



HIV & AIDS in Ghana's Northern Region

Needs Assessment

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Introduction

HIV/AIDS is a significant issue throughout Ghana and efforts have been mobilized for prevention and care across the country. The Northern Region often receives less direct attention and funding for HIV, as it does not rank as high in HIV prevalence as more population-dense urban centers. This lack of attention is problematic, especially considering the recent doubling in HIV prevalence in the Northern Region from 0.6% in 2014 to 1.2% in 2015, according to the Ghana AIDS Commission (GAC). There are also distinctive barriers faced in the North, such as unique traditional beliefs and practices and a deficit in comprehensive knowledge that affect stigma and discrimination around HIV/AIDS.

The WAAF office in Savelugu has been involved in community-based work to combat HIV issues in the Northern Region. WAAF works hand-in-hand with the GAC in the Northern Region on outreach, education and screening and collaborates with community leaders and HIV stakeholders to develop projects and infrastructure around HIV and tuberculosis (TB). This report is intended to explore the needs of the Northern Region and how to address them, with a particular emphasis on how WAAF can best serve a role in meeting those needs.

This report has been organized so that the first several sections provide an in depth review of the HIV/AIDS experience in Northern Ghana. The purpose of this review is largely to identify the current issues relating to HIV in the North, which involve many complex layers of culture, social practice, economics, medicine, gender dynamics and psychology. Identifying these issues then provides a foundation for assessing the needs going forward in the treatment of HIV/AIDS in the Northern Region. The strategies and priorities to address these needs are discussed in further detail in the Recommendations section of the report.

Throughout the report I identify numerous opportunities to enhance the response to HIV in the Northern Region, but I recognize that there are limited resources and that funding must be allocated with discretion. So, I have strived to attach priorities to actions that may yield the strongest impact.

Methods

I spent eight weeks living in Savelugu conducting projects on HIV/AIDS in the Northern Region. I led educational outreach sessions, where I traveled to communities across the Northern Region to comprehensively explain important topics around HIV. These outreaches were discussion-based and interactive, and I encouraged questions and participation. The groups I visited included Junior High Schools, vocational schools, women's seamstress groups and men's agricultural groups. My outreaches to groups of both genders gave me a meaningful perspective on gender dynamics: I spoke with all-male agricultural workers and also all-female students during a special girls' empowerment outreach I initiated. These direct interactions and conversations with community members of both genders and diverse age groups were highly informative on community attitudes, opinions and understanding around HIV.

I then also conducted targeted site visits and interviews to make specific inquiries and gather perspectives from community HIV stakeholders, organizations and NGOs. The stakeholders I met with in the Northern Region include: Ghana AIDS Commission (GAC), NAP+, Models of Hope, Tamale West Hospital, Tamale Teaching Hospital, Savelugu Hospital, Savelugu National Health Insurance Scheme Office, Ghana Education Services, Youth Advocacy on Rights and Opportunities (YARO) and Simli Aid. I inquired about barriers to HIV prevention, treatment retention and testing, the status of ongoing projects, approaches for vulnerable populations, challenges faced during fieldwork and experiences and opinions on culture and community attitudes. During these visits I also discussed opportunities to coordinate with WAAF in community-based projects, including educational outreach, screening and support for persons living with HIV (PLHIV).

This report compiles the information and ideas gathered from these first-hand outreaches, visits and interviews. It evaluates the dynamics, barriers and initiatives around HIV/AIDS in the Northern Region and proposes recommendations to address community needs in a way that will be achievable, effective and impactful.

Issues facing Persons Living with HIV (PLHIV)

Stigma and Discrimination

Stigma and discrimination against PLHIV is widely seen as a leading problem in the Northern Region. When an individual is identified as HIV-positive, they are often seen as pariahs in the community; community members refuse to eat with them, spend time with them or visit their home. People may even refuse to buy or sell food or merchandise with them. PLHIV are often seen as bringing shame upon their family, and family members themselves may participate in stigmatization, sometimes even abandoning the PLHIV.

The causes of stigma and discrimination are complex, but seem to stem from the interaction of two primary factors:

- 1) *Morality*: An HIV diagnosis can signal to others that the PLHIV has supposedly led a 'reckless', 'careless' and 'immoral' lifestyle. The Northern Region is predominantly Islamic and highly religious and so many people collectively condemn promiscuity. Community members may assume a PLHIV has engaged in 'immoral' sexual behavior, intensifying the discrimination against them and the 'shame' they bring to their house.
- 2) *Misunderstanding/lack of knowledge on HIV transmission*: many individuals are not aware of how HIV is spread, so are fearful that by being near PLHIV they are at risk of acquiring it themselves. It is often not just a lack of knowledge around transmission, but also the perpetuation of myths that compounds the problem. For example, some people believe that eating with or shaking hands with PLHIV can transmit the disease, or that mosquitoes can carry HIV.

PLHIV face so much more intense discrimination compared to individuals with other STIs or even diseases that have more visible symptoms. This can be explained by (a) fear of the unknown – HIV is a complex disease that people may not fully understand and (b) the sense of serious finality and permanency of HIV because it has no cure and may be seen as a death sentence.

The effects of discrimination against PLHIV are palpable. They extend past damaging emotional hurt and expulsion from communities, and also lead to consequences that affect HIV transmission and treatment. Below is a list of practical consequences arising from discrimination. Many of these items will be expanded on in later sections in the report.

- 1) *Emotional hurt and abuse*: PLHIV may be excluded from the usual social activities in their community, and sometimes even lose the support of their own family. As published in the most recent Multiple Indicator Cluster Survey (MICS) in 2011, only 63.5% of women in the Northern Region would be willing to care for a family member with HIV in their own home, the second lowest result out of all regions in Ghana. PLHIV are often labeled and chastised. They are especially vulnerable to physical and emotional abuse, within or outside their household. The abuse may go unnoticed or unpunished and the PLHIV can feel isolated with no one to whom they can reach out for help.
- 2) *Self-stigma*: PLHIV may adopt the same type of negative feelings towards themselves that they see in the community. They may experience self-loathing and self-blame.

Consequently, they may believe they do not deserve treatment. They may also withdraw from social activities.

- 3) *Financial issues*: It is very common for PLHIV to lose their employment when they disclose their status. In addition, they may experience periods of sickness where they are unable to maintain their income. As such, it becomes difficult for them to support their own health with nutritious and sufficient food, or transportation to pick up their medications. This problem is exacerbated for PLHIV who are already struggling with poverty or who may not have the support of their family or community.
- 4) *Non-disclosure of HIV status*: Aware that they will be stigmatized if they disclose their positive HIV status, PLHIV may choose to keep their HIV status secret, even from their family, or may enter a state of denial. This puts their family members or partners at high risk of acquiring HIV.
- 5) *Foregoing treatment*: PLHIV are often reluctant to pick up their antiretroviral therapy (ART) from their local hospital, because they are fearful that it will identify their HIV status. For some, this means they are either not consistent with or entirely forgo taking their medications. For others, they travel to districts outside their community where they will not be recognized to acquire their medications; however, transportation can quickly become a financial burden and result in defaulting on their treatment.

Key Takeaway Points: Stigma and Discrimination

- Stigma and discrimination arises from misconceptions on HIV transmission and judgments on the morality of PLHIV
- The consequences of discrimination affect the quality of life and health of PLHIV. It may also discourage people from getting tested and subsequently treated, as the stigma of a possible positive diagnosis is a deterrent.
- Education is a key solution in dispelling stigma around HIV/AIDS

Barriers for Retention to Treatment

Patients may choose or be forced to stop their course of HIV treatment for many reasons, which are described below, or a combination of these reasons. Sometimes this may be a temporary problem and with time they restart their course of treatment. The challenge here is to readjust the medications to account for their lapse and any drug resistance that may have developed. In other cases, the patient forgoes their treatment entirely and will die from AIDS.

Economic

Economic barriers for PLHIV are multifold. They may experience periods of sickness due to their HIV infection where they cannot work or earn income, or they may lose their jobs due to discrimination if they disclose their HIV status. Losing a steady stream of income means it can be an immense challenge to nourish their bodies healthily, an important part of maintaining the immune system. Organizations such as the World Food Programme and Catholic Relief Services assist in providing staple food items, but the availability is not always reliable and these programs have decreased in magnitude in recent years. In addition, PLHIV may not have the time or means for transportation to pick up their ART from the hospital in the prescribed regular

one or two month intervals. If they do not take their ART for even a few weeks, they may experience setbacks such as drug resistance when they seek treatment going forward.

Traditional Medicine and Religious Healing

PLHIV may seek out, be taken to by family members, or be approached by soothsayers upon receiving an HIV diagnosis. This often takes the format of a prayer camp or regular sessions where the PLHIV gives a monetary donation for the soothsayer to use anointing oil and pray for them with the claim that it will comfort and cure their condition. The key problem is that the soothsayer will prevent the PLHIV from using their drugs, so they become sick and eventually die if they continue without treatment. PLHIV are especially vulnerable to this scenario if they do not have a support network or feel hopeless. They feel reliant on the spiritual healing of the soothsayers as they have no one else to guide them in managing their health with their medications.

Mental Health

An HIV diagnosis can affect not only the physical but also the emotional and mental wellbeing of a patient. Some patients may develop depression or related mental health issues. HIV may have affected their prospects of marriage or sexual life, their friends and family may stigmatize them, or they may be worried about the quality of their health. These profound changes undoubtedly change a person's way of living and can affect their outlook. Sadness or clinical depression may devolve into apathy towards life and PLHIV may feel unmotivated or elect not to continue their ART. This can be exacerbated if the PLHIV does not have access to a strong support network, through family or a structured support group.

Key Takeaway Points: Barriers for Retention to Treatment

- An HIV diagnosis can leave PLHIV physically, emotionally, mentally and financially vulnerable
- PLHIV would greatly benefit from, but often lack, a strong support network to support their adherence to treatment

Confidentiality and Quality of Care

Given the stigma and discrimination surrounding HIV patients, PLHIV are often particularly sensitive to the confidentiality and discretion of the care they receive. They may also still be deciding which of their family and friends they feeling comfortable informing of their status. Facilities must take every precaution and be willing to adapt to protect the HIV status and health information of PLHIV and ensure patients feel protected. The more respect and sensitivity the patient and their information is given, the more trusting they will be in the staff and health facility, and the better support they can receive. Improvements have already been made and hospitals should continue this effective system of evaluation and modification. For example, PLHIV patient hospital folders used to have a different format than general patients', which differentiated them, but now they have all been standardized.

Additional progress can still be made across hospitals in the Northern Region. For instance, at certain hospitals there is a designated location for ART pickup, which would allow an observant onlooker to identify the patient's HIV-positive status. Certain hospitals have changed this layout and mix treatment distribution for ART and other STIs at the same pickup location so PLHIV cannot be explicitly identified. It may be even more preferable for PLHIV to be able to pick up their ART from the more nondescript, general pharmacy in the hospital. Another solution that some hospitals have implemented is that hospital staff or a family relative serving as a proxy pick up the distributed medication on behalf of the PLHIV, which gives them more flexibility and increases their feeling of security.

Key Takeaway Points: Confidentiality and Quality of Care

- Health personnel must be particularly sensitive regarding the confidentiality of the HIV status and identity of HIV patients
- Periodic and frequent training and reminders for hospital staff will encourage confidentiality and sensitivity
- Hospitals can continue to improve ART pickup procedures by distributing a broader range of varied medications at the pharmacy so as to not identify HIV patients
- Allowing a proxy for ART pickup can secure the anonymity of HIV patients

Barriers for Prevention of HIV/AIDS

Lack of Knowledge on HIV Transmission and Prevention

The Northern Region is behind other regions in level of knowledge around HIV/AIDS. Gaps in knowledge around HIV transmission cause not only the stigma discussed earlier, but also put people in increased danger for HIV infection as they are not aware of high-risk behaviors. For example, sharing blades for shaving is common and many people are unaware that they can be infected with HIV through blood transmission. Not only are people not sufficiently aware of all high-risk behaviors, but also they are not well versed in prevention. Even if they recognize that HIV can be sexually transmitted, they may not recognize that faithfulness to one partner and using a condom to have safe sex will offer significant protection. Moreover, many young people and adults have confusions about proper condom use (checking the expiry date, proper use of lubricant, preventing tears, using a condom only once).

The Northern Region's gap in comprehensive knowledge is supported by statistics from survey results. The 2011 MICS defines comprehensive knowledge as knowing "the two ways of HIV prevention (having only one faithful uninfected partner and using a condom every time), that a healthy looking person can have the AIDS virus, and [rejecting] the two most common misconceptions." The two most common misconceptions are that HIV can be transmitted by supernatural means and mosquito bites. The survey results are staggering; the Northern Region trails behind all other regions in Ghana by a wide margin in comprehensive knowledge. Only 16.6% of women and 29.3% of men have comprehensive knowledge. In comparison, 47% of women and 42.7% of men in Greater Accra have comprehensive knowledge.

Additional statistics in the MICS report gathered from regions across Ghana indicate that wealthier people are more likely to have comprehensive knowledge. Only 14% of women in the poorest quintile had comprehensive knowledge compared to 52% of women in the richest quintile. Also, those living in rural areas had significantly lower comprehensive knowledge than those in urban areas; 24.6% of women in rural areas compared to 41.5% in urban areas. The Northern Region has an agricultural focus and so is significantly rural, and poverty is also a prevalent issue. Accordingly, these factors predispose the Northern Region to challenges to comprehensive education around HIV/AIDS.

Key Takeaway Points: Lack of Knowledge on HIV Transmission and Prevention

- The Northern Region is significantly lagging in its population's level of comprehensive knowledge around HIV transmission and prevention, as supported by MICS statistics
- Lack of knowledge means people may not take steps to avoid high risk behavior and use proper preventative measures to protect themselves from HIV infection

Health-Seeking Behavior

Oftentimes in the Northern Region, patients only seek hospital care as a last line of defense when their ailment has progressed to a serious stage. This is especially problematic when a person's symptoms indicate they should get tested for HIV. If they do not seek hospital care immediately and are unknowingly HIV-positive, they may transmit the disease to others, and also decline rapidly in their health, as they are not receiving ART.

There are several factors affecting health-seeking behavior in the Northern Region.

- 1) *Patients favor traditional healers*: It is common practice to visit a traditional healer for natural remedies to medical issues. While this may sometimes be sufficient care, in more serious cases, especially those involving potential HIV patients, it is important they visit a hospital immediately.
- 2) *Patients dislike hospital dynamics*: Especially given that many patients already favor and trust traditional or natural healing, they may be discouraged by elements of a standard hospital visit. After waiting in a long queue to see a doctor, many are of the opinion that if they have an ailment, they should receive an appropriate drug or medicine as a remedy. Since certain ailments cannot be treated with medicine, the patients feel they have wasted their time visiting the hospital. In addition, testimonials from health administrators revealed concerns about how certain patients may be treated by hospital staff. The Northern Region has the third highest poverty headcount in Ghana at 44.2% (Ghana Statistical Service). There are concerns that on occasion, hospital staff may not take less wealthy patients' concerns as seriously or treat them with unequal respect.
- 3) *Uninsured patients*: Although the National Health Insurance Scheme has a tiered insurance system based on income, there are still certain individuals who are unable to afford insurance, either temporarily or for extended periods of time, so they do not visit the hospital or clinic. In the Ghana Living Standards Survey published in August 2014 (GLSS 6), 36.7% of respondents in the Northern Region were not registered or covered by a scheme, higher than the national average. Moreover, some patients may only seek out insurance once they become sick and they must wait for the processing time to be registered before visiting the hospital. However, pregnant mothers are covered by the scheme, which is very important for not only general maternal care but also PMTCT.

Key Takeaway Points: Health-Seeking Behavior

- Many patients in the Northern Region prefer traditional healers over hospitals and clinics
- Economic or personal barriers often mean patients wait until their condition is serious before visiting a medical professional
- The reluctance to visit hospitals or clinics for ailments delays identification and treatment of potential HIV patients

Non-Disclosure of HIV Status due to Stigma

As detailed previously, there is tremendous stigma and discrimination against PLHIV. As such, certain PLHIV may be in denial of their status, or choose not to tell their family, friends or partners. While disclosure is the PLHIV's choice in their broader community, it is their obligation to inform their sexual partners. Unfortunately, certain PLHIV choose not to do so and subsequently infect their partners. Similarly, there are cases where PLHIV do not disclose their status to their fiancé or fiancée because they fear the marriage will not proceed. Clearly, stigma is so powerful that it not only creates discrimination against PLHIV but also can create dangerous circumstances that may lead to HIV transmission.

Key Takeaway Points: Non-Disclosure of HIV Status due to Stigma

- It is the obligation of PLHIV to disclose their HIV status to prevent infection of others
- Some PLHIV may be in denial or choose not to disclose their status to protect themselves and their families from stigma

Cultural and Religious Factors

The Northern Region is predominantly of traditional and devout faith, predominantly Islamic. According to GLSS 6, in the Northern Region, 83.6% of the population is Islam, 14% is Christian and only 2.5% identify with no religion (the lowest atheist prevalence in Ghana). In certain cases, very religious individuals may have beliefs against condom use. In a marriage if one spouse already has or elsewhere acquires HIV, this means it is highly likely the partner, or additional wives in the family, will also be infected with HIV.

In certain communities there is also a discrepancy between cultural and religious beliefs and behavioral practice. For example, it may be conventionally taboo to discuss sex or condom use, but in practice, individuals are having marital, premarital or extramarital sex. This means these practices – which may be high risk for HIV transmission – continue, but individuals in the community are reluctant to acknowledge or talk about ways to have safe sex and prevent HIV transmission. This can especially be seen as a generational discrepancy. For example, NGOs who work with peer educators observe that more elderly members of the community may be scandalized when young peer educators are speaking with other young people or adolescents about safe sex and condom use, as they feel sex should be a topic reserved for mature adults. However, it is important and realistic that young people and adolescents be well informed, as they should be safely prepared if they choose to engage in sexual activity. In addition, discussions with students and young adults, both men and women, indicate a social trend where they feel embarrassed or ashamed to purchase condoms. Moreover, they may use condoms improperly because they are uncomfortable asking parents, friends, mentors or peers for clarifying advice and instruction.

Key Takeaway Points: Cultural and Religious Factors

- Although people may be sexually active, there is insufficient dialogue surrounding safe sex, appropriate protection and correct condom use
- Condom use is not always guaranteed or encouraged because of cultural and religious dynamics

Gender Dynamics

The Northern Region has unique social and gender dynamics. Men often have multiple wives. This setup inherently facilitates rapid transmission of HIV around a family if one spouse is affected – once HIV is in the household, all the wives are likely to become infected if they do not take protective precautions. Moreover, there are many cases where men, especially those with greater power, wealth or status, feel emboldened to have extramarital affairs. However, if they acquire HIV from these affairs, they affect their wife or wives. These women are at risk of becoming victims of circumstance; because of power dynamics where women may be expected to obey and be subservient to their husband, even if they are aware of the affairs, they may not feel empowered to forcefully insist on condom use or their husband may refuse.

Female sex workers are particularly vulnerable to obtaining HIV and, if they are HIV-positive, may also transmit HIV. The nature of having frequent sexual encounters with many different and unknown partners puts sex workers at higher risk of encountering HIV. The GAC and other organizations have already taken steps to install condom machines in areas around the Northern Region where sex workers are known to often visit. Unfortunately, male clients may sometimes offer to pay a higher price if the female sex worker agrees to not use a condom. This means that if either party is HIV-positive, there is a high chance of HIV transmission. In addition, there are female sex workers who have been tested as HIV-positive, yet for economic reasons, continue as sex workers without disclosing their status. They may pass on HIV to multiple male clients.

Key Takeaway Points: Gender Dynamics

- The family setup where men may have several wives means that HIV can spread rapidly around the household if one spouse is infected
- Women are often at risk of becoming victims of circumstance of HIV infection, especially if their husband or boyfriend has extramarital affairs
- Female sex workers are a vulnerable population for HIV transmission

Issues Affecting Testing and Counseling

Gender Bias in Testing and Counseling

Women are much more likely than men to get tested for HIV. The main circumstances in which men get tested are: (a) a physician develops a high index of suspicion and orders an HIV lab test for a man who has visited the hospital for a different ailment (b) the man's wife has recently tested positive for HIV so the husband is also tested. Even at widely advertised screening and testing events and special outreaches, the majority of patients who voluntarily come to get tested are women. Men rarely take the initiative to know their HIV status.

The higher rate of testing in women than men is in part because of extremely successful PMTCT efforts, where pregnant mothers test for HIV as one of the first steps in their hospital or clinic visit. Pregnancy is a highly structured way to reach out to a large number of women for HIV testing. However, it is also very important for men to know their status, especially in the Northern Region where they may have several wives.

There are cultural and psychological reasons why men are less likely to get tested. Women are more likely than men to recognize the effect their HIV diagnosis may have on their family (husband and current or unborn children) whereas men are more apt to see themselves as a single, independent unit and be less cautious about their HIV status' effect on their wife, family or sexual partners. Certain men may also develop a sense of invincibility, even if they have many sexual partners. Combined with a level of ignorance or misunderstanding about HIV transmission, this causes them to see testing as relatively unimportant. There is also a cyclic effect, where it is unusual already for men to get tested and so fewer men are willing to break the pattern and get tested, unless they see an urgent need. Additionally, my discussion with a young men's agriculture group revealed that especially during farming season, they feel they do not have the time to spend their day at a testing and screening event, as they must provide for their families.

Key Takeaway Points: Gender Bias in Testing and Counseling

- More women than men are tested for HIV
- Men may not feel the necessity for testing or believe that testing is not a priority in their work schedule
- Because of PMTCT protocols, pregnant women are consistently tested for HIV

Limited Resources and Funding

In the Northern Region there is a shortage of funding for test kits that prevents testing and counseling of the maximum number of patients. Although there are many efforts underway for increased testing, there are still a number of important populations that cannot be tested and additional outreaches that cannot occur.

One deficit in funding is that many clinics or hospitals are well funded to cover test kits for pregnant women, often through The Global Fund, which is linked to the PMTCT program;

however, they cannot actively encourage men or other demographics to get tested, as they do not have sufficient test kits for these groups in addition to pregnant women.

The GAC currently sets up testing and counseling events, often spanning over a series of days, at various health clinics. Often, they test for other STIs, such as syphilis, along with HIV. These events are usually very busy and especially well attended by women. GAC advertises for these events and uses radio announcements to encourage people to come and get tested. Ideally, there would be testing and counseling sessions in diverse locations across the Northern Region, as it may be hard for people in more distant regions to travel to get tested. NGOs could supplement these larger testing and counseling events with mobile outreaches, where they bring staff and nurses to travel directly to a series of smaller communities and offer testing and counseling services. However, funding for these types of projects can currently only be secured by special lobbying efforts to stakeholders. Although funding is currently insufficient for the breadth of testing that would be ideal, it is hoped that with the active implementation of the 90-90-90 target treatment and testing campaign, more funds can be allocated to testing efforts in the Northern Region.

Key Takeaway Points: Limited Resources and Funding

- There is a shortage of test kits for maximum testing
- Test kits for the general population are especially limited, because many are acquired through PMTCT-specific funding
- The 90-90-90 campaign will hopefully mobilize more funds towards testing and counseling resources

Current HIV/AIDS Projects in the Northern Region

Education

Education campaigns have been introduced at varying degrees in schools as well as communities. The Ghana Education Service encourages teachers to integrate material on HIV into their subject curriculum. In addition, certain schools will invite nurses to provide educational sessions on sexual and reproductive health (SRH), especially to female students. Occasionally there will be targeted educational workshops. For example, I conducted interactive classroom sessions on HIV in several Junior High Schools. I provided information and answered student questions on the meaning of HIV/AIDS, transmission, prevention, treatment, testing and stigma/discrimination. Many of the schools I visited were especially grateful, as they had not had an HIV workshop for their students in several years.

Schools are a very structured way to reach a large number of students with the support of teachers and the school system. At each of my in-school programs, I was able to reach between 100 and 200 students. However, there are many young people who are not in formal schools part of the Ghana Education Service. Community members in general would also greatly benefit from education campaigns. So, field visits to community groups are a strong way to educate community members on HIV. For example, I have worked with WAAF to lead educational outreaches to seamstress groups, vocational schools and agricultural groups in the Northern Region.

Peer educators under the support of NGOs such as YARO and Simli Aid provide a permanent educative presence in communities that provide a point person for ongoing questions as well as follow-up proceeding education sessions. So, solutions of targeted community outreaches and active peer educators go hand in hand. One challenge regarding peer educators is ensuring there is sufficient funding for them to obtain transportation to their occasional check-in meetings as well as for any tokens to keep them motivated, such as t-shirts or food at meetings.

Testing and Counseling

In addition to regular testing and counseling provided by hospitals, especially for pregnant women, the GAC organizes formal testing and counseling days in different regions. As discussed previously in this report, community members are encouraged to attend these events to get tested for HIV and simultaneously other STIs such as syphilis. These events are also advertised by radio.

The GAC also assigns NGOs to various districts across the Northern Region with the hope that they will initiate community-based screening events. Depending on its resources, each NGO is responsible for approximately 6 districts. However, due to a lack of funding, it is challenging to mobilize these additional testing and counseling initiatives.

Media Campaigns

Radio is a good tool that is currently used to advertise for testing events, campaigns for health-seeking behavior and against stigma and discrimination. At this point, media use across both radio and television for HIV campaigns is not fully widespread, but the GAC is working on developing contracts for further media campaigns. The GAC also has informative brochures and posters that they distribute at outreach events. They offer information and resources on abstinence, safe sex and testing and counseling.

Models of Hope

Models of Hope are PLHIV who are open about their HIV-positive status and are willing to work with other PLHIV to offer support, and also speak to communities about HIV to change views regarding stigma and discrimination. Models of Hope are key resources for PLHIV who may not otherwise have a support network in their own community or family. They can offer advice on how to manage their nutrition and lifestyle in a way that supports their immune system and retention of ART. Their emotional support is also important especially for newly diagnosed PLHIV. The Models can share their own experiences in coming to terms with and managing with their HIV status. Models of Hope work through hospitals, such as Tamale Teaching Hospital, NAP+ and NGOs.

Support Groups

There are support groups for PLHIV where they have monthly meetings for socialization, sharing ideas and experiences, and motivating each other to see the way forward. Newcomers benefit immensely from these groups, as they hear testimony and may be filled with renewed hope as well as practical advice from peers on ART. The NAP+ office has 22 registered support groups across the Northern Region. Other NGOs, such as YARO, may also be involved with support efforts. However, a lack of funding has caused some support groups to dissipate or meet infrequently, because it is hard for members to afford transportation to the meetings, especially if they come from more distant communities.

Focus Groups and Collaborative Efforts

Sometimes communities or districts will assemble focus groups to discuss HIV/AIDS and the way forward. These groups are meant to be small, roundtable discussions and exceed no more than 10 people. The composition of these groups varies – it may be a group of only PLHIV, or a diverse collection of community members, health experts and traditional authorities invested in HIV issues.

WAAF is also behind a significant new initiative for the Northern Region, the Regional Social Accountability Monitoring Committee (SAMC), which is a group of 11 representatives from the GAC, traditional authorities, Ghana Health Services and additional NGOs involved in HIV activities. This is an exciting new platform that will aim to boost accountability and transparency, collaboration, monitoring and innovation for sustainable projects among stakeholders.

Recommendations

Data Collection and Monitoring

Community-Based Data Collection

It would be constructive to pair more current projects with community-based data collection and tracking, which would monitor for evidence-based project success and accountability. The type of data collected could range from simple to complex, depending on the type of project in the given community or region. Examples of statistics might include the number of PLHIV living in the community, number of condoms distributed, number of encounters with PLHIV per day or month as part of the project, number of bed-ridden PLHIV, number of known defaulters and number of PLHIV who have reported as suffering from domestic abuse. This data, if collected consistently, can serve to track the progress of the work over time to gauge its success and make necessary improvements, better understand the community's needs in order to adjust services appropriately, and also identify whether services are over or underutilized in order to allocate resources efficiently (which is especially important given limited funding and resources). A good example of this type of project is The Sharpening HIV/AIDS Response Partnership and Evidence-Based Research (SHARPER) Project, which concluded after four years in 2013. It targeted Ghana's most-at-risk populations while collecting evidence-based results. This combined implementation and data collection approach is a good model that will be especially effective if sustained over the long term.

Surveys

Another branch of data collection is surveys. While massive surveys have been conducted on a national level, it would be very useful to tailor survey questions and distribution to the Northern Region, even if the sample size is not as large, as results will be highly specific and informative. WAAF in collaboration with GAC or other NGOs could select a representative demographic of people from diverse communities across the Northern Region and conduct verbal or written surveys that ask questions to determine level of knowledge of HIV/AIDS and transmission, the degree of stigma and general opinions on PLHIV, level of condom usage, willingness and frequency of HIV testing, and the importance of HIV-related and general health needs in their community. These questions could be standardized and simple; literacy may be a barrier, so instead of open-ended questions, surveys could involve yes/no answers or a rating system on a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree. Surveys can be used and administered on a big scale and small scale:

- 1) Big scale: Surveys can clarify or confirm big picture views and knowledge on HIV/AIDS across the Northern region. They could help identify vulnerable groups and give especially strong information on the sources and consequences of stigma, which may also vary by region. Selecting diverse communities could facilitate very interesting analysis that may explain and distinguish why certain regions have different rates of HIV prevalence, stigma or defaulters.
- 2) Small scale: An individual community's survey results could be very informative on its needs and status before beginning a new initiative. At the moment, most projects begin by conversations with community leaders or stakeholders. However, not all voices are

equally powerful in communities, so surveys are a helpful tool to develop an objective picture on the status of the community.

Targeted Education Campaigns

Education is widely regarded as a powerful approach to combat stigma and discrimination, which often arises from a fear of the unknown and myths about transmission. Having education campaigns can also stimulate increased dialogue surrounding HIV/AIDS, make it a subject that people are more comfortable with, and encourage community members to ask clarifying questions. It may also promote more proactive health-seeking behavior, as people will have improved awareness about the dangers of HIV, STIs, TB as well as SRH in general.

Schools

As discussed previously, there are already education campaigns underway, such as educating students in schools about HIV. One way to improve the efficacy of these structured education campaigns in a school environment would be to administer pre-tests and post-tests to the students to evaluate how much knowledge they retained and can apply after a workshop or series of classroom lessons on HIV. In addition, many schools either do not have or have inactive clubs on health, SRH or HIV. It would be very helpful to support schools to revitalize these clubs, which can operate without significant resources. This type of club would complement formal HIV education well because it moves the students from learning passively about HIV and SRH to thinking actively about how they can prevent it in their own communities. Especially if encouraged by their teachers or headmaster, students may be motivated to join because of future career interests or personal interests in health, the opportunity for leadership roles and to feel engaged in the school community. Their active club participation might empower them to share their knowledge with their friends and family.

Workplace

While many education initiatives are youth-based, another structured environment to encourage education around HIV for adults is the workplace. Education can be provided at workplaces of all kinds: grocery stores, seamstress shops and offices. Some workplaces already have HIV awareness campaigns or run special events on World AIDS Day. It may be useful to develop a manual or list of suggestions for recommended workplace HIV awareness plans to standardize programs in more workplaces so that employees are not just aware of HIV but also can develop comprehensive knowledge. Some suggestions could include displaying posters and providing free GAC brochures on HIV, having quarterly or yearly workshops where a nurse gives an informative presentation and fields questions, or hosting a roundtable discussion on stigma and discrimination.

Community Groups

Moving forward, there should be increased coordinated efforts among NGOs to provide education to community groups as fieldwork. It would be constructive to identify and target towns or communities where stigma or HIV prevalence is known to be high and the vulnerable

groups within those communities, as well as more distant villages that might not otherwise be reached. Community leaders can help NGOs get in touch and coordinate with vulnerable populations. In addition, although many students can be reached through schools, it is important to follow the lead of organizations such as Simli Aids to support improved efforts to reach out-of-school youth. For example, I was able to reach large groups of young people through outreaches to seamstress groups, vocational schools and young men's groups with WAAF in the Northern Region, and going forward these programs could be a successful way to structure outreach on an ongoing basis. WAAF and partner NGOs can also lead whole community outreach sessions in public locations (such as a local market) as well as several smaller talks to meet the needs of these target groups, and then begin to train peer educators to sustain the effort and answer follow-up questions.

In addition, it would be ideal to pair education outreaches with screening opportunities. Often, the new information from the outreach triggers many questions and anxieties about testing and how people can prevent HIV infection, a phenomenon I observed during my own outreach sessions. It would be very useful to secure funding to have test kits, a nurse and counselor prepared to test and also answer questions in private following an educational outreach.

Mass Media Outreach

Direct community-based outreach is highly effective, but it is also constructive to consider how to reach a large number of people with messages about HIV/AIDS. Radio has already been a successful tool for advertising for screening events. Going forward, Northern Region radio and television can be used in the same way to disseminate messages such as "know your status," "HIV is not a death sentence" and to counter stigma and discrimination by raising awareness and dispelling misconceptions. WAAF could lend its support as a cosponsor and help direct Northern media campaigns. In general, using popular media sources to speak about HIV/AIDS may break the seal on taboo discussion about the issue, encourage dialogue and begin to change stigmatized or fearful mindsets.

In addition to shorter messages and advertisements, longer airtime segments on radio or television could be used to host interviews with Models of Hope, HIV allies and stakeholders as well as question and answer sessions with HIV experts. These programs would be especially useful in boosting comprehensive knowledge. They could run regularly, or be structured around special events, such as World AIDS Day or World Tuberculosis Day.

Social media is also a growing platform for disseminating information to many people. This is an especially important tool for reaching young people. WAAF or GAC can use Facebook and Twitter to advertise for testing and counseling events in the Northern Region, share articles and information to educate about HIV/AIDS and spread positive messaging to reduce stigma and discrimination. Already, WAAF has a strong Facebook and Twitter presence, which it could build on or use as a model for additional social media campaigns specific to the Northern Region.

Improved Condom Access and Distribution

This report identified insufficient condom use as a barrier for prevention. While condoms are often readily available at many shops, individuals may be reluctant to purchase condoms because of shame and sometimes cost. GAC already has a great initiative of stationing condom machines in locations across the region. These machines are very effective and more anonymous, and these should continue to be installed.

It is also important to consider additional ways for community distribution of condoms. For example, following education outreach sessions or testing and screening events, staff could distribute condoms and also use the opportunity to explain how to properly use them. They can also explain the importance of condom use, attempt to dispel any shame around condom use and identify where to buy condoms in the future.

Clinics, CHPS compounds and other community organizations (such as the WAAF Savelugu office) could also carry condoms. It would likely be unsustainable from a funding perspective for these condoms to be entirely free and would also undermine other vendors of condoms. So, these centers could provide condoms at a minimal cost. Since sensitive staff administration would be involved in this distribution approach, people are less likely to feel judged for going to buy condoms and can also ask questions on proper condom use.

Structured Counseling and Support for PLHIV

Clinical

An HIV diagnosis and its consequences can be a trigger for depression, anxiety or stress. Mental health is very important but often overlooked. Mental sickness can manifest itself in a lack of motivation, loss of employment, lack of appetite, and eventually even physical ailments. It is rare for patients to choose to visit a hospital for psychological reasons, and there are limited mental health-specific resources and outreaches.

There should be a more structured support network to identify and care for HIV patients with mental health concerns such as depression. Clinical depression is best cared for by professionals, and often, with antidepressant medication. So, a good place to develop infrastructure around clinical mental health issues would be at the hospitals where patients must already visit monthly or bimonthly to procure ART. Already, at many hospitals patients have a check-in with a doctor or physician's assistant during this monthly visit to discuss their progress. This point person should be thoroughly trained in identifying signs of depression, anxiety and suicidal notions. They should be prepared to provide counseling and be able to direct the patient to additional resources. Diagnosis is a key step, as mental health issues cannot be dismissed as temporary sadness. If the patient has a mental health issue they should receive follow up counseling from a psychologist, doctor or trained nurse. While some hospitals have designated counselors for HIV patients, these counselors often do not broach emotional issues and instead focus on practical plans around treatment retention, physical health and nutrition. Any implementation or training of additional psychological counseling resources could be done through Ghana Health Services and the Regional Health Directorate in a way that also reinforces the importance of respect for HIV patients and sealed confidentiality.

Managing mental health is a significant issue that is often ignored, even beyond the scope of HIV. It is challenging to follow up with and track patients with chronic concerns, especially those who may live far away from major hospitals or clinics. CHPS compounds in communities could be constructive tools for more frequent support, so it would be helpful to offer training sessions for their staff on identification of mental sickness, tools for therapy and sensitive and confidential counseling of HIV patients.

Ongoing Support Networks

In addition to diagnosis of clinical mental health issues, living with HIV comes with many stressful challenges. This is where support groups are fundamental in providing a safety net and community for PLHIV. While support groups already exist, unfortunately many are not always functional, perhaps due to funding constraints. It would be constructive to allocate resources to ensure these groups are always active. In addition to the work NAP+ already does with support groups and Models of Hope, motivating, meeting with and supporting Models of Hope in ongoing dialogue as they manage support groups would really help their continuation. Moreover, the hospital point person who works with PLHIV should actively encourage PLHIV to attend support groups and be entirely familiar with the logistics of registered group locations, meeting times and contact information. They should check in to ensure their patients are able to attend their support group and that they feel they are benefitting from the experience. They can relay any feedback they receive from the patients about the support group to Models of Hope who have taken on leadership roles. Ultimately, the goal should be to create a closed loop where the patient can seek help and is accounted for by community-based support as well as hospital care. This constant communication and building of community support will not only improve PLHIV quality of life, but also help identify patients who may be at risk or who have defaulted on ART.

Defaulter Tracing

A more comprehensive and structured system to track PLHIV who have defaulted on ART would serve as an important safety net. Currently, there is no region-wide system in all health facilities that keeps track of PLHIV and their retention. It is mostly up to each hospital's own initiative to be thorough in identifying whether their HIV patients are following up appropriately. Thanks to many dedicated and caring health professionals, many hospitals have been successful in setting regular schedules for their HIV patients to have check-in appointments and pick up their medications, and call them for follow-up if there are ever any issues. Ideally, every single ART-distributing hospital caring for HIV patients would have this same standard of care continuity.

It would be useful to work through the Northern Regional Health Directorate to ensure hospitals follow specific delineated protocols to track HIV patients. One infrastructural approach is to ensure every HIV patient has one constant primary contact person at the hospital that they always see for checkup when they visit the hospital to pick up their ART. This contact person should be in regular communication with them by appointments and by phone, and should reach out immediately if they miss an appointment or ART pickup. This will not only ensure that there is an identifiable communication link, but will also help develop an ongoing personal rapport that can be used to support the PLHIV.

Most hospitals keep patient contact information (address, phone numbers) as well as an emergency contact or relative on record. However, defaulting patients may prove unreachable. One solution for defaulter tracing is to recruit and train counselors or social workers to perform home visits to clients. If a doctor is unable to reach their patient and deems additional outreach necessary, they could call this service to request the nearest social worker to reach out directly to the home of the patient. This would need to be done very carefully and professionally, as the matter is highly sensitive. Counselors at hospitals across the Northern Region or social workers could be trained on how to handle these circumstances and perform home visits. While this training and service may be resource-intensive, it would ensure comprehensive follow-up for PLHIV that could rescue them from extenuating circumstances that have caused their defaulting. This targeted tracing and outreach could also be integrated as part of Home and Community Based Care programs for PLHIV, which are discussed in the next section.

Home Based Care, Training and Outreach

WAAF has recently collaborated with the GAC to develop a National Home Based Care Training Manual. Home based care is a national initiative that is gaining increased attention; establishing home based care for vulnerable groups is listed in the GAC's National HIV and AIDS Strategic Plan for 2016-2020. Home based care is an important approach for PLHIV, especially those who have progressed to AIDS, who are suffering from other health issues that may leave them bedridden or confined to their house, or who do not have access to a support network or registered support group. Hospital visits to pick up ART and meet with counselors often serve as an important anchor for treatment retention and monitoring. Home based care helps ensure that patients not visiting the hospital regularly are cared and accounted for, and will be an important program to expand in the Northern Region, especially given its rural demographic. As discussed in the Manual, the next step would be to train community health care providers to in turn train home based care providers (relatives, household members, friends, volunteers) to take care of PLHIV mentally and physically, and also be capable of connecting them with a network of resources. Home based care and its training process also has the benefit of increasing visibility and awareness around HIV, improving comprehensive knowledge among those involved in the care, and involving the community, which can begin to reduce stigma.

Targeted home visits are another approach for purposes of education, testing and counseling. Although they may be time intensive, they could be planned for hard-to-reach communities that do not otherwise participate in HIV outreach events. Trained personnel go house-by-house to discuss HIV and offer free testing. This could increase awareness, decrease stigma and improve prevention at the family level.

Connecting PLHIV to Basic Necessities and Resources

As discussed earlier in the report, many PLHIV may lose their jobs or face economic challenges, which prevent them from obtaining quality nutrition or providing for their families. Already, organizations such as the World Food Programme often provide staple food items to PLHIV in need. Especially since the Northern Region has the benefit of being a center for agriculture, there is strong potential for nutritious food distribution efforts. These efforts could be expanded

through collaborations with home based care, where volunteers or caretakers would be able to collect food on behalf of PLHIV and distribute it to those in need in the community.

In addition, guidance in the employment search or job retraining could economically empower PLHIV and also instill in them a sense of hope. In addition to regular counseling that PLHIV receive at hospitals on their visits, hospitals could invite consultants on a monthly or quarterly basis to meet with groups of PLHIV and offer advice on how to navigate the employment market. If this is not possible, counselors can be informed on job opportunities or how to search for jobs, or have a list of phone resources, suggested websites and brochures available for PLHIV.

Additional Health Facilities and Visibility

Increasing Number of Clinics

In the long term, it would be very important to have a greater number of clinics throughout the Northern Region. As it stands, not all geographic areas are sufficiently serviced by clinics and hospitals. Moreover, many clinics are often very busy and already have long waiting times. The reason clinics are so important for HIV is that they are often the first line of defense to identify patients whose symptoms and behavior may point to a need for an HIV test. Moreover, clinics are used as venues for special testing and counseling events. Clinics can serve as a way to distribute reputable information on HIV to dispel stigma and encourage prevention and testing (during the doctor visit itself, or by pamphlets and posters in the waiting room). For people who are always working or who cannot travel easily, having a more nearby available clinic would make a big difference. From WAAF's perspective, establishing an IHCC location would be a very meaningful next step in the Northern Region, especially if WAAF could work with Ghana Health Services to identify currently underserved, but accessible areas with a population density where opening a clinic could reach many new patients.

Increasing Clinic Visibility

Existing clinics can use advertising and messaging campaigns to boost their visibility and emphasize their mission. As discussed earlier, usually with the exception of pregnant mothers, many people lack active health-seeking behavior or prefer traditional healing. Although many clinics are already very busy, using positive media campaign messaging to popularize health-seeking behavior and clinic visits might help push back on the instinct to always first visit traditional healing, rescue people from their sicknesses before they become more serious and identify HIV patients and get them started on ART sooner. Clinics are also important resources that can help provide or direct patients to resources for HIV testing. MICS 2011 indicates that the Northern Region is behind in knowledge of places for HIV testing as well as people knowing their HIV status; only 49.4% of women knew a place to get tested, and only 8.7% had been tested in the past 12 months and knew their results, both statistics being the lowest in all regions in Ghana. While these figures have likely improved since the 2011 survey, increased clinic prevalence and visibility could help provide more testing events and improve access to information and resources about testing opportunities.

WAAF/IHCC Development in the Northern Region

It would be terrific for WAAF to be involved in many of the recommendations described in the report as WAAF becomes increasingly involved in HIV projects in the Northern Region. This may also involve collaborative efforts with government and health organizations, traditional authorities, community stakeholders and NGOs. In general, WAAF's efforts could make a big difference through community interventions as well as infrastructural changes.

In addition, WAAF/IHCC could consider how to maximize its current presence and space in the Northern Region. The office space itself could be a very important resource in Savelugu and neighboring towns and villages – it is accessible and easy to identify, as it is right near the landmark of the Custom Barrier. It could become a comfortable and safe community visiting space and hub for SRH and HIV efforts. The Savelugu office could host weekly or monthly structured events on HIV/AIDS or SRH. This could take on many forms: testing and counseling sessions, male and female condom distribution, and presentations or confidential counseling on SRH. Groups could be invited from the community holistically so that individuals would not feel stigmatized or vulnerable about being associated with HIV/AIDS. Overtime, as events become more popular and frequent after an initial investment or trial period, they could be expected to generate greater funding to become sustainable.

WAAF's Savelugu office has the potential to continue and strengthen its impact at the community level. In order to amplify this impact, WAAF should increase its visibility in the Northern Region. The educational outreaches that WAAF has been doing in the North as well as outreaches relating to HIV and TB are a great way to familiarize community members with WAAF's staff and resources. In addition to visiting community groups and young people for education sessions, WAAF could host several larger sessions in high-visibility locations, such as Savelugu Market, to do education and ideally also HIV screening, resource-permitting. WAAF should continue to network with community stakeholders and fellow NGOs to stay in the loop and identify high-priority projects it can collaborate on, which would also strengthen its community reputation. In order to bolster its name recognition, WAAF can distribute HIV awareness and information posters to workplaces, schools and stores that feature WAAF's logo, services and contact information. At education or screening events, WAAF can hand out brochures or cards with this same information. WAAF can also increase its visibility by co-sponsoring media campaigns (radio, television and social media) along with GAC or other organizations, or even host its own radio or television spots and use Facebook to advertise for its community services.

Conclusion

In this report, I compiled extensive first hand research to identify the current status and barriers relating to care of PLHIV, HIV prevention and testing and current projects underway in Ghana's Northern Region. I identified recommendations on how to best meet HIV needs in the region and in particular, specific initiatives that WAAF can lead and support given the Northern Region's unique cultural, social and practical challenges. While resources and funding can be limited, this report can be used to identify specific projects that will yield high impact results and that can be priority initiatives. In working at the community level to reduce stigma and discrimination, improve education and prevention, support PLHIV and expand efforts for testing, WAAF can become a strong force in the Northern Region in addressing, caring for and managing HIV.