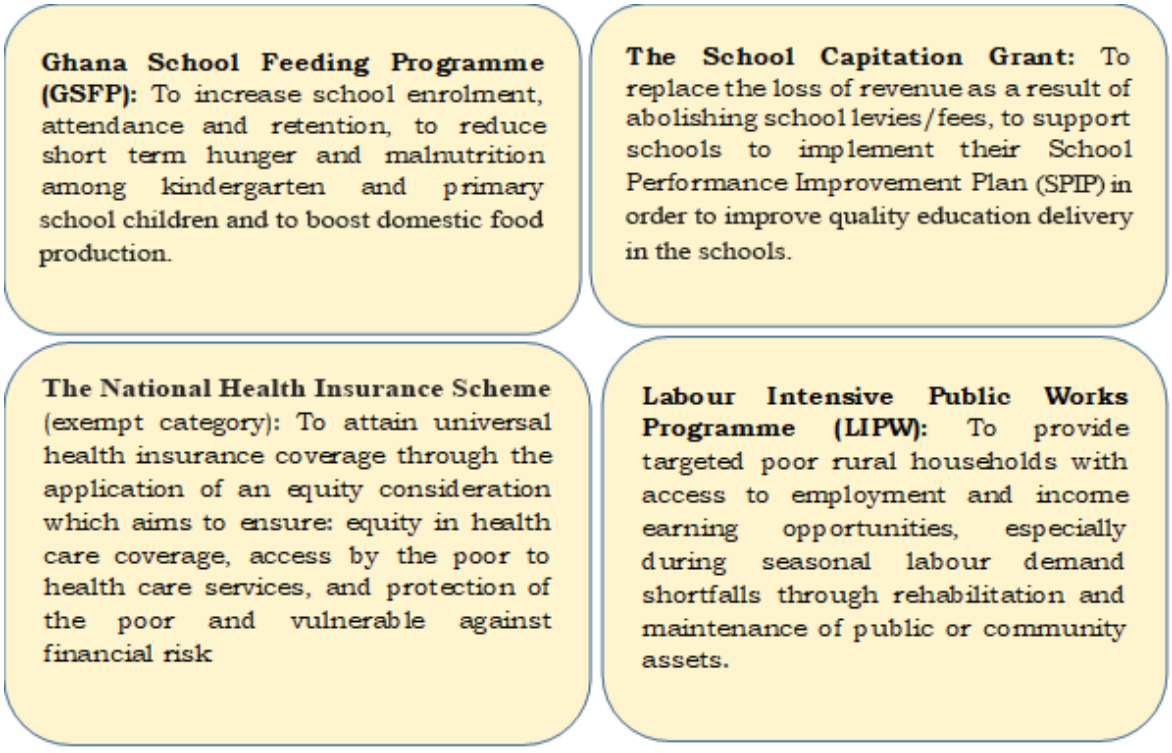
23 Ghana Productive Safety Net Project (GPSNP) POM Volume 3: Livelihood Empowerment Against Poverty (LEAP) Programme Operational Manual, April 2019, Ministry of Gender, Children and Social Protection (MoGCSP)

Six main categories of people that are to benefit from cash transfer[24]

- Subsistence farmers and fishers and extremely poor households
- Extremely poor older people who are 65 years or older without any support
- Persons with disabilities (PWD) and without productive capacity
- Caregivers and orphaned (particularly children orphaned by AIDS) and vulnerable children (OVC), and persons living with HIV (PLHIV)
- Extremely poor pregnant women with children under one year
- Low-income victims of natural or man-made disaster.

Additionally, the LEAP Programme also provides technical support for managing Emergency LEAP Interventions when requested by the National Disaster Management Organization (NADMO) through the MoGCSP. This emergency programme supports victims of disasters such as floods or fire, support for relief and reconstruction support, with extra assistance earmarked for people in low-income distressed communities. An example of such emergency programmes is the MoGCSP's Covid-19 emergency social protection assistance during the partial lockdown in 2020.

Figure 1: Four flagship social protection programmes



The other social protection programmes or interventions in Ghana listed in the GNSPS include the energy and utility subsidies, provision of free school uniforms and exercise books, free bus ride for children in uniform, supplementary feeding programme (where food is distributed to malnourished children to boost their energy and supply them with micro-nutrients), national youth employment programme, national forest plantation programme, mass cocoa spraying programme, integrated

24 Ghana National Social Protection Strategy (GNSPS), Investing in people for a better Ghana, Ministry of Employment and Social Welfare (MESW), Draft, January 2012

agricultural input support, social security and national insurance trust (SSNIT), community-based rehabilitation programmes for persons with disability among others.

2.3. Selection and Identification of Beneficiaries for the Social Protection Programmes in Ghana

A critical issue faced by all countries in developing social protection systems is how to select beneficiaries. The numbers of people in need are huge and place excessive demands on a country's financial resources. The Ghana National Household Registry (GNHR) is a unit established under the Ministry of Gender, Children and Social Protection (MoGCSP) with the mandate to establish a single national household register from which social protection programmes are to select their beneficiaries in Ghana. The registry launched in October 2015 is part of the efforts by the Government of Ghana to sustain and deepen the progress made in poverty reduction by ensuring that a larger share of benefits of social protection interventions goes to the extremely poor and vulnerable. **Thus, the two main criteria for selecting beneficiaries for Ghana's social protection programmes are poverty and vulnerability**.

The national social protection policy identifies three main vulnerability categories as follows:

- The Chronically Poor: such as the severely disabled; terminally ill; rural unemployed; urban unemployed; and subsistence small-holders;
- The Economically at Risk: including food crop farmers, persons on the street, refugees and internally displaced persons, orphans, informal sector workers, widows, older persons and migrants;
- The Socially Vulnerable: comprising PLHIV, tuberculosis sufferers, victims of domestic violence, homeless persons, people living on the street, internally displaced persons and female-headed households, amongst others.

2.4. What the National HIV and AIDS Policy and Strategic Plan say about Social Protection

Since the first case of HIV was recorded, in 1986, Ghana has proactively responded to it including the establishment of the National AIDS/STI Control Programme (NACP) in 1987, the Ghana AIDS Commission (GAC) in 2000 and the preparation and execution of National HIV and AIDS Strategic Frameworks/Plans and policies. The current National HIV and AIDS Policy[25] provides the overarching perspective, position and direction of Ghana, as it continues on its journey to reach the fast track targets and ultimately the SDG 3 specific target 3.3 which calls for an end to the epidemic of AIDS by 2030. In addition to ending the AIDS epidemic, Ghana, through this policy, intends to ensure that the impact of HIV and AIDS on the socio-economic life of people affected and living with HIV, in Ghana, ceases to be of public health and socio-economic concern.

The policy, therefore, sets out to achieve four objectives with the second and third objectives being to ensure the availability of and accessibility to prevention, treatment, care and support service and to mitigate the vulnerability and social and economic effect of HIV on persons infected and or affected by HIV. Part of the desired outcomes is that persons at risk of, affected by and living with HIV can live a life free of stigma, discrimination and economic hardship on account of HIV by providing social protection to persons affected and or living with HIV.

25 National HIV and AIDS Policy, Universal Access to HIV Prevention, Treatment and Care Services towards Ending AIDS as a Public Health Threat, Ghana AIDS Commission (GAC), September 2019

The National HIV and AIDS Strategic Plan (NSP) 2021-2025[26] as in the case of the policy, also recognizes the importance of providing social protection services to persons infected, affected or at risk of HIV in the country. With the goal to achieve epidemic control and the fast-track targets of 95-95-95 by 2025, one of the strategic objectives of the NSP 2021-2025 is to mitigate the social and economic effect of HIV on persons infected and or affected by HIV.

One key activity under the NSP 2021-2025 is linking PLHIV households and OVC severely impacted by the HIV and AIDS epidemic to appropriate social protection programmes such as the government-run Livelihood Empowerment Against Poverty (LEAP) programme and social services provided by NGOs and FBOs. Mention is also made (under the emergency preparedness response section) of the enrolment of all PLHIV on the NHIS as it will enable them to better withstand and recover from crises.

Sections of the GAC Act 2016 (ACT 938) were established to protect the rights of PLHIV:

- Section 21 sub-section (1) of the Act, indicates that the object of the Fund is to provide financial resources for the national HIV and AIDS response to the target, in particular, HIV prevention, including the reduction of mother-to-child transmission, stigma reduction, treatment and care and support for persons living with HIV.
- Section 31 (on insurance benefits and other benefits) sub-section (1) states that the actual or perceived HIV status of a person shall not constitute a reason to deny or exclude that person from (a) the benefits of health insurance or terminate a health insurance contract, (b) entering into a life insurance contract, or (c) the enjoyment of any retirement benefit, social security or other rights the person may claim.
- Section 41 on interpretation defines "care and support" as including institutional and home-based health services and palliative care, psychosocial and financial assistance to undertake income-generating activities and support for comprehensive nutritional programmes for persons living with HIV or AIDS and periodic HIV testing and counselling.

Thus, the GAC Act supports the treatment, care and support as well as the health and socio-economic wellbeing or social protection of persons infected, affected or at risk of getting infected by HIV. According to the Ghana 2019 State of the HIV and AIDS Epidemic Report[27], Ghana implements an approved social protection framework that recognizes PLHIV, adolescent girls and young women, people affected by HIV (children and families) as key beneficiaries[28].

26 National HIV and AIDS Strategic Plan (NSP) 2021-2025, Ghana AIDS Commission (GAC), October 2020

27 The Ghana 2019 State of the HIV and AIDS Epidemic Report, June 2020, GAC

28 The Ghana 2019 State of the HIV and AIDS Epidemic Report, June 2020, GAC

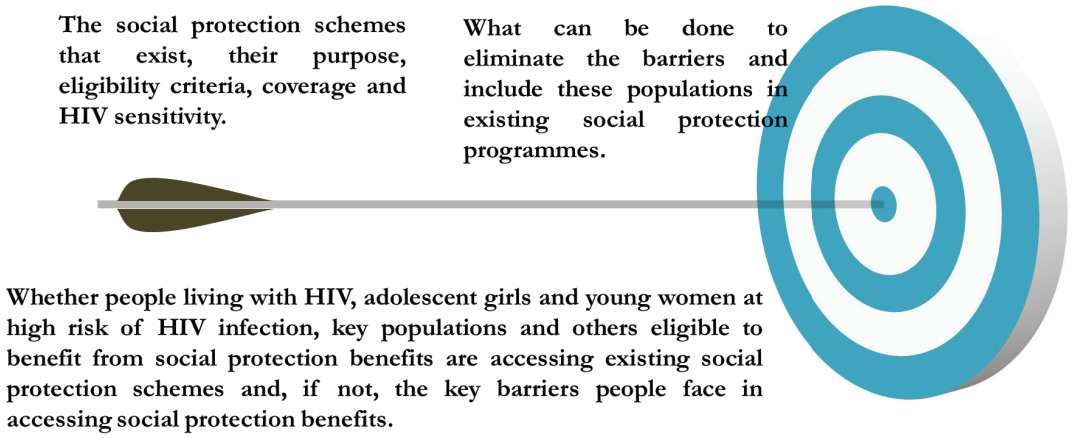
3.0. OBJECTIVES OF THE ASSESSMENT

The primary objective of the assessment was to provide tailored analysis on HIV and social protection. As stated above the main goal of the assessment was to provide information to support decision-making in strengthening the HIV sensitivity of social protection schemes to better reach PLHIV, adolescent girls and young women, key population etc. and inform the development of national policies.

The UNAIDS HIV and Social Protection Assessment Tool used for the exercise provided the country with tailored analysis on HIV and social protection to address the specific objectives which were:

- To fill the gap in-country evidence on HIV and social protection.
- To identify entry points for joint action on HIV and social protection such as:
  - reviewing the national social protection policies, programmes and schemes to make them HIV-sensitive,
  - supporting the development of HIV-sensitive social protection policies, programmes and schemes
  - as well as supporting the co-programming of HIV and social protection in national AIDS plans, poverty-reduction plans, development assistance plans and broader social policies.

Figure 2: Objective of the HIV and Social Protection Assessment



3.1. Assessment Questions

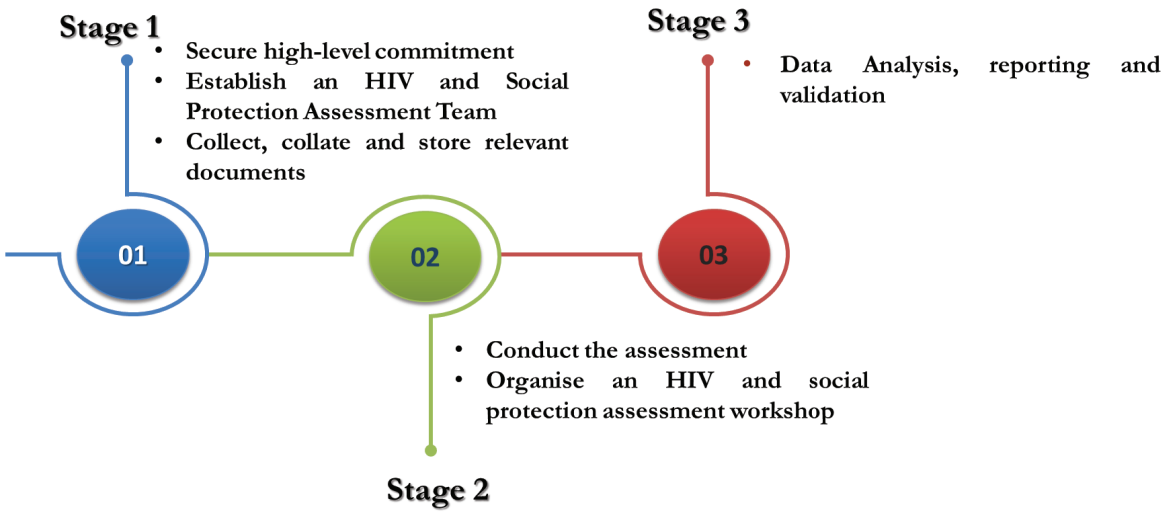
The assessment, therefore, sought to gather information on the following:

- The social protection schemes that exist in the country, their purpose, eligibility criteria, coverage and HIV sensitivity.
- Whether people living with HIV, adolescent girls and young women at high risk of HIV infection, key populations and others eligible to benefit from social protection benefits
    - are accessing existing social protection schemes
    - and, if not, the key barriers people face in accessing social protection benefits.
- What can be done to eliminate the barriers and include these populations in existing social protection programmes.
- Whether some NGOs/CSOs are implementing some social interventions targeting PLHIV and if yes, which interventions are they and which PLHIV groups are they targeting
- What are the recommendations for improving the HIV sensitivity of the national social protection programmes?

4.0. METHODOLOGY AND APPROACH FOR CARRYING OUT THE ASSESSMENT

This assessment led by the Ghana AIDS Commission (GAC) with financial support from the World Food Programme (WFP) was carried out in three (3) stages/phases (presented in Figure 3 and described in detail in the sessions below) between December 2020 and May 2021. The stages/phases involved stakeholder engagement and desk review, primary data collection using the HIV and Social Protection Assessment data collection tool and KII guides as well as data analysis, reporting and validation of the findings.

Figure 3: Stages for Conducting the Assessment



4.1. Stage One (1)

According to the protocol attached to the assessment tool, some key preparatory activities were to be carried out before the assessment and these included securing high-level commitment from the government agency leading the AIDS response in the country and other key stakeholders involved in social protection activities in the country, establishment of an HIV and Social Protection Assessment Team, as well as collection, collation, storage and extensive review of relevant documents. The Ghana

AIDS Commission (GAC), the key government agency leading the AIDS response commissioned the assessment with financial support from the World Food Programme's Ghana Country Office.

4.1.1. Securing High-Level Stakeholders' Commitment

Before the assessment was carried out there was the need for GAC to hold high-level discussions and engagements with policy and decision-makers as well as partners who have an interest in implementing the findings in order to secure their commitment in participating in the entire assessment and ensure implementation of the recommendations from this assessment. These stakeholders included development partners, government ministries, departments and agencies (MMDAs) responsible for the social protection programmes and interventions as well as NGOs and CSOs.

4.1.2. Establishment of the HIV and SP Assessment team

The assessment team was set up to provide overall strategic guidance and support for the assessment. The team members were representatives from the WFP and UNAIDS Country Offices, the Director-General of GAC, the Ag. Director of Research, Monitoring and Evaluation of GAC, the Research Coordinator and Research Officer of GAC, Deputy Programmes Manager of the National AIDS Control Programme (NACP), the National President and Secretary of NAP+, the Director in charge of Programmes Coordination of the Ministry of Gender, Children and Social Protection as well as the Consultant. Because of the Covid-19 pandemic most of the meetings and activities by the team were carried out virtually.

4.1.3. Extensive Engagements with key Stakeholders

As part of the first stage between December 2020 and March 2021 extensive engagements with key stakeholders concerned with policy/decision making and management of HIV and social protection as well as those with interest in the implementation of the findings were carried out at both the national and zonal levels. Representatives from relevant government ministries, departments and agencies, United Nations agencies and civil society representatives, including people living with HIV and representatives of other key populations, participated in the national and sub-national level stakeholders' engagement workshops.

For the sub-national stakeholders' engagement and data collection, the country was divided into 3 zones (northern, middle and southern) due to the similarities of demographic characteristics within these zones. The Northern Region represented the Northern Zone made up of Northern, Savannah, North East, Upper East and Upper West Regions; Ashanti Region represented the middle zone being made up of Ahafo, Bono, Bono East and Ashanti Regions and Central Region represented the southern zone being made up of the Greater Accra, Central, Eastern, Western, Western North, Oti and Volta Regions. All meetings held for these national and sub-national level engagements were documented; records of the list of the names and organizations of the participants for both the national and zonal workshops have been included in the Appendix to demonstrate wide stakeholder involvement in the assessment.

Two (2) stakeholders' workshops were held at the national level. The first workshop which was carried out virtually introduced the national level stakeholders to the assessment, the purpose for the assessment and the methods to be used to carry out the assessment including an introduction to the UNAIDS HIV and Social Protection Assessment Tool. The second national workshop (which was also virtual) was used to give the stakeholders an overview of the Social Protection efforts in Ghana, the

five flagship national social protection programmes, case studies situations of some very poor PLHIV and why the need for social protection for the poor and vulnerable persons living with, affected by and at risk of being infected by HIV especially the adolescent girls, women and caregivers of OVC as a result of HIV. Participants were once again taken through the HIV and SP Tools to ensure they could contribute to the completion of the tools. The third national stakeholders' workshop was used to complete the tool for the national level.

The zonal stakeholders' engagement involved two-day workshops each at Tamale, the capital city of the Northern Region for the Northern Zone; at Kumasi, the capital city of the Ashanti Region for the Middle Zone and at Elmina of the Central Region for the Southern Zone. Just as was done for the national level engagement, the participants of the zonal level stakeholders' workshops were introduced to the purpose for the assessment, the methods to be used to carry out the assessment including an introduction to the UNAIDS HIV and Social Protection Assessment Tool and an overview of the Social Protection efforts in Ghana, the five-flagship national social protection programmes. The second day of the zonal workshops was used to complete the HIV and SP Tool for the zonal level.

4.1.4. Collation, Collection and Review of Key documents

As indicated in the guidelines attached to the UNAIDS HIV and SP Assessment tool, an extensive collation, collection and desk review of key national and subnational level documents on HIV and social protection was also conducted as part of this phase. This is because not all the issues of HIV and social protection in the country could be captured or assessed using the tool. Thus, the information gathered from the extensive review of these documents formed the background for this assessment, were used to complement and validate the information gathered using the tool and are presented as part of this report. The desk review continued throughout the study in order to compare the findings and base the recommendations on best practices and lessons learnt. The list of all the documents reviewed is included in the Reference section of this report.

The documents reviewed as part of this assessment included:

- the National Social Protection Policy (2015),
- the Ghana National Social Protection Strategy (2007 revised in 2012),
- the National HIV and AIDS Policy
- the National Strategic Plan (2021-2025),
- the Global AIDS Strategy 2021-2026,
- the UNAIDS 2011 HIV and Social Protection Guidance Note,
- the 2017 Ghana Multiple Indicator Cluster Survey,
- the 2019 National and Sub-national HIV and AIDS Estimates and Projections,
- the 2019 State of the HIV and AIDS Epidemic Report, etc.
- documents on HIV and social protection from other countries,
- reports from the implementation of the National Social Protection Programmes
-

4.2. Stage Two (2)

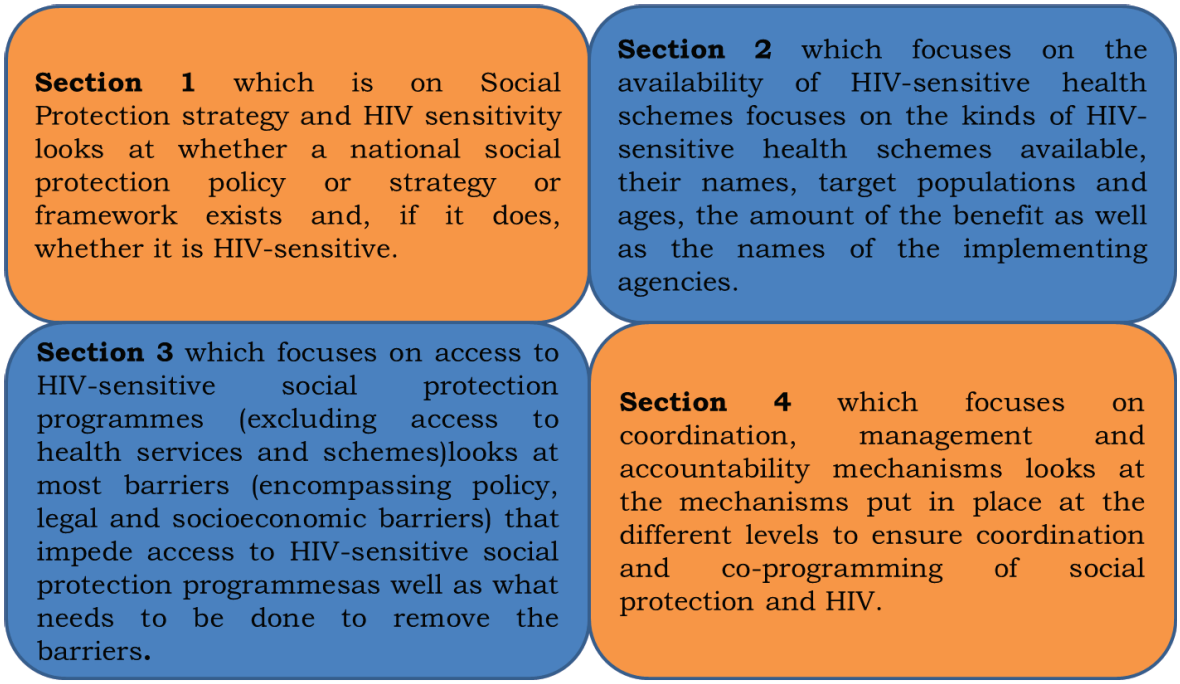
Stage 2 involved primary data collection at the national and zonal levels using the HIV and Social Protection Assessment Tool developed by the Joint United Nations Programme on HIV and AIDS (UNAIDS), and key informant interviews using KII Guides. Secondary data used to complement and

validate the primary data was gleaned from the documents reviewed. Thus qualitative methods were used for the collection of the data for the entire assessment.

4.2.1. Data Collection Using the UNAIDS HIV and Social Protection Assessment Tool

The UNAIDS HIV and Social Protection Assessment Tool which was the main tool used for the primary data collection is made up of four (4) sections.

Figure 4: Sections for Primary Data Collection



The third national stakeholders meeting which was a one-day face-to-face workshop (all Covid-19 protocols were observed), was purposefully used for the completion of the tool for the national level. At this workshop, a presentation on the different categories of social protection interventions was made which was intended to assist participants to complete or fill in the HIV and social protection assessment Tool after which the participants were divided into groups to complete the various sections of the tool.

Each of the groups presented their work after the group exercises and the entire team of participants accepted the groups' works which were pulled together and adapted as the completed HIV and Social Protection Assessment Tool for the national level. It must be noted that the Programmes Coordinator and Focal Person of the Aged from the Ministry of Gender, Children and Social Protection (MoGCSP), who is a member of the Assessment Team, played a very important role in providing further information and clarifications for the participants on the various categories of social protection interventions in the country whiles they were completing the tool. It must also be noted that some of the experts who could not participate in the final face-to-face national workshop to complete the tool sent their inputs to the assessment team to be added.

In addition to the information collected using the tool, the national level participants carried out an exercise to score HIV Sensitivity of the national social protection programmes. This was based on the

discussions that had been held while completing the tool on the social protection efforts in Ghana and whether the programmes were targeting persons infected, affected or at risk of being infected by HIV.

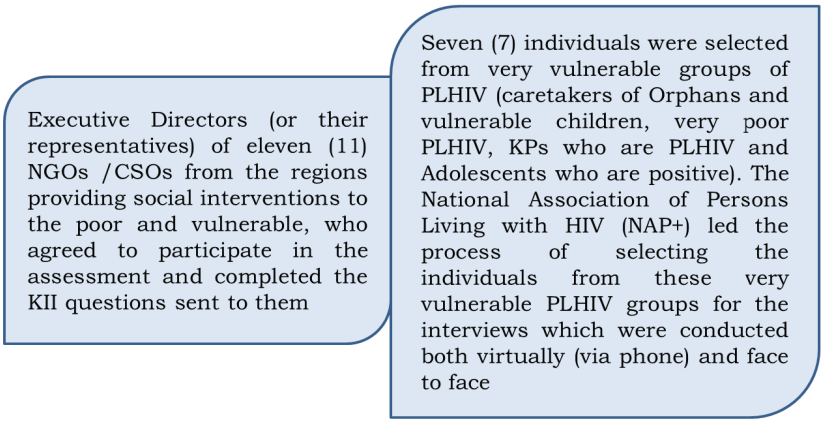
The criteria used for considering and scoring the HIV sensitivity[29] [30] of the national and sub-national level social protection programmes included whether there existed an approved national social protection strategy, policy or framework, and whether the strategy, policy or framework refers to HIV and recognizes people living with HIV, key populations, adolescent girls and young women, children and families affected by HIV as key beneficiaries.

Thus, the scoring exercise was to assess or score the degree to which people living with, at risk of or affected by HIV are considered and included in the design and implementation of social protection schemes. On a scale of one to ten (1 being the lowest score and 10 being the highest), each participant was asked to give a score for the level of HIV sensitivity of the national social protection programmes giving reasons to why they gave such scores. The average of the scores given by all the participants was taken to represent the average score the national level participants gave to the degree of HIV sensitivity of the national social protection programmes.

This method of completing the HIV and SP tool was replicated at the zonal level (for all three zones). Prior to the zonal level data collection, the Regional Technical Support Units (TSUs) Coordinators of the Ghana AIDS Commission and their M&E Officers, who have constant interactions with the target groups for this assessment in the regions, districts and at the community level, were trained using the Assessment Tools. These regional teams were supported by a team from the national level (made up of the Consultant, the Ag. Director for RM&E, the Research Coordinator and the Research Officer all of GAC), to lead the zonal stakeholders' engagement and data collection at the zonal level.

4.2.2. Key Informant Interviews using the KII Guides

In order to gather further in-depth information to support and complement the qualitative responses gathered from the national and zonal stakeholders' workshops using the Assessment Tool, key informant interviews (KIIs) were conducted via phone using KII guides (copies attached in appendix). The KIIs became necessary instead of the FGDs initially planned because of the Covid-19 pandemic and they involved two categories of respondents:



29 HIV and Social Protection Guidance Note, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011

30 HIV - sensitive social protection: what does the evidence say by Mariam Temin, UNAIDS 2010

4.3. Stage Three (3)

The third stage/phase included data analysis, reporting and validation of the findings. Based on the information gathered, an analysis informed by the tool was conducted and recommendations were drafted. The main questions of the assessment guided the analysis of the information that was collected using the tool and when applicable the suggested analysis format described in the protocol included in the assessment tool was used.

In addition to the information collected using the tool and in order to provide more in-depth information to complement and clarify the responses from the tool, the responses from all the KIIs (of the 11 NGOs and the 7 PLHIV) were transcribed and the emerging issues were summarized and presented as part of the results and findings of this assessment. Findings from the assessment have been reported clearly and simply with graphics that convey the key issues identified and key messages to be taken into consideration. An executive summary has also been extracted from the main report and has been made available during the validation meeting for easy assimilation of the main findings and recommendations of the research.

The report was shared and endorsed by key HIV and social protection stakeholders and actors in a public event (national stakeholders' workshop) to increase the visibility and awareness of the findings and to generate political and stakeholders' support for the implementation of the recommendations. Relevant high-ranking government, United Nations, donor and civil society representatives, including people living with HIV and representatives of other key populations, were invited to participate in the validation of the assessment report. Comments and inputs from the validation exercise were used to revise and finalize the assessment report.

4.4. Limitations

One major limitation was the non-availability of segregated data on the estimated sizes of the populations or groups that were identified during the assessment as vulnerable and facing barriers in assessing the social protection interventions. This made it difficult to estimate the sizes of these identified vulnerable populations at both the national and sub-national levels.

Another area of possible limitation was the process of individual scoring of the HIV-sensitiveness of the national social protection interventions/programmes. Apart from the score derived after using the eight HIV-sensitivity criteria, the team came up with a scoring procedure where individuals that participated in the completion of the tool were to give their scores (from a scale of one to ten) and provide reasons why they gave such scores. Though the HIV-sensitivity criteria were some of the reasons given for the individual scores it is expected that the individual scores could be subjective depending on the individuals' knowledge about the accessibility of the social protection programmes by persons living with, affected or at risk of being infected by HIV. Yet the average score given at the national level was almost the same as the average scores given for all three zones, and hence it can be said that the limitation presented by the scoring process was very minimal.

A few challenges were also encountered during the period of this assessment hence presenting other forms of limitations. It must be noted that this assessment was carried out during the period of the Covid-19 pandemic and hence the initial estimated three months' duration for the completion of the study by the Assessment Team during the inception meetings, extended to six months (from December 2020 to May 2021). This was because the team had to re-strategize several times to convert some

of the stakeholders' engagement workshops planned to have been carried out in person into virtual meetings and this resulted in several postponements of some of the meetings.

Additionally, because a lot of the stakeholders were not very familiar with the Assessment Tool, they had to be oriented and taken through the sessions of the tool several times for them to be able to complete it. However, because of the second wave of the covid-19 pandemic, some stakeholders who had been taken through several tool-completion exercises and had been invited for the face-to-face workshop to complete the tool could not participate in the final exercise. Yet some who could not participate in the face-to-face workshop submitted their inputs via email to help in the filling in of various sessions of the tool.

Despite the presence of these few challenges and limitations, the Assessment Team is confident that very good efforts were put in to conduct this assessment in order to capture and gather all the information needed as prescribed by the guidelines accompanying the assessment tool. Hence the Team considers the results presented in this report to be of the best and highest possible quality.

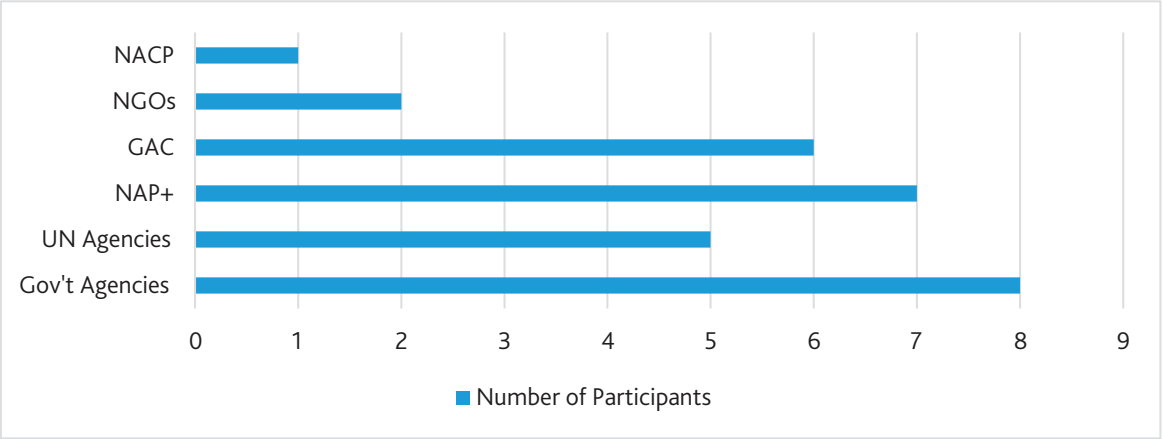
5.0. RESULTS AND MAIN FINDINGS

This session highlights the most important findings organized around the assessment questions. As indicated in the limitations session above, this assessment took a total of six (6) months (from December 2020 to May 2021) to complete from the unset of extensive desk reviews, stakeholders' engagements through the completion of the assessment tool for the national and zonal levels, through to the conduct of the KIIs, the analysis of the results and compilation of the report as well as stakeholders' validation.

5.1. Representativeness of Contributors for the Completion of the Tool at the National and Zonal Levels

A total of twenty-nine (29) people contributed to the completion of the Assessment Tool at the National Level **(list of contributors and their organizations is attached in the appendix)**. These included 16 females and 13 males. As presented in **Figure 5 below**, eight (8) of them were from government agencies that implement social protection interventions including the Ministry of Gender Children, Ministry of Local Government and Rural Development and the National Health Insurance Authority; Seven (7) from the National Association of PLHIV (NAP+); five (5) from UN agencies (WFP, UNAIDS and UNICEF); two (2) from NGOs involved with the implementation of social interventions for PLHIV and KPs; six (6) from the Ghana AIDS Commission (GAC) and one from the National AIDS Control Programme of the Ghana Health Service (NACP, GHS). The seven persons from NAP+ included adolescents and young people living with HIV as well as KPs living with HIV.

Figure 5: Distribution of participants from the different institutions and agencies that completed the tool at the national level



This representation of contributors from diverse and relevant institutions and agencies that implement social interventions at the national level was very essential to ensure the use of adequate and relevant information to complete the tool. However, it must be noted that out of this number only twelve (12) could participate in the final national face-to-face workshop to complete the tool and the rest either submitted their inputs via email to the assessment team to be added or provided key information to be used in completing portions of the tool.

Similarly, at the zonal level, the participants for the stakeholders' engagement workshop who also contributed to the completion of the tool were from the Department of Social Welfare (both Regional and District levels), Department of Community Development, Ghana Health Service, the District Assembly, NAP+, NGOs and Ghana AIDS Commission (Please refer to the Appendix for the participants' list for the three zones).

5.2. HIV Sensitivity of National Social Protection Programmes

The answers provided at the national and zonal levels for four (4) out of the eight (8) criteria for monitoring the HIV sensitivity of national social protection programmes[31],[32] were "yes" as listed below. It must be noted that all the eight HIV-sensitivity criteria were given the same weight.

- There is the existence of approved national social protection strategy[33] and national social protection policy[34]
- The approved national strategy, policy or framework on social protection
  - refer to HIV
  - recognize people living with HIV, adolescent girls and young women, children and families affected by HIV as key beneficiaries (but not key populations)
  - address the issue of unpaid care work in the context of HIV (through the GAC Act, 2016, Act 938)

The other four HIV-sensitivity criteria that the social protection programmes didn't meet are also described as follows:

31 HIV and Social Protection Guidance Note, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2011

32 HIV and social protection in GAM 2021, by Taavi Erkkola and Victoria Bendaud, UNAIDS Social Protection webinar, 23rd March 2021

33 Ghana National Social Protection Strategy (GNSPS), Investing in people for a better Ghana, Ministry of Employment and Social Welfare (MESW), Draft, January 2012

34 Ghana National Social Protection Policy, December 2015, Ministry of Gender, Children and Social Protection (MoGCSP)

- People living with, at risk of or affected by HIV are not included in the design and implementation of the social protection schemes.
- The social protection programme targets do not specifically accelerate actions that remove barriers to accessing social protection services by people living with, people at high risk of contracting HIV infection including adolescents and young women and key populations as well as people affected by HIV including orphans and vulnerable children.
- There is limited knowledge about or awareness of the existence of the social protection programmes by persons living with, affected or at risk of HIV who are supposed to be beneficiaries of these services
- The inability of these groups that the programmes seek to target to access (or very low level of access to) these programmes and services.

Thus, based on the 8 HIV-sensitivity criteria, even though the national social protection programmes can be considered as being HIV-sensitive the overall level of sensitivity is 4 out of the 8 (based on the sensitivity criteria) – that translates into 50% level of HIV-sensitivity. This corresponds very well with the average scores given at the national and zonal levels (approximately 5 out of 10 also translating to 50%)

5.2.1. National and Zonal Scoring of the HIV-Sensitivity of Social Protection Programmes in Ghana

At the national level, the scoring exercise was carried out at the face-to-face stakeholders' workshop for completing the assessment tool. The scoring was generally on all social protection programmes but not the different types of social protection programmes. Seven (7) out of the twelve (12) participants gave their scores as presented in Table 1 below. Four (4) of the participants had left the workshop before the time for the scoring exercise and hence didn't participate. The Consultant who facilitated and oversaw the scoring exercise also didn't participate in the scoring.

Table 1: HIV-Sensitivity Scoring by participants of the National Level Workshop

Participant	Score
1	5
2	5
3	7
4	3
5	4
6	3
7	6
Total Score	**33**
Average Score	**33/7 = 4.71**
	Approximated to a score of 5 for the national level

Thus, the total score was 33 and the average score was 4.7. Reasons given by the participants for the scores they allocated are presented in the text box below. Similar scores and reasons were given by

the participants of the three zones and their average scores were 5.1 for the southern zone, 4.7 for the middle zone and 4.8 for the northern zone – all these scores rounded up to the nearest whole numbers give scores of 5 each **(refer to appendix for details of the scores at the zonal level)**. Again, the reasons they gave for allocating such scores were similar to those given by the national level participants.

Reasons for the HIV-sensitivity Scores given at both the national and zonal levels

- The social protection programmes are HIV-sensitive but persons living with, affected by and at risk of being infected with HIV are not prioritized. The interventions are not specifically targeted at the poor PLHIV
- Social Protection interventions for PLHIV are mentioned in the strategy and policy documents for SP in Ghana but persons living with, affected by or at risk of being infected with HIV are not considered during the implementation of those strategies and policies
- Children, adolescents and the aged who are among the vulnerable groups do not have access to these interventions
- All the social protection interventions are made to target the very poor and vulnerable in society however knowledge about and access to these programmes and services are generally low among these groups that the programmes seek to target. The coverage is low and that means that less PLHIV will benefit.
- PLHIVs are not wholly involved in the formulation and implementation of policies that affect them.

5.3. Information Gathered Using the Assessment Tool

5.3.1. Accessibility to Health Services Operational in Ghana

Given the critical role the health sector plays in the AIDS response, a section on health services is included to understand the different health schemes that exist to increase access to health care and identify opportunities for increasing access to health care for people living with, at risk of or affected by HIV. Session two of the UNAIDS HIV and Social Protection Assessment Tool, therefore, focused on the different health schemes and services available in the country.

Populations and groups that face most barriers in accessing the health schemes and hence are considered as vulnerable both at the national and sub-national levels were listed and those listed included:

- Extremely Poor PLHIV and their households (especially women, widows)
- Adolescents PLHIV in boarding facilities
- Aged/Elderly PLHIV
- PLHIV in rural areas and people from hard-to-reach areas
- PLHIV with severe disabilities
- Illiterate PLHIV
- OVC by HIV
- Women especially those who are PLHIV and sacked from their homes and widows
- KPs (MSM, FSW, IDUs) especially those who are PLHIV
- Pregnant and lactating mothers
- Young persons (especially young girls) in the streets and at-risk (homeless e.g. Kayayei)

- Unemployed youth
- Refugees

Information used to complete this session and the rest of the sessions were from very diverse sources including:

- MoGCSP/Social Protection Directorate, Annual Report 2019/GPSNP/ LEAP,2019
- MoF, MoGCSP, GHS/NHIA, National Health Insurance Act 2012, (Act 852)
- MoGCSP and NADMO Annual reports
- MoGCSP and Ghana School Feeding Programme (GSFP) Annual reports, School Feeding Coordinators
- Private Insurance Companies/Schemes; the websites of the companies and Beneficiaries of private insurance schemes
- Free SHS Secretariat,
- Scholarship Secretariat
- MoGCSP/GSFP and Ghana Education Service, National School Feeding Policy, 2015
- MLGRD Reports, 2019 Annual Project Report (RDCU)
- Ghana Federation of Disability.
- Health Staffs,
- Staff from DSW& DCD, NCCE, GES, at all levels and MMDAs,
- Anecdotal information from Public Knowledge and Grapevine
- Staffs of NGOs,
- Social Media Platforms, Media (TV & Radio Stations), News, Internet searches etc.

The various health schemes available in the country, the name of the schemes, target populations and their ages as well as the names of implementing agencies or institutions are listed in Table 2 below. Key among these health schemes is the National Health Insurance Scheme (NHIS) being implemented by the National Health Insurance Authority and the Ministry of Gender, Children and Social Protection (under the LEAP beneficiaries' category that targets specific population groups). Other schemes listed included private health insurance schemes (including the insurance schemes by Telcos) and other in-kind support provided to poor and vulnerable groups by the District Assembly, political parties, radio stations, telcos, MPs, NGOs and CSOs, churches, keep fit clubs and other individual philanthropists.

The most common barriers that prevent access to health care for people living with, at risk of or affected by HIV (especially those groups listed above) and the activities to be carried out to remove those barriers are also listed in Table 3 below.

The common barriers listed included:

- Stigma and discrimination
- Poverty /Financial barrier for renewal, no financial resources to register for the NHIS and Lack of funds for T&T to NHIA Registration Centres
- Insufficient information and low knowledge about the existence of the health schemes available as well as the benefits from these schemes
- Geographical and physical access/distance and location of the offices and stress associated with enrolment process to the scheme including long waiting time at registration Centres
- Gender inequality to services including gender stereotyping
- Unfriendly attitude of some NHIA officials

The key activities suggested to be carried out to remove these barriers include:

- Advocacy against stigmatization including education on the various myths and misconceptions on HIV among the general population as well as training of Health Service Providers on stigma reduction
- Livelihood empowerment by providing training in skills to economically empower and financial support in terms of loans and credits to engage in productive business
- Awareness creation about the existence of these schemes, the benefits and how to access them
- Fee waivers for all vulnerable groups (conditional exemption for PLHIV on NHIS) and expanding services under NHIS to cover OIs and all lab costs as part of treatment for PLHIV
- Identify reasons for non-enrolment of the vulnerable groups and take steps to address inclusion of all these vulnerable target populations
- Make access easy for all eligible groups especially the vulnerable and poor
- Increase active membership contributions to improve resource mobilization and ring-fence the NHIL
- Mainstream gender equality (ensure elimination of gender stereotyping)
- Train NHIA officials and all officers involved in the implementation of the various health schemes on good customer services
- Appeal to private operators to reduce subscription fees in order for as many people as possible to subscribe to the services

The other barriers that specifically apply to some specific health-related schemes and services for the poor and vulnerable were also listed. The Free Transport System, for example, was deemed to be a very good initiative but the key barrier was its non-availability in most regions and hence it was suggested that the scheme should be extended to all regions. The rest are presented in the text boxes below.

Barriers associated with the Department of Social Welfare Central Destitute Infirmary

- Limited knowledge or awareness on the existence of the facility or service.
- Insufficient resources for operations, such as staff and logistics.

Activities to remove these barriers are:

- Create awareness of the existence of such a facility,
- Subventions should be released regularly and on time for the running of the facility,
- The Centre should be adequately staffed and be provided with the needed logistics for effective operations

Barriers associated with the Orphanages (residential) and children's homes –

- Limited funds of foster homes and orphanages to cater for the OVC and hence very few people interested in providing foster care.

Activities to remove these barriers are:

- The plight of such homes should be publicized by media (within the protocols) to solicit funds for the upkeep of the OVC as the nation embarks on the deinstitutionalization process
- Tax incentives should be given to people (foster care parents) who take up foster care of OVC and those who provide support for residential homes for children

Barriers to other in-kind support/public-private charity

- Inability of some of the vulnerable to access this help due to distance especially for people in hard-to-reach communities,
- Over publicizing of in-kind support in the media (that may lead to stigma)
- Irregularity of in-kind support

Activities to remove these barriers

- Encourage philanthropists to reach out to the aged in remote areas.
- Hard to reach communities to be specifically targeted
- Efforts to be made to shield the identities of beneficiaries (people don't want their identity to be known because of stigma),
- More private institutions, churches, NGOs/CSOs and philanthropists etc. should be encouraged to reach out regularly to the vulnerable

Barriers to the two Feeding programmes – (GSFP and Nutrition Programme in some health facilities)

- Not all public schools are covered and not all health facilities are covered as well (selected few) – review targeting criteria
- Quality of food is sometimes poor,
- Delay in release of funds –

Activities to remove these barriers

- All public schools should be covered and all health facilities should be covered;
- The need for strong supervision to ensure the quality of food is improved qualified caterers should be engaged
- Timely release of funds to caterers

Barriers that were associated with the COVID-19 Relief Support

- The COVID-19 Relief was limited to very few people due to inadequate funds to support large numbers of vulnerable PLHIV and those affected by HIV
- Inadequate data on the persons affected, at risk of and infected with HIV for them to be targeted appropriately

Activities to remove these barriers

- Engage and lobby relevant corporate institutions and create a "GOFUND" account to provide feeding support to very poor and vulnerable PLHIV during such emergencies
- There is the need for NAP+ to be supported to fully update the data on its members especially the very poor and vulnerable among them

Other specific barriers pertaining to specific vulnerable groups were also listed. For OVC for example the specific barrier to accessing these health schemes and services was the caregivers not having funds to purchase other drugs and laboratory investigations that are not covered by the NHIS and hence not seeing the importance of and not interested in registering the children. Educating the caregivers of OVC on the need for enrolling the children on the schemes is therefore very important to remove such a barrier and allow the OVC to access the service and other benefits available to them.

PLHIV with severe disability was another vulnerable group that was found to be facing specific barriers not common to the other vulnerable groups listed and hence it was worth drawing attention to such barriers by mentioning them in this report in order for measures to be put in place to remove them.

The barriers for PLHIV with disability:

- Most Offices are not disability friendly,
- Stress associated with enrolment process to the health scheme,
- Distance and location of the offices,
- Few caregivers and guides available to lead PHLIV with severe disability to the NHIA offices.

Activities to remove these barriers:

- Offices should be designed to be disability-friendly.
- More officers should be made available to enroll clients who are PLHIV with disabilities e.g. open more mobile service points within the communities
- The Ghana Federation of Disability should be appealed to provide guides/caregivers to its members when they are visiting NHIA offices.

Adolescents PLHIV in boarding facilities and young persons in the streets at risk of getting infected (homeless e.g. Kayayei) also came up as very key vulnerable groups with peculiar barriers in addition to the common barriers listed. For the adolescents in boarding facilities restrictions imposed by conditions of the boarding house were a key barrier and the suggested activity to remove it is for the Adolescent Treatment Supporters (CATS) to deliver drugs to them in the boarding house in collaboration with the health facilities they access ART services from. The "kayayei" need consistent education in SRH.

The last vulnerable group with peculiar barriers was PLHIV Women with very low income (including widows and those that had been sacked from home due to their HIV status). The barriers listed for this group included:

- Financial barrier to renewal and lack of basic needs especially for food
- Accessibility to the facilities (funds for transport to the facilities)
- Limited Knowledge about services
- Health scheme has lower priority for them
- Legal avenues for seeking redress for SGBV they experience either do not appear to function or take a long time for results to be achieved (the back and forth and bureaucratic processes discourage them)

The suggested activities to remove these barriers:

- Provide financial support to engage in productive business and link them to the LEAP cash transfer programme
- The NHIS should be free for them from age 60
- Identify this target population through the Community Health Volunteers and Social Workers and link them up with an existing, relevant and effective scheme and/or identify partnerships and interventions to address the needs of this population
- Violation of the rights of these women (through SGBV) should be addressed by ensuring policies against SGBV due to one's HIV status are strictly implemented and monitored

Table 2: Different Categories of Health Services and Schemes Operational in Ghana

Categories of health schemes	**Name of the scheme**	**Target population of the scheme**	**Age group of the target population**	**The benefit of the scheme**	**Name of the implementing agency(s)**
1. Taxation/government financing that offers free health services at point of use	NHIS	Universal for workers who pay tax and NHIS levy	All	Free health service at point of use	National Health Insurance Authority
2. Mandatory/social insurance that targets Specific population groups	NHIS	LEAP Beneficiaries	All age groups	Free health service at point of use	NHIA and LEAP, Ministry of Gender, Children and Social Protection (MoGCSP)
		Children	Up to 18 years		
		The aged	60+		
		Pregnant women and lactating mothers	All ages of pregnant women and lactating mothers		
3. Voluntary health insurance	Private Insurance Companies	Active working contributors and their families	Under 60 years	Varied benefits based on the policy and premium paid	Various Private Insurance Companies
4. Community based health insurance	Not operational in Ghana				
5. Other healthcare financing	Telcos	Opened to all adults who can afford	18+	Varied value depending on policy type and the premium paid	Various telcos
	Refund of hospital bills upon presentation of receipt by some companies	Employees and dependent	All employees, their spouses and dependants below 18 years	Refund of hospital bills upon presentation of receipts	Police Service, AGA, Health Foundation, MTN

6. Short-term housing	Department of Social Welfare Central Destitute Infirmary	Destitute Adults	Adults who are 18 years and above	Short term housing on need basis	Department of Social Welfare
	Orphanages (Residential) and Children's Homes	Children	Children below 18	Short term housing on need basis	Department of Social Welfare
7. Feeding programme	Ghana School Feeding Prog. (GSFP)	For pupils in targeted basic schools	5 -19 (school going age)	One hot meal a day	GSFP/MoGCSP
	Enablers Package and Nutritional Support Programmes for Health Facilities (Malnourished children, Multi Drug Resistance(MDR)TB Clients,	Malnourished Children MDR TB Clients	Malnourished children Below 15 And All ages of MDR TB Clients	Nutrition supplements and fortified foods	Ghana Health Service (TB Control Program), Ministry of Health
8. Transport scheme	EBAN Card, Ayalolo Bus & Metro Bus	Aged and school children	Aged Above 60 Children below 18	Free bus ride within the city of Accra	Ghana Urban Transport Metro Mass Transport MoGCSP/GSFP
9. Other in-kind support (specify)	NHIS Exemptionand Free Health screening for School Children,	For children in Public Schools	5-15yrs	Free health screening	Ghana Health Service (GHS)
	Free maternal care for pregnant women and lactating mothers	Pregnant women	No age limit for pregnant women	Free maternal health care	GHS
	District Assemblies, Political Parties, Radio Stations, MP's, NGO's, Churches, Individuals, Keep fit clubs	Poor and vulnerable groups, PWDs, PLHIV, Orphans, Homeless	All age groups	Dependent on the situation, the amount is not fixed	District Assemblies, Political Parties Radio Stations, MP's, NGO's, Churches, Individuals, Keep fit clubs

Table 3: Common Barriers in Accessing Health Schemes and Suggested Measures to Remove them

S/N	Common Barriers	Measures to Remove the Barriers
1.	Stigma and discrimination	Advocacy against stigmatization and discrimination against PLHIV and KPs Training of Health Service Providers on stigma reduction Education on myth on HIV targeted at wider population
2.	Poverty /Financial barrier for renewal No financial resources to register for the NHIS Lack of funds for T&T to NHIA Registration Centres	Fee waivers, Livelihood empowerment Provide training in skills to economically empower so they can pay the premium Financial support to engage in Productive business
3.	NHIS does not cover all laboratory costs but only Viral load tests	Expand services under NHIS to cover OIs and NHIS should cover all lab costs as part of treatment
4.	Not all are enrolled on NHIS for various reasons e.g., not being identified as a target group for support	100% exemption for PLHIV on NHIS Identify reasons for non-enrolment and take steps to address inclusion of all these vulnerable target populations
5.	Limited information and low knowledge about the existence of the health schemes available as well as the benefits from these schemes	Awareness Creation about the existence of these schemes, the benefits and how to access them
6.	Geographical and physical Access/Distance and location of the offices	Provide the infrastructure, Make available the NHIS facilities in the various communities Open More officers should be made available to enrol clients Community outreaches on HIV services and SP schemes
7.	Stress associated with enrolment process to the scheme Long waiting time at registration Centres and /or Process for Indigents Registration (even at the community levels) under the LEAP those in the neighbouring communities	Promote reintegration schemes Make Access easy for all eligible groups especially the vulnerable and poor
8.	Coverage of schemes and services still not optimal	Increase coverage to include all PLHIV especially those that are vulnerable and poor
9.	Revenue put into consolidated fund Few individuals are active contributors	Increase active membership contributions to improve resource mobilization and Ring-fence the NHIL

10.	Gender inequality and stereotyping in services and interventions especially those that are labour intensive	Mainstream gender equality in these SP programmes and interventions, ensuring the elimination of all forms of gender stereotyping
11.	Unfriendly Attitude of some NHIA officials	Train NHIA officials and all officers involved in the implementation of the various health schemes on good customer services
Appeal to private operators to reduce subscription fee in order for as many people as possible to subscribe the services		

5.3.2. Availability of and accessibility to HIV-sensitive Social Protection Schemes (excluding health schemes)

This section gathered information to establish the focus and coverage of existing social protection programmes. It looked at the kinds of social protection programmes available and operational in the country, their names, target populations and ages, as well as the names of the implementing agencies. Information on most policy, legal and socioeconomic barriers that impede access to these social protection programmes by the vulnerable populations that were identified at both the national and sub-national levels. This section also looked at what can be done to remove the barriers to accessing HIV-sensitive social protection programmes for these populations.

Listed in Table 4 below and the textbox are the various categories of social protection programmes in Ghana implemented both at the national and sub-national levels. Out of the 14 categories of social protection programmes listed in the tool, only one (1) – the Non-Contributory Pension, was not operational in Ghana.'

The types and names of the various programmes under the various categories are:

- Conditional Cash Transfer – LEAP, SSNIT Pension Scheme, GOG Pension Scheme, District Assembly Common Fund (DACF) for PWDs, Teachers and Nursing Training Allowance, Student Loan Trust Fund and Guide allowance (for PWDs)
- Unconditional Cash Transfer – LEAP, Scholarship benefits in cash, School Maintenance Allowance (for brilliant but needy students)
- Scholarships – Study leave with pay, GETFUND Scholarship, International Scholarship, Cocoboard Scholarship and Private Scholarships
- Fee Waivers – Free Basic Education and SHS, Social Welfare facilitated treatments for paupers/poor patients, Tax Relief for PWDs and Educational Fee Waivers (for brilliant but poor students)
- Food and Nutrition Programmes – Ghana School Feeding Programme, Nutrition Enablers Package (TB/HIV clients), Iron Supplementation for Adolescent Girls
- Public Works Programmes – Labour Intensive Public Works, NABCO, Police Assistance Programme, Youth in Afforestation, Youth in Agriculture (for youth)
- Emergency Support – Emergency LEAP, Covid-19 Relief Support, NADMO Support, Ambulance Services, Integrated Social Services (Piloted in 60 districts nationwide - Disaster Management Emergency response to child protection)
- Other Regular Cash Payment – Capitation Grant

- Housing Subsidies - Accommodation in times of disaster, Housing allowance to Government workers, Housing schemes for some category of workers, Affordable Housing scheme (for all working-age groups)
- School Block Grants - Capitation Grant, GETFUND, DACF and Cooperate Social Responsibilities
- Teacher Support - Best Teacher Award Scheme and Study leave with pay
- Other In-Kind Support - Support from Philanthropists including parliamentarians, churches, CSO/NGOs etc.

It is obvious therefore from the lists that there are myriad categories and forms of social protection schemes and programmes being implemented in the country and hence with proper targeting, the poor and vulnerable especially those affected, at risk of and living with HIV should be benefiting from them. This will reduce their levels of poverty and vulnerability and in turn have a positive impact on the AIDS response in Ghana. Even though the criteria for benefiting in the LEAP cash transfers include PLHIV, the forms to be completed for people to be considered as beneficiaries does not have any portion where those completing the forms can indicate whether they are affected by or living with HIV. When inquired further it was explained that the main two inclusion criteria of poverty and vulnerability are also expected to result in the inclusion of most vulnerable and poor persons living with and affected by HIV.

The populations most likely to encounter the most barriers in accessing these social protection programmes (which according to the national social protection policy, are to be HIV-sensitive and target the poor and vulnerable) are as listed in the textbox below:

- Adolescents
- OVC
- Aged including those who are PLHIV
- Very poor households
- People with disabilities
- Key populations (Injection drug users,
- FSW and MSM)
- Hard to reach communities (people living in very remote areas)
- Low-income women
- Widows and pregnant women
- Indigenes
- Unemployed youth

The common barriers known to prevent these vulnerable populations of people at risk, living with or affected by HIV from accessing the social protection programmes and services in Ghana are listed in Table 5 below. About 13 barriers were listed including:

- inadequate knowledge and information about the social protection interventions that the vulnerable groups can benefit from; stigma and discrimination,
- improper targeting,
- poor physical access to the offices where these services are delivered;

- gender bias and stereotyping (especially for labour-intensive interventions);
- interference from influential officials and favouritism among others.

Important measures and activities to remove these barriers were also described and listed in Table 5 below. Among these measures are:

- Public education on the existence of the various programmes, who is to benefit and the various benefit packages from them;
- anti-stigma campaigns among the general population, beneficiaries and service providers;
- making the interventions easily accessible by removing impediments in the enrolment processes (and making the offices disability friendly);
- gender equality orientation and education for leaders or owners of companies that implement labour-intensive interventions
- active and intensified resource mobilization to enable the programmes to be extended to cover as many vulnerable populations as possible;
- detaching the programmes from political heads and influential people so the inclusion and exclusion principles and criteria in identifying beneficiaries for these programmes can be adhered to
- as well as curtailing favouritism and nepotism among others.

Table 4: Different Categories of Social Protection Programmes in Ghana

Categories of schemes	Name of the scheme	Target population of the scheme	Age group of the target population	The benefit of the scheme	Name of the implementing agency(is)
1. Conditional cash transfer	LEAP (condition is to ensure all children are enrolled in schools)	Extremely poor households with OVCs,	Member of extremely poor HHs including OVC 0 to 15	GHC 64 a month for an eligible member household to GHC 106 for 4 or more eligible members of the HH	MoGCSP
	LEAP	Poor persons living with disabilities	15 to 39	GHC 64 a month	MoGCSP
	SSNIT Pension Scheme,	Aged OVCs, Aged	60yrs & above	Depends on amount contributed	Social Security and National Insurance Trust (SSNIT)
	GOG Pension Scheme	Aged	60yrs & above	Depends on amount contributed	GOG pension trust
	DACF for PWDs	Persons with disabilities	All ages	Its sometimes in kind (provision of working gear and equipment such as sewing machines etc.	District Assembly
	Teachers and nursing training allowance	Teachers and nursing trainees	All ages	Monthly stipend	MOE and MOH
	Student loan trust fund	Tertiary students	18yrs & above	Depends on the amount requested for	Student loan trust
	Guide allowance (for PWD)	Youth	20yrs- 30yrs	-	Department of Social Welfare

	Microfinance and Small Loans Centre (MASLOC)	People in SMEs	Youth	Depends on the amount requested for	MASLOC
2. Unconditional cash transfer	LEAP	Extremely poor with PWD, Aged	All age groups	GHC 64 a month for an eligible member household to GHC 106 for 4 or more eligible member Household	MoGCSP
	Scholarship benefits in cash	School Bursaries to brilliant students from poor households	School going age	Depends on the amount of the bursary	Ghana Education Service and Scholarship Secretariat
	School maintenance allowance	Extremely poor government schools	15yrs & above	amount of the allowance not fixed for all, is on as needed basis	Government of Ghana & International Institutions GES/MOE
Scholarships	Study leave with pay	Private and public sector workers	Working age	Dependent on the amount of the school fees and stipend given	Scholarship secretariat
	GETFUND scholarship	Brilliant but needy student	19-50yrs	Amount depends on the level of education and the amount of the fees	GETFUND
	International Scholarship	Qualified Students	19-50yrs	Dependent on the level of education, amount of the school fees and stipend given	International Agencies
	Cocoboard Scholarship,	Brilliant students from Cocoa growing areas	19-50yrs		Ghana Cocoa Board
	Private Scholarships	Qualified Students	19-50yrs		Private Agencies/ Companies

4. Fee waivers	Free Basic Education and SHS	All students in public basic and secondary schools	All children of school going age	Free education	MoE and GES
	Social Welfare facilitated pauper treatments for poor patients	paupers	all ages	Free or subsidized treatment (amount depends on bill)	Department of Social Welfare
	Tax relief for PWDs	PWDs	working class	Tax relief	GRA
	Educational fee waivers	Bright but needy students	Up to 19yrs-	Depends on the fees	MMDAs-IGF
5. Food and nutrition programmes	School feeding programme	Selected public basic and SHS school	School age group	One hot meal a day	MoGSFP (Ghana School feeding program)
	Enablers Package	TB/HIV patients	All ages	Fortified foods	NTP/NACP (GHS)
	Iron supplementation	Primary school children	Primary one to 6	Daily provision of iron supplements	MoH/GHS iron supplementation. Ministry of Gender Children and Social Protection for School Feeding
6. Public works programmes	Labour Intensive Public Works	Poor HH mainly from LEAP and Communities and Youth from the project/ programme catchment area	18 and above	Rate per day is fixed at the National Minimum wage	Ministry of Local Government and Rural Dev't
	Nation Builders Corps (NABCO) Programme	Unemployed Graduates	18 to 40 years	GHS 700.00	NABCO Secretariat under Min. of Employment

	Police Assistance Programme	Unemployed Graduates	18 to 40 years	Between GHS 300 to 400.00	Nationa Youth Employment Agency (NYEA)
	Youth in Afforestation	Unemployed Youth	18 to 40 years	Between GHS 400.00 to 700.00	Forestry Commission and
	Youth in Agriculture	Unemployed Youth	18 to 40 years	Beneficiaries are provided with the initial support depending on their programme of interest	Min.of Agriculture
7. Emergency support	Emergency LEAP and NADMO support	Poor HH also affected by crisis	All categories	Food, Blankets, clothing and temporary accommodation	MoGCSP Ministry of Interior/NADMO
	Ambulance Services	Emergency cases	All ages	Being provided with emergency health care and conveyed by an ambulance o the health care centre	National Ambulance Service
	Integrated Social Services (Piloted in 60 districts nationwide) Disaster management and				
Emergency response to child protection issues	Response to Child Protection Cases	Below 16 years	-	Dept. of Community development and Social Protection Directorate	

8. Other regular cash payment	Capitation Grant	All public basic schools	Basic schools – Primary 1 to JHS 3	Financial support provided for the repairs of school buildings (amount is dependent on the type of repairs)	Ministry of Education / Ghana Education Service
	MPs Common Fund	Vulnerable	All ages	Support in cash or kind	Member of Parliament
9. Housing subsidies	Accommodation in times of disaster	Disaster Victims (survivors)	All ages	Temporary or permanent accommodation	Ministry of Works and Housing in collaboration with NADMO
	Housing allowance to Government workers	categories "A&B" and its analogous grades	From 30 years and above	Between 25% to 40% of ones salary	Controller and Public Service Commission
	Housing schemes for some category of workers	teachers, health workers, police, prison officers, military officers, mine workers	Working class	Housing accommodation of various kinds with various kinds of payment arrangements	GES, GHS, Police Service, GAF, Mining Companies
	Affordable Housing scheme	All working class	Working Class	Housing accommodation of various kinds with various kinds of payment arrangements	Ministry of Works and Housing
10. School block grants	Capitation Grant	For Minor repairs and renovation of school blocks	Schools in need	Minor repairs and renovation of school blocks	MOE and GES
	Ghana Education Trust Fund (GETFUND)	Building school blocks	Schools in need	Building of classroom Blocks and other school facilities	MOE and GES

	District Assembly Common Fund (DACF)	Building school blocks	Schools in need	Building of classroom Blocks and other school facilities	District Assemblies
	Cooperate Social Responsibilities	Building school blocks	Schools in need of school blocks	Building of classroom Blocks and other school facilities	NGOs/CSOs and Cooperate bodies
11. Teacher support	Best Teacher Award Scheme	All Teachers	Working age	Various wards for various categories at different levels	GES
	Study leave with pay	Qualified teachers who have served three years and above	25 years to 50	Beneficiaries salary	GES/MOE
	laptops to teachers	all teachers	Working class	Laptops	GES/MOE
	teachers training allowance	all teacher trainees	Working class	Monthly stipend	MOE
12. Other in-kind support	Support from Philanthropists CSO/ NGOs	All categories of people	All ages	Various in-kind support	Individuals CSOs/NGOs

Table 6: Common Barriers to accessing the social protection interventions and services and measures to remove them

S/N	Common Barriers	Measures to remove the Barriers
1.	Limited access to information on the programmes, the categories of beneficiaries and the benefits from such programmes Poor information seeking behaviors among the vulnerable groups	Public education on the existence of the various programmes, who is to benefit and the various benefit packages from them Educate and encourage communities to seek information on services
2.	Fear of disclosure and Stigma/discrimination	Anti-stigma campaigns to sensitize the general public against stigma and discrimination (against PLHIV and KPS) should be intensified (all forms of stigma including self and perceived stigma) and Psychosocial counselling for those who have experienced stigma
3.	Not identified as or not included in part of the target group	Make all vulnerable PLHIV and KPs a target group by advocating for their vulnerabilities and needs to be considered and for them to be listed as target groups at the policy and programme level to facilitate their access to SP services
4.	Poor physical accessibility to the service points Access to the office because offices are not disability friendly	Bring the programmes to the people and make the programme's offices disability friendly
5.	Insufficient financial resources	Access to income-generating activities/ financial support Provide options to improve livelihood
6.	Identification of beneficiaries – The age criterion used for LEAP OVC does not allow an orphan above 14yrs to benefit from it	Adopt an effective targeting mechanism, Review the age bracket used in determining OVC beneficiaries LEAP programme
7.	Inadequate amount of benefit under the cash transfers	Increase or revise amount to reflect the current economic situation
8.	Poor linkage of the social protection interventions to other services that are accessed by the vulnerable populations	Link as many of the social protection interventions as possible to other services provided to the vulnerable groups. This will improve targeting and identification of beneficiaries e.g., link LEAP to ART services
9.	Limited resources for the programmes including inadequate numbers of skilled social workers to assess the situations and identify vulnerable and poor populations and limited resources to ensure programmes are implemented at scale	Resource mobilization to be intensified to expand coverage of programmes to include all the vulnerable groups and resource DSW to be able to provide quality service to all the beneficiaries
10.	Long process for waivers and inadequate allocation for waivers	Simplify the waiver process and allocate adequate resources for waivers

11.	Non-compliance of beneficiary inclusion and exclusion aspect of some of the interventions including occasional interference from influential people and favoritism	The inclusion and exclusion principle should be made to function by detaching the programmes from political heads and influential people favoritism and nepotism should be curtailed.
12.	Gender bias and stereotyping among some of the programmes that are labor intensive	Gender equality orientation and education for leaders or owners of companies that implement labor intensive interventions
13.	School feeding programme does not cover all schools and the nutrition enablers programme has halted	Expand the coverage of school feeding programmes to be implemented in all schools and re-activate the food and nutrition programmes in the hospitals

5.3.3. Coordination, management and accountability mechanisms

For social protection programmes to operate sustainably, government ownership and effective aid coordination and harmonization are critical. Different government agencies and ministries implement various aspects of social protection programmes requiring strong collaborative relationships and coordination. Where opportunities for direct representation of people working on the AIDS response exist in social protection coordination agencies, these people should be represented in appropriate fora where they can advocate for the strengthening of the HIV sensitivity of the social protection programmes. It is also crucial that representatives of people living with HIV and key populations participate in appropriate coordination and decision making fora, so they can voice their concerns, propose ideas and work with others to find appropriate solutions to making these SP programmes accessible.

People working on the AIDS response and people living with HIV and key populations should also be represented in health schemes under social health protection, which is often run by the ministry of health separate from other national social protection programmes. Similarly, social protection actors should be represented in national AIDS mechanisms to ensure coordination and co-programming of social protection and HIV .

The coordinating and management mechanisms for the social protection programmes and health schemes being implemented in the country were also looked at and Table 6 below summarizes the coordinating bodies. It can be seen that some of the coordinating bodies neither had representatives from the AIDS response nor representatives of the vulnerable groups for their meaningful participation. This has to be looked at and addressed because even though some indicated they have representatives from the health sector, not all health sector workers are well abreast with issues pertaining to the AIDS response in the country and the vulnerable groups that need to be advocated for and targeted to benefit from these social protection programmes. The inclusion of persons or officials specifically involved in the implementation of interventions for the AIDS response in these coordinating mechanisms at the different levels is therefore critical.

Table 6: Coordination, Management and Accountability Mechanisms for SP Programmes and Health Schemes

Coordinating mechanisms for social protection and health services	Names of the coordinating mechanism	Is the AIDS response represented in the coordinating mechanism?	What can be done to improve HIV sensitivity of the coordinating mechanism
Social Protection	District LEAP Implementation committee,	YES (It is expected for the Health rep. to have information on HIV and AIDS)	Representatives from the populations to be targeted by SP schemes need to be represented in this coordination mechanism (women, young, disabled, PLHIV, KP, other community-based or civil society organizations
2. Social Protection	Social Protection Sector Working Group of the Ministry of Gender, Children and Social Protection	No	Elements of HIV should be made a part of the Social Protection agenda
3. Social Protection	Development Partners in Social Protection group	No	Elements of HIV should be made a part of the SP agenda. Funding mechanisms should be expanded to include HIV
4. Social Protection	The District Assembly Common Fund has 1% allocation for social services and a team identifies eligible individuals for support.	Yes	Representatives from the populations to be targeted by SP schemes need to be represented in this coordination mechanism
5. Social Protection	District Assemblies (DAs) with technical support from Zonal Coordinating Offices (ZCOs) and a Rural Development Coordination Unit (RDCU		

		Representatives from the populations to be targeted by SP schemes need to be represented in this coordination mechanism	
Health Services			
6. Health Scheme	Nutrition partners sector group	Yes	
7. Health Scheme	Coordinating team to ensure PLHIV are eligible to be registered under exemption policy	No	At the district level, there is the need for coordination between PLHIV groups, NHIA and district assemblies to ensure that they access the exemptions.
8. Health Scheme	National Health Insurance Scheme coordinating body	Yes (It is expected for the Health representative to have info. on HIV and AIDS)	representatives from the populations to be targeted by SP schemes need to be represented in this coordination mechanism

5.4. Key Responses from the KIIs involving the NGOs/CSOs

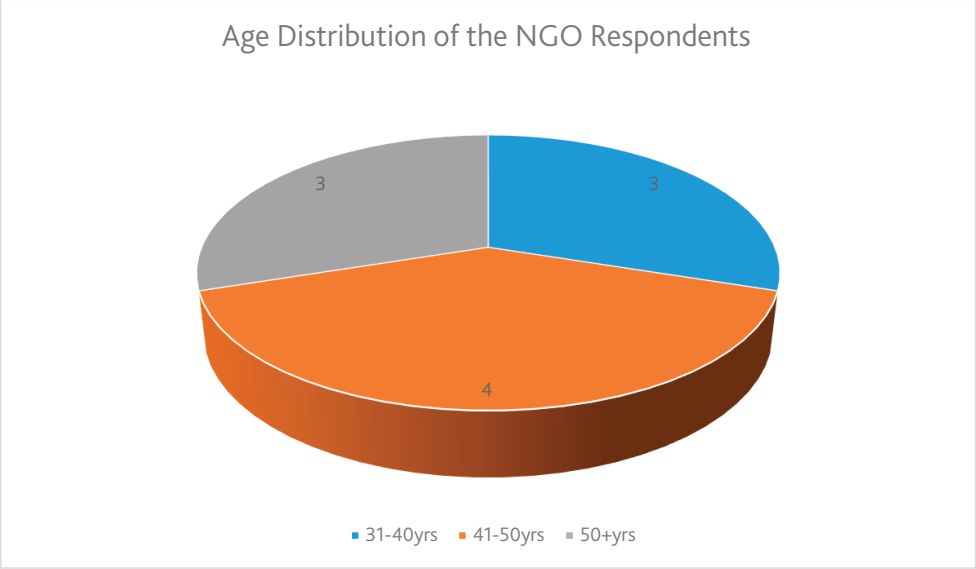
Eleven NGOs/CSOs participated in the key informant interviews. Three (3) of them were from the southern, and four (4) each from the northern and middle zones (Table 7 below). The respondents were Executive Directors or their representatives including programme or project directors, managers and officers.

Table 7: List of the NGOs/CSOs that participated in the KIIs

S/N	Name of NGO	Region/Zone
1	OHF Initiative	Cape Coast/Southern Zone
2	West Africa Program for Combating AIDS and STIs (WAPCAS)	Greater Accra/Southern Zone
3	Christian Rural Aid Network (CRAN)	Central Region/Southern Zone
4	World Vision Ghana	Northern Region/Northern Zone
4	Savannah Women Integrated Development Agency (SWIDA-GH)	Northern Region/Northern Zone
6	Norsaac	Northern Region/Northern Zone
7	Savannah Signatures	Northern Region/Northern Zone
8	Network of PLHIV Associations and NGOs in Ashanti (NPANASH)	Ashanti Region/Middle Zone
9	Hope for Future Generations (HFFG)	Ashanti Region/Middle Zone
10	MIHOSO International Foundation	Bono Region/Middle Zone
11	Voice of Children Living with HIV (VOCH Gh)	Ashanti Region/Middle Zone

Five (5) of the respondents were males with six (6) being females. The age distribution of the NGO respondents is presented in Figure 7 below; out of the ten (10) of them who provided their ages, six were between 31 and 50years and 3 were above 50 years of age.

Figure 7: Age Distribution of the NGO Respondents



The key areas of interventions implemented by these NGOs that participated in the KII included:

- Health, Education, Agriculture, Nutrition and Food Security Programmes
- Water and Sanitation Programmes
- HIV Education, Testing and Counselling (HTC) as well as psychosocial counselling services
- Community Outreach and home-based care
- Women and girls' empowerment through skills training

- Health-related advocacy programmes including Malaria, HIV and Covid-19
- Though some of the organizations said their work targeted the general population (adult males and females) the vulnerable populations these NGOs and CSOs were working with included
- PLHIV including young persons living with HIV (YPLHIV)
- Key populations (IDUs, FSWs and MSM)
- Adolescents and young people
- Persons with disabilities
- Orphans
- Pregnant women and lactating mothers

> "Our organization does not have projects directly targeting PLHIV, though our programmes target women, youth, children and excluded groups. These groups could include PLHIV though the emphasis is not on HIV status of beneficiaries" (Response from one of the NGOs).

All the respondents from these NGOs and CSOs had heard about social protection programmes in Ghana. The common ones mentioned by almost all of them included the National Health Insurance Scheme (NHIS), the School Feeding Programme, the Livelihood Empowerment against Poverty (LEAP), the Basic Education Capitation Grants, the Social Security and National Insurance Trust (SSNIT) and the Free Secondary Education.

> Other social protection programmes that didn't seem to be commonly known among the respondents but were still mentioned by a couple of them included:
> - Labour-Intensive Public Works,
> - National Youth Employment Programme
> - Integrated Agricultural Support Programme
> - Persons with disabilities (PWDs) Common Fund
> - Social Welfare Programmes under the Department of Social Welfare
> - Rice Sector Support Programme (RSSP) – mentioned by only one NGO
> - Emergency Social Relief Project (ESRP) – mentioned by only one NGO
> - Local Initiative Fund (SIF) – mentioned by only one NGO

The social interventions implemented by most of these NGOs interviewed for PLHIV and other vulnerable groups included:

- Food security and Nutrition enhancement programmes and food stimulus package during the onset of the Covid-19 pandemic and partial lockdown.
- Livelihood empowerment programmes, providing training in vocational skills such as dressmaking, fashion design, decoration, beads making, bakery and other Income generation activities such as poultry, soap making, animal rearing, batik tie and dye, with the aim of empowering them economically.
- Nutrition improvement programme for pregnant women, lactating mothers and adolescents
- Skills development for poor and needy girls who have no chance of going back to school and livelihood support to pregnant girls who drop out of school.

For over a couple of years now, our organization has not had a project directly targeting PLHIV, however, our interventions are open to all without emphasis on the HIV status of beneficiaries. We do not discriminate in terms of who our beneficiaries are inclusion is key for us ". "Our organization does not single out PLHIV but the programmes are implemented generally in the communities where PLHIV who are in the communities also benefit". (Indicated by two of the NGOs)

The target groups for these social interventions implemented by the NGOs are:

- women (including pregnant and lactating mothers)
- needy girls,
- PLHIV,
- young persons living with HIV,
- aged PLHIV,
- bedridden PLHIV
- KPs
- and orphans

Barriers mentioned by these NGOs as preventing access of PLs to the SP programmes:

- Low level of awareness of and ignorance about the social protection programmes as well as inadequate information on how one can benefit from such programmes.
- Self-stigma, mainstream stigma and discrimination against PLHIV, KPs and other vulnerable populations such as TB clients as well as lack of privacy or fear of losing privacy after accessing the service.
- PLHIV networks and NAP+ are not well organised to advocate for these services for their members.
- Inadequate resources to be able to reach all vulnerable populations and hence making the programmes resort to prioritization of some vulnerable groups as beneficiaries and leaving others. National interventions are supposed to be inclusive by their nature, the constitution guarantees each person equal access. However, limited resources bring about prioritization.
- Though PLHIV (but not KPs) are mentioned in the Ghana National Social Protection Strategy (GNSPS) and the Policy to be part of the beneficiaries for the LEAP, for example, a PLHIV and other KP status is not a criterion on the forms for being a beneficiary.
- Over politicization of every social protection programme in Ghana sometimes results in a lack of political will and duty bearers (MMDA) not being or fear being supportive to PLHIV groups at the district level.
- Inconsistency in dealing with issues brought to the implementing agencies concerning how the vulnerable groups are treated.
- Lack of funds for the beneficiaries to even transport themselves to the service points to access the services.

Suggestions were given by the respondents from the NGOs pertaining to measures to be taken to remove these barriers so the very poor and vulnerable populations could access the social protection interventions being implemented by the nation included:

- More education should be carried out to create more awareness about the existence of these social protection interventions and how to benefit from them among the general population and especially among the vulnerable populations through the media and traditional channels.
- Stigma and discrimination should be addressed holistically. PLHIV and other vulnerable populations who have been victims of stigma and discrimination also need psychosocial counselling, education and awareness programmes on self-acceptance and rehabilitation. There is also the need for further sensitizations at the community/local level to generate interest in protecting the rights and dignity of such individuals and work on eliminating stigma from all diseases including HIV and TB and treat them as any other ailment; by so doing, it becomes very easy for them to ascertain their status for such support.
- There is the need to form a strong alliance of PLHIV groups and networks of KPs to advocate for the removal of all the barriers. Ghana Aids Commission and NAP+ should engage government, thus the key ministries responsible for these social protection agencies to support these vulnerable groups living with or affected by HIV at all levels
- Processes or requirements should be made simple for easy accessibility and this should include the revision of some of the qualifying criteria for accessing the government SP interventions such as LEAP; priority should be given to vulnerable PLHIV as part of the rollout of these social protection programmes and the delivery of these programmes should be PLHIVs-friendly so they can easily access the benefits
- Efforts should be made for the collection of accurate data on PLHIV and KPs to inform decisions on the vulnerable amongst the community and the type of needs they have and the Governments must prioritise the needs of the vulnerable PLHIV and KPs and involve them in formulating programmes which targets them. Planning SP for the vulnerable should involve them as partners and active ones for that matter.
- Generally expanding the scope of such government interventions implies that more resources need to be mobilized.

> **"How does one define vulnerable? This should be clear and also a way of accessing the list/names of vulnerable populations within districts should be found so as to ensure that such people's needs are met or context and age specific and sustainable solutions are found" (One NGO Respondent)**

5.5. Results and Key Responses from the KIIs involving the PLHIV

Out of the seven PLHIV that participated in the KIIs, four (4) were females and three (3) were males. Three (3) of them were between 21 and 24years; one was 37years, two (2) were 41 years and one was 67years of age.

The vulnerable categories they belonged to were young persons (girls) living with HIV, caretakers of OVC due to HIV, very poor and aged PLHIV and MSM living with HIV.

"My husband and I are both PLs and because of the high level of poverty and not too good health to enable us to work very well the 3 children we have are not going to school" (one of the PLHIV respondents).

Initially three (3) out of the seven (7) PLHIV respondents said they did not know about social protection interventions or programmes being implemented in Ghana, however, upon further explanations and with examples they all responded in the affirmative. All of them said they had benefited from the national health insurance scheme (NHIS); actually, that was the only social protection programme all of them knew about except two people who also mentioned LEAP as one of the programmes and one of them who additionally mentioned School Feeding Programme and the Emergency support for vulnerable groups by the MoGCSP during the early period of Covid-19.

"The WFP used to give us some food supplements but it's no more there. The District Assembly also used to help small small but for the past 5yrs, they have stooped. Some of the PLs even come for their drugs and are not able to take their drugs. We are really suffering but it appears the people at the top don't care at all about us. Some of the PLs are not even able to come for their drugs because they don't even have lorry fare. Sometimes its as if they want us to die, if they don't do anything for us, we will never reach the global goals of 95:95:95" (Passionately said by one of the PLHIV respondents).

"The assembly used to give us some money (from the District Assembly Common Fund) for the various ART facilities in every district that was used to support some of the PLs who didn't have money to use for transport to come to the facilities for their drugs, but now they have stopped and they will be disgracing you on top when you go and inquire about why they have stopped!!" said another PLHIV respondent.

Four (4) of them said they had no idea of other social interventions that existed for PLHIV (either being implemented by the NGOs or CSOs) in their communities. Thus, in addition to lack of awareness and knowledge about the social interventions put in place by the government for the vulnerable and poor groups to which some PLHIV belonged, they also didn't know about other interventions that could help their poverty or vulnerability situations. This is because even though some of these social interventions being implemented by some NGOs and CSOs exist, they target very specific groups due to the limited resources from the donors supporting or providing funds for such services.

The main barriers the PLHIV respondents mentioned as preventing their access to the social protection services included:

- insufficient information and knowledge on the National Social Protection interventions and Programmes
- perceptions of stigma from the officers as well as stigma and discrimination from the family, neighbours and the society
- low confidence by some PLHIV in the Health Insurance scheme (one key social protection intervention known by a lot of PLHIV) because the scheme does not work or cover some costs like some of the lab tests they are required to carry out as part of the health service provided to them
- poverty and financial problems – no money for transportation even to where the services are being delivered. No money to even renew the card for the National Health Insurance Scheme

On issues of stigma, this is what two of the PL respondents had to say	
I know some PLs don't have anything but they will not come for anything because of the stigma by family, neighbours etc. It is not easy to come out as a PLHIV but I don't care about the stigma because I am not sick and I don't look sick (said one respondent).	If you apply for a job and they get to know your status, nobody would even want to come closer to you left alone to employ you and even if you have been employed and they get to know you are positive, they will stigmatize you until you resign from the work (said another respondent).

Measures for the removal of the barriers mentioned by the PLHIV respondents:

- Provide education to vulnerable PLHIV and KPs about these interventions and the benefits (information must be translated to the various local languages for them to easily understand) and create opportunities for vulnerable PLHIV to learn/know more about these interventions.
- Make these programmes easily accessible to vulnerable and poor PLHIV and KPs.
- There is the need for financial support and some skills training will help for PLHIV who are very poor so they can use for transportation from their villages to the facilities in order to get their drugs/medication and even so they would be able to access the social services they are to benefit from.

More suggestions from the PLHIV respondents on the removal of barriers to accessing the social protection services

There used to be a lot of education on HIV on radio, TV etc. but for the past years we've not been hearing anything on radio or TV about HIV & AIDS and it's like people have forgotten about it and HIV is still spreading, especially among the adolescents and the youth. There used to be a programme where some PLs appeared on TV to show that even though they are positive, they are not sick, but these days it is not more like that. The government should make it clear about how the disease is so people will know that even if one is positive and takes the ARVs the person will be healthy and this will reduce the stigma. I want the government to start talking about it on radio and TV just like the efforts being put in to educate people on Covid-19, most of the PLs suffer from discrimination because of their appearance due to malnutrition and lack of proper nutrients that prevent some from taking their medication. If we get a bit of support for us to be able to have a trade so we can have some income to eat well for us to get a bit better (our body will look a bit better), we will be able to feel better about ourselves and be able to mix with people and not feel low self-esteem and not feel stigmatized.

6.0. CONCLUSION

The assessment looked at and addressed all the objectives and assessment questions about the existence of social protection schemes in Ghana, their purpose, eligibility criteria, coverage and HIV-sensitivity, whether people living with, at risk of or affected by HIV, are benefiting from them as well as what needs to be done to remove access-barriers. Thus, a lot of key issues that need to be prioritized and addressed in order to improve access and HIV sensitivity of the social protection interventions in the country have been brought to light.

The fact that social protection schemes exist in the country has been demonstrated by the myriad categories of the different social protection programmes and the various groups the programmes seek to target as well as the benefits. It has also been clearly shown from the national social protection strategy and policy framework that the main criteria for one to benefit from such interventions are poverty and vulnerability.

It can also be said from the documents reviewed and the information gathered using the assessment tool as well as the KIIs, that the social protection interventions in the country including the health schemes and services are HIV-sensitive. However, the level of their HIV sensitivity (which was estimated at 50% or an average score of 5 out of 10) still needs to be improved by the removal of all the barriers and improving access by persons living with, affected by or at risk of HIV who are also vulnerable.

The groups identified as experiencing the most barriers in accessing these programmes in the country have also been listed including PLHIV who are very poor, adolescent girls and young women, OVC, pregnant women and lactating mothers living with HIV, KPs (people who inject drugs, FSW and MSM), people with disabilities, and people aged 50 years and older among other. These are populations that are more at risk, more vulnerable and more affected by HIV due to their exclusion and discrimination, and hence there is, therefore, the need to strengthen programmes to reach these people by removing the barriers and meet their multiple needs including health, education, social, economic, employment, housing, food and nutrition, psychosocial and legal needs.

The main barriers preventing the identified vulnerable groups from accessing the social protection interventions including both the health services and schemes listed by the national and sub-national level participants as well as the respondents from the KIIs included:

- barrier of some groups (including key populations) not being recognized by the SP policy and strategic plan as vulnerable groups that need to be targeted as beneficiaries
- barriers presented by the social protection system including issues of implementation of the strategic plans and policies in terms of selection of beneficiaries of the interventions,
- barriers associated with insufficient resources to enable all the vulnerable and poor populations to be included in such programmes resulting in prioritization of some beneficiaries
- barriers associated with a low level of awareness and knowledge about most of the social protection programmes and services and even how to access them. The fact that almost all the PLHIV interviewed only knew about the NHIS and not any of the other many social protection interventions operational in the country from which they are eligible to benefit makes this barrier the most important that need to be removed
- barriers due to self-stigma, perceived stigma and previous experience of stigma and discrimination perpetuated by the society and some service providers
- barriers due to lack of identification cards to help identify vulnerable groups as beneficiaries
- barriers due to inadequate information and data on the vulnerable and poor (especially among those at risk of, living with and affected by HIV) who are supposed to benefit from such programmes to help in targeting the right beneficiaries
- barriers due to gender biases and stereotyping
- barriers due to lack of resources/funds to be used for transportation to access the services

Important measures and activities to remove these barriers have also been described and need to be implemented to help alleviate the plight of these poor and vulnerable groups who are also affected by HIV. Among these measures are:

- public education on the existence of the various programmes, who is to benefit, how to benefit and the various benefit packages from them,
- anti-stigma campaigns among the general population,
- making the interventions easily accessible by removing impediments in the enrolment processes (and making the offices disability friendly),
- orienting and educating service providers, leaders or owners of companies that implement labour-intensive interventions on the importance of gender equality and elimination of gender stereotyping
- active and intensified resource mobilization to enable the programmes to be extended to cover as many vulnerable populations as possible,
- detaching the programmes from political heads and influential people so the inclusion and exclusion principles and criteria in identifying beneficiaries for these programmes can be adhered to as well as curtailing favouritism and nepotism among others.

These measures if applied and implemented would also help to improve the HIV sensitivity of the social protection programmes and health schemes in Ghana.

7.0. RECOMMENDATIONS

This final chapter identifies or sifts the key actions emerging from the assessment that should be taken forward given the context of the HIV-sensitivity situation of the social protection system and programmes in Ghana as a country. These important recommendations are for stakeholders whose roles are critical in strengthening the social protection programmes in Ghana as well as improving the HIV sensitivity of the national SP interventions and services.

These stakeholders include the Ministries and the government agencies implementing social protection programmes and health insurance schemes in Ghana, PLHIV groups and networks, Ghana AIDS Commission (regulatory body for the AIDS Response) and the National AIDS Control Programme (service provision institution for the AIDS Response), the UN agencies and development partners as well as the NGOs and CSOs that provide services and social interventions to who are living with, affected by or at risk of being infected by HIV, including key populations.

For making the national social protection programmes HIV-sensitive the recommendations for further actions by the various stakeholders are as follows:

i. **Ministries and the government agencies implementing social protection programmes in Ghana**
   - Recognize and include all populations who are living with, affected by or at risk of being infected by HIV, including key populations, as beneficiaries of the various social protection interventions and health schemes in the country
   - Improve the HIV sensitivity of the social protection programmes through the removal of all the access barriers and ensure the meaningful involvement of some of the vulnerable groups and other stakeholders (to come out with inclusive programmes) through the design stage, planning, implementation, monitoring and evaluation stages at all levels.
   - Carry out extensive public education to create awareness of such schemes and interventions, the various government agencies and institutions that are responsible for such social interventions, who is to benefit from the schemes and how to be included as a beneficiary through advertisements both in the media and through flyers so the very poor and vulnerable groups including persons living with, at risk of and affected by HIV who are intended beneficiaries would be made aware

- Some criteria used in selecting a qualified person for such benefits or interventions should be reviewed to capture all age brackets who have become poor and vulnerable due to the HIV pandemic. There should also be dialogue with all relevant institutions at the national level to make provisions for persons living with and affected by HIV in these interventions. There should therefore be more stakeholder engagements to drum home the significance of making such programmes HIV-sensitive.
- Mainstream gender not only by increasing the number of female beneficiaries but by also ensuring the elimination of any forms of gender biases and stereotyping by the service providers
- Carry out active and intensified resource mobilization to enable the SP and health schemes/service programmes to be extended to cover as many vulnerable populations as possible
- As much as possible all social protection interventions and health schemes/services which are allocated to PLHIV should be integrated at all levels with other services to avoid stigma and discrimination unless it is impossible to do so. However, in situations where it is not possible to make general SP programmes meaningfully HIV-sensitive and accessible to these populations, the National Social Protection Programme should have some interventions and services that are solely focused on PLHIV and KPs. Such SP programmes should be aligned to the national AIDS response in collaboration with the GAC and be part of the GAC's annual reports.

ii. Ghana AIDS Commission (regulatory body) and the National AIDS Control Programme (service provision institution) in collaboration with PLHIV groups and networks and NGOs and CSOs

- Carry out continuous and intensive anti-stigma and discrimination campaigns among the general population to reduce the stigma and discrimination towards PLHIV and KPs so they can freely access the SP interventions and health services without fear of stigma or discrimination
- Conduct further research to ascertain the impact of making the SP programmes HIV-sensitive thereby informing what works best and how it should be approached to ensure maximisation of resources.
- Support PLHIV and KP networks to also include the SP inclusiveness to HIV in the community-led monitoring initiatives being implemented under the Community Systems Strengthening Programme of the Global Fund's New Funding Model (NFM3)
- Generate data on the numbers of persons who are vulnerable and poor who are supposed to be appropriately targeted and included as beneficiaries for these interventions and services
- Build the capacities of Civil Society Organizations working on HIV, Health and Education field on advocacy plan development and implementation as well as including SP to HIV thematic areas. There is also the need for building the capacities of CSO/NGOs to assess vulnerability among HIV-affected populations, and to create demand for SP services, etc.

iii. UN agencies and development partners

- Provide funding and technical support to introduce or reinforce existing social protection programmes that contribute to the prevention of school dropouts, especially among more vulnerable children e.g. "kayeyes" and teenage mothers. Children dropping out of school leads to important losses in human capital that are neither easily nor cost-effectively recovered and hence measures should be put in place to ensure that all children of school-going age enrol and are retained in school till completion.
- A team can be set up to facilitate and follow up on the implementation of the recommendations from this assessment.

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9.0 APPENDIX

National HIV and Social Protection Assessment Team

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Please note that the lists of stakeholders that participated in the workshops to complete the HIV and Social Protection Assessment Tool at the national and zonal levels have been added in the Appendix

Table 8: List of People that Contributed to the Completion of the Assessment Tool at the National Level

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6.	Edwina Gilda Annan	Nyanis Restore Foundation
7.	Justice Ekow	Community Development
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14.	Abukeri Abdul-Razak	GAC (TSU-NR)
15.	Siaka Osman	GAC (TSU-NR)
16.	Fareeda Seidu	GAC (TSU-NR)
17.	Emmanuel Larbi	GAC
18.	Jewel Lamptey	GAC
19.	Daniel Narh	GAC

Table 9: Scoring by participants of the National Level Workshop

Participant	Score	Reasons for the Score Given
1	5	The social protection programmes are HIV-sensitive but persons living with, affected by and at risk of being infected with HIV are not prioritized.
2	5	
3	7	Social Protection for PLHIV are mentioned in the strategy and policy documents for SP in Ghana but persons living with, affected by or at risk of being infected with HIV are not considered during the implementation of those strategies and policies.
4	3	
5	4	
6	3	Children, adolescents and the aged who are among the vulnerable groups do not have access to these interventions.
7	6	All the social protection interventions are made to target the very poor and vulnerable in society however access to and knowledge about these programmes and services are generally low among these groups that the programmes seek to target.
Total Score	**33**	**Average Score = 33/7 = 4.71** **Approximate to a score of 5 for the national level**

Table 10: Southern Zone Scoring for HIV Sensitivity of SP Programmes in Ghana

Participant	Score	Reasons for the score given
1	7	The national social protection strategy mentions PLHIV for social protection interventions but the LEAP eligibility criterion is silent on this group of people.
2	5	There are lots of agencies and institutions providing almost the same/similar social protection interventions which lead to a clash of functions leaving some beneficiary groups not catered for while other groups are overrepresented. The case would have been different if all social interventions are handled by one agency/institution.
3	6	Improving coordination of social policies is a major priority. An integrated perspective on social protection sensitivity must come from political leadership in connection with civil societies.
4	5	Lack of awareness on the various benefits that the government agencies are rolling out to the beneficiaries. The benefits are not known to the beneficiaries. The inconsistency of some of the programs makes it difficult to track the impact of such interventions.
5	7	The age criterion OVCs to access the LEAP intervention should be increased to 18 years instead of being pegged at 14yrs.
6	5	PLHIV could easily benefit from the LEAP, NHIS among others. However, the challenge is that they are not taking advantage of these interventions as a result of stigma. Addressing the issue of societal and self-stigma (PLHIV) is the sure way to ensure the full utilization of these interventions by PLHIV.
7	5	PLHIV has clearly stated in the SP Policy however the implementation is very poor whiles other benefits go to very few people and also more education should be done to enable easy access to all less privileged PLHIV.
8	5	Though there is a Social Protection Policy Document with clearly stated provisions for PLHIVs, the knowledge level of the public is very low with implementation being sub-optimal
9	4	The 'noise' that we hear about HIV AND AIDS has reduced drastically now giving way to the COVID-19 pandemic
10	4	MMDAs only recognize HIV AND AIDS issues as a health issue instead of a socio-developmental issue and hence PLHIV are not included in their Medium-term or long-term plans. The negative public perception on issues of HIV AND AIDS leads to low public discourse in the media and churches.
11	3	Did not give any reason for the score given.
Total	**56**	**Average is 56/11 = 5.09**

Table 11: Middle Zone Scoring of HIV Sensitivity of the SP Programmes

Participants	Score	Reasons for the Scores Given
1	3	Most people are still unaware of some of the policies.
2	4	The policies available are not targeted at HIV clients.
3	5	Though the policies are there on paper, implementation is a problem.
4	5	PLHIVs are not wholly involved in the formulation and implementation of policies that affect them.
5	4	More officers should be employed.
6	5	For PLHIV to assess some interventions (e.g. LEAP), their confidentiality must be breached.
7	6	Most of them are unwilling to enrol on the LEAP program because they are unwilling to let the Social Welfare officials know their HIV status.
8	4	The interventions are not specifically targeted at the poor PLHIV.
9	6	The coverage is low and that means that less PLHIV will benefit.
10	5	Delay in payment of caterers leads to periodic stoppage of the intervention thereby beneficiaries do not access the programme during such periods.
11	5	The quality of the foods served are of less quality most of the time. This means that the intended purpose of providing nutritious foods for pupils and students are not achieved.
12	4	Most vulnerable PLHIV are not aware of the existing programmes and interventions.
13	5	There is a deficiency in monitoring and evaluation of interventions targeted at vulnerable PLHIV.
Total Score	**61**	**Average is 61/13 = 4.69**

Table 12: Scoring by participants of the Northern Zone workshop

S/N	Score	Reasons For The Score Given
1	6	It's good we have all the social protection interventions available but some persons living with HIV do not have access to them and so more work should be channelled to creating more awareness and putting drastic measures in place to ensure that each individual get access.
2	5	In terms of putting policies in place, the country has done well but the actual implementation of these policies are below expectations. E.g. no one has benefited from the National AIDS Fund even though it is stated in the GAC Act.
3	5	The policies on the SP are well placed on paper but at the grace root, it does not tell the actual picture of the policy. For instance, the vulnerable aged do not have the equipment to be trained in possible livelihood skills to enable them to earn a living.
4	4	In Ghana, we only come up with policies but implementation is poor. For instance, people living with HIV and the vulnerable cannot have access to most of the interventions.
5	4	Poor policies in the Northern region for people living with HIV are evident in the school feeding (poor selection of Caterers and late release of funds) as well as political interruptions.
6	6	It is evident that policies and strategies that are HIV sensitive exist however, their rollout is ineffective. Most individuals who should be benefited do not or have no knowledge of such initiatives. Public awareness should be created and assist eligible individuals to have access to these interventions to bring about social/ human development.
7	5	The policies and framework have been put in place but as to whether these policies are really working and putting the PLHIV as a priority. The awareness creation is poor as well as the implementation of activities.
8	4	There are a number of good social protection policies but they are not sustainable as a result of inadequate funding.
9	4	The policies are not helpful to most beneficiaries, especially to PLHIV. There is also a result of the stigma PLHIV go through.
10	5	Policies exist but accessibility is a challenge to PHHIV as a result of stigmatization and hence an implementation challenge.
11	4	The policies are good but implementation is a challenge as a result of poor monitoring and coordination of the implementation process and for the fact that the implementation agencies are not well resourced and above all the lack of the existence of the services for the beneficiaries or key population.
12	5	The policies exist but inadequate funds to implement the policies and inadequate awareness to make the policies known and accessible to potential beneficiaries.
13	6	The policies and framework is good but the PLHIV are not able to access the services due to stigma and unavailability of services and periodic stock out of ARTs.
14	4	Social protection policies exist and are good but are white elephants. Implementation is a problem as a result of inadequate funds and resources.
Total Score	67	Average Score = 67/14 = 4.7857 Approximated to a score of 5 for the northern zone

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