Unburying the Ostrich’s Head and Opening Pandora’s Box:
A Paradigm Shift to Address HIV among Men who have Sex with Men in Ghana’s National AIDS Response

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Unburying the Ostrich’s Head and Opening Pandora’s Box: A Paradigm Shift to Address HIV among Men who have Sex with Men in Ghana’s National AIDS Response

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For the first twenty-five years of Ghana’s national response to HIV/AIDS, the government, like most nations in Africa, did not include gay and bisexual—locally known as sasoi—and other men who have sex with men (MSM) as a high-risk group for HIV in its policies. In 2011, Ghana finally addressed this policy blind spot by acknowledging sasoi and other MSM as a key population at-risk for HIV and in need of policy and programmatic interventions—a shift that is occurring in many parts of Africa. Using Ghana as a case study of this policy shift on the continent, my dissertation examined: why sasoi and other MSM were not initially acknowledged in Ghana’s national AIDS policies; why and how the government decided to include MSM as a key population in its national AIDS policies and programs; what cultural, social, and political factors have affected the development, implementation, and reception of these policies and programs; how sasoi and other MSM perceive and experience these policy and programmatic efforts; and how sasoi and other MSM experience life in a country that criminalizes and stigmatizes same-sex sexual activities. Using ethnographic methods, I conducted a 12-month qualitative study in Ghana. I conducted: interviews with 43 state and non-state policymakers and stakeholders, HIV frontline workers, and sasoi and other MSM; focus group interviews with 18 peer educators; participant observations of policy and HIV prevention work, and meetings and other events related to the research scope; and archival research of media coverage of homosexuality. My findings indicate that Ghana’s MSM policy blind spot was due to: 1) the criminalization and stigmatization of same-sex sexualities in the country, 2) a construction of the Ghanaian epidemic as driven by migrant female sex workers, and 3) international AIDS researchers’ categorization of HIV in Africa as heterosexual, which informed donor policies and stipulations. However, in 2011, the government shifted to include MSM as a KP at risk for HIV in
light of mounting epidemiological data on MSM HIV prevalence and risk, NGO advocacy efforts, and international donor policy changes that now recognize MSM as a KP in Africa. I conceptualize this change as a paradigm shift in Ghana’s national AIDS policies from a general population paradigm to a key populations paradigm that includes MSM as biomedical citizens at higher risk for HIV. The country’s progress in addressing HIV among sasoi and other MSM using evidence-based policies has earned it status as a model country in Africa in MSM HIV efforts. Stakeholders, however, face significant challenges rooted in the country’s sociocultural context, namely institutionalized homophobia and heterosexism, a dated and underfunded healthcare system, and inadequate HIV funding. Implementation of MSM HIV policies has come into conflict with the country’s legal and sociocultural realities in Ghana, where male same-sex sexual activities are criminalized and socially stigmatized. Moreover, stakeholders are strategically discreet in how they implement MSM HIV policies and programs and are hesitant to publicly push any advocacy efforts that might come across as supporting or promoting homosexuality, in fear of social and political retribution. Despite this strategy, I argue that MSM HIV efforts have attracted public attention and criticism and have constituted, in part, the politicization of homosexuality in Ghana, reshaping public representations and perceptions of homosexuality and presenting challenges to the ongoing efforts to address HIV among MSM. Stakeholders must evaluate these unintended consequences alongside the intended policy objectives and outcomes to strengthen efforts to reduce the burden of HIV among sasoi and other MSM in Ghana.
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral treatment</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
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<tr>
<td>CEPEHRG</td>
<td>Center for Popular Education and Human Rights Ghana</td>
</tr>
<tr>
<td>CHRAJ</td>
<td>Commission for Human Rights and Administrative Justice</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>FHI 360</td>
<td>Family Health International 360</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex workers</td>
</tr>
<tr>
<td>GAC</td>
<td>Ghana AIDS Commission</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>GPA</td>
<td>Global Programme on AIDS</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRAC</td>
<td>Human Rights Advocacy Centre</td>
</tr>
<tr>
<td>IBBSS</td>
<td>Integrated Bio-behavioral Surveillance Survey</td>
</tr>
<tr>
<td>KP</td>
<td>Key Populations</td>
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<tr>
<td>KP TWG</td>
<td>Key Populations Technical Work Group Steering Committee</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, and Queer</td>
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<tr>
<td>MARPs</td>
<td>Most-at-risk populations</td>
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<tr>
<td>MoT</td>
<td>Modes of Transmission</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NACP</td>
<td>The National HIV/AIDS/STI Control Programme</td>
</tr>
<tr>
<td>NSF</td>
<td>National Strategic Framework</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The U.S. President's Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PREP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>STD/STI</td>
<td>Sexually Transmitted Disease/Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>The United States Agency for International Development</td>
</tr>
<tr>
<td>WAAF</td>
<td>West African AIDS Foundation</td>
</tr>
<tr>
<td>WAPCAS</td>
<td>West Africa Project to Combat AIDS &amp; STI</td>
</tr>
<tr>
<td>YPEP</td>
<td>The Youngsters Peer Education Project</td>
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DEDICATION

To three brilliant African women: my late grandmother, Yaa Badu, my mother, Leticia Osei, and my sister, Ama Gyamerah. For a world without borders.
...Mr. Speaker, there are key populations in which HIV infections remain much higher than the national average. Among sex workers the infection rate is 11.3%. It has dropped significantly from 25% in 2009, but it still remains well above our target, as does the infection rate among men who have sex with men, which currently stands at 17.5%. Mr. Speaker, education has proven to be the most effective tool in the battle against the spread of HIV/AIDS...We will continue our public awareness campaigns, specifically ones targeting those populations at greatest risk.

-President John Dramani Mahama, State of the Nation Address, 2014

In his second State of the Nation Address (SONA) on February 25, 2014, the president of Ghana, John Dramani Mahama, made history when he mentioned men who have sex with men (MSM) as a key population (KP) at risk for HIV in Ghana’s AIDS epidemic. This was the first time a president of the country had acknowledged homosexuality in a major public address in a manner that recognized homosexuals as members of the state in need of government support and resources. It was also the second time a president made reference to homosexuality in the SONA. The first time, in fact, was during Mahama’s first SONA the year before, in which, amidst a media moral panic about homosexuality, he denied public accusations that his administration planned “to promote gay rights” (Mahama, 2013). The significance of Mahama’s reference to men who have sex with men, although brief, cannot be overstated. Homosexuality has become a politically charged topic in Ghana, sparking numerous panics from nearly every sector of society about its encroaching influence and morally and socially destructive power. Thus, for many in Ghana’s Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community, the President’s acknowledgement of their sexuality was a beacon of hope—a sign that perhaps things might improve for same-sex loving people in the country.

1 I use LGBTQ here to identify the population, community, and network of same-sex loving individuals in Ghana in lieu of an emic umbrella term for the group. Although LGBTQ is commonly used by members within this community in Ghana, I recognize the limitations of its applicability to Ghana, given its Western roots.
The president’s recognition of men who have sex with men would not have been possible if the government—particularly the Ghana AIDS Commission (GAC)—had not decided just three years prior, to include men who have sex with men as a key population in the country’s national AIDS policies. This inclusion of the men, formalized in the 2011-2015 National Strategic Plan (NSP) for Most at Risk Populations—the first such policy document by an African country—earned Ghana a status as a model country in KP efforts. This development was concurrent with a broader shift in the region, whereby a growing number of nations were beginning to recognize MSM as an at-risk population for HIV over three decades after the discovery of the virus.

The HIV Epidemic in Ghana

HIV was first identified in Ghana in 1986, six years after its discovery in the United States. Three decades later, with a prevalence of 2.0%, the West African country has maintained one of the lowest HIV prevalence in sub-Saharan Africa, although, its prevalence has increased over the past few years. In 2015, 12,635 people were newly diagnosed with the virus, while 10,958 died from it (Ghana AIDS Commision, 2016). According to the most recent Mode of Transmission (MoT) report, the HIV incidence rate for 2015 was 0.08%, with 72.3% of incidence occurring among the general population (Ghana AIDS Commision, 2016). Currently, there are approximately 274,562 people living with HIV (PLHIV), with 89,113 on antiretroviral treatment (ART) (Ghana AIDS Commision, 2016). Within this population, women continue to bear the brunt of the epidemic, making up 60% of PLHIV, while children make up about 8% of PLHIV. Although the country boasts 2,335 testing sites and increasing testing rates, these rates remain low, with 43% of women and 20% of men testing for HIV.

While Ghana currently defines its HIV epidemic as a generalized one, it has identified female sex workers, men who have sex with men, people who inject drugs (PWID), and prisoners as key populations in its national AIDS response. Particularly, among female sex
workers, HIV prevalence is 11%, while among men who have sex with men, it is 17.5%—the highest among KPs. Despite the inclusion of PWID and prisoners as KP, there is not yet a credible prevalence estimate for these populations. A 2013 study, however, reports a prevalence of 2.3% for the prisoners studied (Ghana AIDS Commission, 2016). The most recent MoT also found PWID to have the highest incidence out of all KPs, with a rate of 3,543 cases per 100,000 people. The same MoT report indicates that out of new HIV infections, MSM and sex workers make up 3.6% and 18.4% of new cases respectively (Ghana AIDS Commission, 2016).

Although Ghana now acknowledges male same-sex transmission of HIV in its national AIDS policies, this has not historically been the case. For most of the epidemic, the country ignored sasoi\(^2\) and other men who have sex with men as a vulnerable at-risk group. This was reflective of decades of international AIDS polices that also ignored homosexual transmission in the global South, especially in Africa.

**Research Questions and Methodology**

Using Ghana as a case study of this AIDS policy shift in Africa, my dissertation examined why sasoi and other MSM were not initially acknowledged in Ghana’s national AIDS policies, why and how the government decided to include MSM as a key population in its national AIDS policies and programs, what cultural, social, and political factors have affected the development, implementation, and reception of these policies and programs, how do sasoi and other MSM perceive and experience these policy and programmatic efforts, and how do sasoi and other MSM experience life in a country that criminalizes and stigmatizes same-sex sexual activities. Of particular interest in this study were the underlying discourses and uses and basic ideologies of these policies and programs (Wedel, Shore, & Feldman, 2005). I also examined

\(^2\) *Sasoi* is the plural noun of *Saso*, a local emic term used to refer to gay, bisexual, and other same-sex loving men in Ghana. While the term is broadly used for this group, it is commonly used to refer to more feminine-presenting male same-sex loving individuals.
the sociocultural context in which these changes are occurring and in which sasoi and other MSM experience life in Ghana

Three key questions guided the study. First, I examined why and how MSM HIV prevention policies in Ghana were developed and what local and international factors have influenced the process. This shift occurred 25 years into the country’s epidemic. Thus, I was interested in understanding why the government took so long to acknowledge male same-sex HIV transmission among its population. Additionally, which developments marked a turning point to them recognizing and including sasoi and other men who have sex with men in national AIDS policies and which actors played a role in this process? I also examined the scope and content of MSM HIV policies, which actors were involved in developing and institutionalizing them, and in what ways stakeholders have received, resisted, and reinterpreted donor guidelines and best practices on MSM HIV prevention? I also examined what local sociocultural factors, such as criminalization and perceptions of homosexuality, inform the policy-making process and how these interact with international processes such as international development aid and global gender and sexual politics.

Second, I examined how MSM HIV prevention policies and programs were being implemented and the experiences of frontline workers who carry-out prevention programs. What is the scope of prevention and care programs and do they reflect policy objectives for MSM? Which aspects of the prevention and care programs are going well and what challenges exist in program implementation? What sociocultural factors shape these processes and what are the impacts of these policy changes, including their intended and unintended consequences?

Third, I examined the experiences of sasoi and other men who have sex with men in living as queer Ghanaians and as a population considered at risk for HIV. Here, I was interested in the legal and sociocultural landscapes that shape sasoi lives in Ghana. How is homosexuality perceived and treated in Ghanaian society? By community and family members? What representations, stories, and discourses about same-sex sexualities are circulated within the
Ghanaian public? Which actors and institutions are involved in these circulations? What social and economic positions do sasoi Ghanaians hold? How do these shape the group’s experiences of accessing HIV prevention and care services? How are these experiences affected by local and international sexual politics and what implications do these have on stakeholder efforts to address HIV among sasoi and other MSM?

Through a sociomedical lens, I conducted a 12-month study using qualitative ethnographic methods to answer these research questions. I conducted 43 in-depth interviews with state and non-state policymakers and stakeholders, representatives of donor agencies, HIV service providers, peer educators, sasoi and other men who have sex with men. I also conducted focus group discussions with 18 peer educators from two MSM HIV and STI prevention community non-profits. I conducted participant observations of Key Populations Technical Work Group Steering Committee3 (KP TWG) meetings; HIV service providers; two community-based organizations engaged in HIV and rights advocacy work for LGBTQ populations; peer educator meetings and community outreach; conferences, meetings and other events related to the research scope, and social venues and settings. Finally, I conducted archival research of print and online news media articles on homosexuality.

A description of “sasoi and other men who have sex with men” is necessary before proceeding. Sasoi is the plural tense of saso, a local term developed by members of Ghana’s LGBTQ community to describe same-sex loving men. It is typically used to describe feminine men, although other gay and bisexual men identify with the term as well. Throughout my dissertation, I use the term “sasoi and other MSM” to refer to homosexually-identified men and gender non-conforming people assigned male at birth and other men who fall outside this category and engage in same-sex sex. This term is emic and is used by members of the LGBTQ community but is not known to, or used by, the broader Ghanaian population.

3 The initial name for this work group was: Most-at-risk populations (MARPs) Technical Work Steering Committee. However, MARPs was replaced by KP a couple of years after the group was formed.
MSM on the Margins: A Blind Spot in the Global AIDS Response

Today, in practically every corner of the African continent, the topic of homosexuality has become a hot button issue, sparking public debates in different localities. This politicization of homosexuality is in large part a product of a polarized international discussion, most visibly in the United Nations, on whether nation states should ensure human rights protections for sexual orientation and gender identity (SOGI) (United Nations Human Rights Council, 2011). Many Western governments and LGBT organizations have especially focused on Africa because a disproportionate number of its nations criminalize some aspect of same-sex sexualities—a direct outcome of colonial legal regimes. Moreover, Uganda's infamous anti-homosexuality law, dubbed the "Kill the Gays Bill" in 2009, served as a catalyst to this international spotlight on Africa. In this polarized context, the African homosexual has become development's newest subject in need of saving on the continent (Gyamerah & Gore, 2015).

The recognition of Africa as home to LGBTQ people in need of international interventions, most prominently within the global AIDS response, is a recent development. During the first decade of the epidemic, as more data was gathered on the pathology and epidemiology of the infection, researchers began to differentiate the epidemiology of the disease in ways that assumed negligible presence of same-sex sexualities in Africa. Notably, one of the key constructions by leading scientists and public health figures from this period about the HIV epidemic was that it was homosexual in North American and other parts of the global North, what they referred to as Pattern I, and heterosexual in Africa and other parts of the global South, referred to as Pattern II (Chin & Mann, 1988; J. M. Mann, Chin, Piot, & Quinn, 1988; Piot et al., 1988; Quinn, Mann, Curran, & Piot, 1986). This epidemiological characterization informed the first two decades of international and subsequently, national AIDS policies, in which same-sex sexual transmission of HIV in global South nations was rendered invisible. Marc Epprecht's
(2008) seminal book, *Heterosexual Africa?: The History of an Idea from the Age of Exploration to the Age of AIDS*, described this as a policy blind spot within the global AIDS response—an error that would have significant implications for gay, bisexual, and other men who have sex with men in these parts of the world, including Ghana.

One of the first reports to examine this blind spot was *On the Margins: Men who have sex with Men and HIV in the Developing World*, commissioned by the Panos Institute and written by Neil McKenna (1996). The report, which aimed to uncover as much as possible about HIV transmission among men who have sex with men in the developing world, was the first comprehensive report to seriously examine the global situation on male-to-male sexual transmission of HIV and the legal and sociocultural contexts underlying this population’s risk. The study surveyed National AIDS Programs (NAPs), National AIDS Service Organizations (ASOs), and local and international NGOs in 133 countries in the Africa, Asia, the Caribbean, Latin America, Middle East, and the Pacific. It additionally surveyed international and local gay and lesbian organizations.

The findings of the study illuminated how little attention global and national responses to HIV had paid to male same-sex transmission outside of North America and Europe, despite the existence of limited but significant emerging research that found male same-sex sexual activities and HIV transmission a reality in the global South. Particularly, out of the 43 completed NAP questionnaires from 39 countries, 78% indicated they had not conducted any socio-behavioral research on the knowledge, beliefs, attitudes, and practices of MSM. Only 19% of respondents had conducted such research. Out of the 119 completed questionnaires by ASOs and NGOs from 60 countries, 73% reported they were unaware of socio-behavioral research on MSM and 24% reported being aware of such research. Most of the countries that had conducted studies on MSM were in Asia and Latin America. Relatedly, 52% of all respondents stated that there was no public awareness or discussion of male-same-sex sex, with Africa reporting the highest level of invisibility and silence, while 47% reported that there was some
discussion or awareness of it. The study also found that 75 out of the 133 countries surveyed had laws that criminalized some aspect of male same-sex sex, although many of the respondents, including two-thirds of the NAPs respondents, shared that they were unaware of such laws when they were asked about them. Moreover, 7 countries used other laws to criminalize male same-sex sex and 34 nations did not have any laws targeting sex between men.

In addition to these findings, the Panos study found that during the early 1990s, the main global program in response to HIV, the World Health Organization’s (WHO) Global Programme on AIDS (GPA), engaged in a doublespeak regarding HIV. That is, they acknowledged internally that male same-sex transmission was a significant part of the HIV epidemic globally; however, in public discussions of the epidemic, their publications discussed the declining role of sexual transmission between men, suggesting that the epidemic was heterosexual as it spread globally (McKenna, 1996). Thus, despite conducting research on male same-sex HIV transmission in the global North, they held the belief that it was primarily heterosexual in the global South.

The report by McKenna did not indicate whether such characterizations were directly responsible for the lack of acknowledgment of male same-sex transmission in NAPs. It does, however, suggest that the blind spot affected these national programs, particularly since the GPA funded many of the National AIDS Programs. It was also significant that many of the National AIDS Program respondents did not think addressing HIV among men who have sex with men was a priority. When asked about how much of a priority understanding the scope and nature of HIV among male same-sex sex and its impact on HIV was, 11% saw it as “an urgent priority”, 27% saw it as “an important priority”, 35% saw it as “a useful exercise”, 14% saw it as “a low priority”, and 11% saw it as “not a priority”. None of the respondents from African or the Middle Eastern National AIDS Programs viewed it as an urgent priority. Moreover, only 25% of National AIDS Programs identified men who have sex with men as part of the groups they target for HIV prevention and out of that group, only one of those programs was in Africa and another
in the Caribbean. Only 24% had services that included men who have sex with men. The only nation in Africa within the group was Mozambique. Finally, only 8% of NAPs—all in Asia and Latin America—indicated that they allocated money for HIV efforts targeting men who have sex with men, while 84% did not. Notably, the report ended with a call for national governments, NAPs, and international agencies and donors to place a higher priority on HIV/AIDS research and programmatic efforts, calling it their moral imperative:

AIDS prevention efforts among men who have sex with men in the developing world will be ineffective, uncoordinated and grossly inadequate unless and until there is clear, determined and sustained international leadership, backed up by an international determination to address the issue. (McKenna, 1996; p. 112)

Other scholars who were among the early critics of the “fictional” construction of heterosexual HIV in the global South were Parker, Khan, and Aggleton (1998). In their article, “Conspicuous by their Absence? Men who have Sex with Men (MSM) in Developing Countries: Implications for HIV prevention”, they problematized the continual silence of governmental and intergovernmental agencies on male same-sex sexual transmission in the global South nearly two decades into the epidemic. They further connected this silence to the ways in which epidemiological data can obscure epidemiological reality. They drew attention to the significant gap between the reality of transmission between men outside of Western nations, and the myth of a heterosexual epidemic in these areas. Calling the lack of inaction “irresponsible”, the authors reviewed the important work of NGOs and community organizations in different parts of the global South were engaged in to fill this policy and programmatic gap. Likewise, agencies like the Red Cross in Norway, the Red Hot AIDS Charitable Trust in the United Kingdom, and HIVOS in the Netherlands were among the few Global North agencies to provide funding opportunities to community organizations and NGOs in the global South to address transmission between men. As researchers and scholars with first-hand experience engaging in research among gay, bisexual, and other men who have sex with men Parker, Khan, and Aggleton (1998) ended their article with the following plea:
Conspicuous by their absence, the widespread denial of the needs of men who have sex with men in the developing world is another example of the long record of neglect that should bring shame not only to government agencies and international donors, but to all of us who work not only for an end to the epidemic, but also for a more just and tolerant world. (p. 342)

As McKenna (1996) and Parker, Khan, and Aggleton (1998) argue, the construction of a heterosexual AIDS epidemic in the global South led to virtually no global and local policies that addressed the epidemic among men who have sex with men. In fact, what little existed in terms of data on or interventions for men who have sex with men was primarily “because of [implementers'] commitment to it than because of any kind of priority within broader, more official research agendas” (Parker et al., 1998; p. 333), a claim that is upheld by the Panos study findings. Yet, despite calls to address HIV among men who have sex with men in the global South during the second decade of the epidemic, these changes did not happen on a systematic level until about a decade later in the mid to late 2000s. The assumption of a heterosexual global South epidemic had an immensely negative impact on research, surveillance, and prevention and treatment efforts related to same-sex sexual transmission for years. Governments then used this lack of debate to justify the absence of HIV funding for men who have sex with men in government and intergovernmental agency efforts (Denis-Cooper et al., 2012; C. A. Johnson, 2007; McKay, 2016; McKenna, 1996).

The WHO/GPA in the late 1980s to early 1990s attempted to address HIV among gay, bisexual, and other men who have sex with men through research and informal directives, but fell short of providing clear policies that would guide funding priorities and NAPs in their national HIV work (McKay, 2016; McKenna, 1996; Parker et al., 1998). Particularly, tensions between different departments of the WHO and GPA, concerns about cultural sensitivity to sexual norms and taboos, and difficulty enforcing GPA’s authority over the global strategy on AIDS presented numerous challenges for the agency to adequately address the needs of MSM in the global South. Furthermore, the GPA’s insistence that the epidemic was predominantly heterosexual outside of the global North in their publications did not help matters.
In addition to the shortcomings of international donors, even when organizations requested funding, they would be discouraged by funders with justifications that reflected bias and stigma against men who have sex with men. For example, the Panos study found that a number of gay organizations and other NGOs in the global South were denied funding for HIV among male same-sex transmission and at times discouraged from requesting such funding. Particularly, among the 57 LGBT organizations and individuals that were surveyed in the Panos study, 39% stated that they were refused funding for AIDS services for men who have sex with men and were given reasons that effectively reflected the silence and stigma around homosexuality. The reason provided to them for the refusals included: “no perceived need” (10%), “social unacceptability” (9%), “political unacceptability” (9%), “more urgent priorities” (7%), “sex between men is very rare” (4%), “shortage of money” (4%), other reasons (4%), and “sex between men does not exist” (1%) (McKenna, 1996; p. 98). For organizations in Asia and Latin America, sociocultural stigma against homosexuality was grave, with 29% of respondents from Asia and 20% of respondents from Latin America being told that such funding would be socially unacceptable, while 21% and 30% respectively were informed that such funding would be politically unacceptable (McKenna, 1996).

While there has been significant progress made over the past 7 to 10 years, the issue of the HIV funding gap for men who have sex with men continues to persist in the global AIDS response. In 2009, UNAIDS reported that MSM and transgender people had the least number of countries report on them for the United Nations General Assembly Special Session of HIV (UNGASS) compared to general and most-at-risk populations (UNAIDS, 2009). Another report found that as of December 2011, 93 nations had not reported any data on HIV prevalence among MSM in the preceding 5 years (Arreola, Herbert, Makofane, Beck, & Ayala, 2012). A study in 2011 on the Global Fund found only 2% ($63 million) of its funding for most-at-risk populations went to interventions for men who have sex with men from 2002 to 2010 (Avdeeva, Lazarus, Aziz, & Atun, 2011). Relatedly, a 2011 Global Forum on MSM (MSMGF) report
highlighted that although a disproportionate percentage of those living with HIV are men who have sex with men, there is still very little funding and programming for this population (Ayala, Hebert, Keatley, & Sundararaj, 2011). A 2004 study discussed in the Global Forum report found that in Latin America, only 0.5% of the total prevention funding for HIV was allocated for MSM-specific efforts despite MSM making up 60% of those with HIV (Ayala et al., 2011). A second study on the Asia-Pacific region, found that the actual funding spent on HIV prevention among MSM was between $41 million and $207 million compared to the needed funding of $550 million to $2.7 billion (Ayala et al., 2011). The MSMGF study also found that only 2% of global HIV funding targeted MSM in 42 low- and middle-income countries (Ayala et al., 2011). Moreover, they found that:

With very few exceptions, a majority of HIV donors do not track or publicly report investments targeted at MSM and transgender people. Only 25% of all national governments reported on HIV prevention spending on MSM in 2010 while none reported HIV prevention spending on transgender people. (Ayala et al., 2011; p. 2)

Put quite simply, the gulf between the funding and programmatic needs of men who have sex with men in the global South is immense. More recently, MSMGF reported in their publication, A Fundamental Shift: The Future of the Global MSM and HIV Movement, that funding for community based organizations that are led by those who do work with MSM specifically is being reduced, creating a larger disparity (MSMGF, 2015).

**The blind spot in Africa.**

In sub-Saharan Africa, the assumption that sexual transmission of HIV between men did not occur or only occurred at a negligible rate caused the neglect of African men who have sex with men as a high-risk group for HIV—a blind spot that a number of researchers have argued has had harmful consequences on human life (Aggleton et al., 1999; Epprecht, 2008; C. A. Johnson, 2007; Lorway, 2006; Muraguri, Temmerman, & Geibel, 2012; Parker et al., 1998; Reddy, Sandfort, & Rispel, 2009; Wakabi, 2007). While millions of dollars were spent on HIV research, prevention, and treatment of heterosexual and mother-to-child transmission, with

...It comes as no surprise that by far the most limited prevention efforts for men who have sex with men continue to characterize sub-Saharan Africa, where, as we have seen above, the denial of same-sex behaviors has been most extensive on the part of researchers as well as governments. Only a handful of documented AIDS prevention programs involving men who have sex with men have been developed in the various nations of the sub-Saharan region. (p. 336)

In fact, the delay in research and interventions was so extreme in the region that the first major behavioral study on HIV among men who have sex with men in sub-Saharan Africa, specifically in Senegal, was not published until 2001, two full decades after the discovery of AIDS (Muraguri et al., 2012). One of the key justifications of the heterosexual African AIDS argument was that Africa’s epidemiological data indicated that male and female HIV prevalence were comparable (Piot et al., 1988; Quinn, Mann, Curran, & Piot, 1986). As Peter Piot, one of the lead researchers on HIV in Africa stated in a 1988 article, “The initial assessments of the AIDS epidemic in African countries revealed a very different epidemiology from that in Western countries. Level of sexual activity with multiple partners, not sexual orientation, was the apparent risk factor” (Piot et al., 1988; p. 574). While it might have been true that the virus was spread predominantly through heterosexual transmission, the assumption that the risk factor of multiple sex partners is mutually exclusive from having a gay or bisexual identity, or that having that identity is itself a risk factor was problematic. Not only did this characterization conflate behavior and identity, it also did not reflect some of the progress that had been made on the complexities of the epidemic. By stating that the epidemic was so different from that in the global North, as Marc Epprecht has argued, researchers were making “definitive statements that homosexual transmission did not merit investigation (which is to say, funding)” (Epprecht, 2013; p. 178).
In addition to Piot’s statement that multiple concurrent partners was more of a risk factor in Africa than in the Western epidemic, the heterosexual African AIDS characterization was deeply steeped in past colonial tropes about African sexualities that caricaturized Africans as having insatiable sexual appetites that manifested in many sexual partners and promiscuous sexual behavior (Flint & Hewitt, 2015; Patton, 2002). Moreover, Cindy Patton (1990) argued early on in the epidemic in “Inventing AIDS”, the discourse on AIDS in Africa produced the concept of “African AIDS”, a discursive formation that collapsed Africa into one entity with the same set of epidemiological risk factors across different regions. This construction was rationalized, she argued, with racist ideas about the continent’s social and economic status, “culture”, and practices. A set of HIV policy directives that reinforced these stereotypes and ignored same-sex transmission came as a result of this “African AIDS” construct.

Over the years, a small but growing number of organizations have advocated for more resources toward addressing male same-sex HIV transmission in Africa (C. A. Johnson, 2007). One such effort was in 2007, when the International Gay and Lesbian Human Rights Commission (IGLHRC) published a major report titled, Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa, to “spark a dialogue and, hopefully, to signal the end of the pervasive silence about African homosexuality and HIV/AIDS” (Johnson, 2007; p. viii). The report listed four key reasons for the lack of policies and funds addressing African same-sex HIV transmission, which were: 1) homophobic stigma and denial on the continent; 2) restrictive international reproductive health policies by major international HIV donors, particularly the US, that have impeded the sexual rights of everyone, including men who have sex with men; 3) the inadequate response of international and local NGOs in attending to the needs of men who have sex with men and not taking on stigma of homosexuality in different local African contexts; and 4) underdeveloped LGBT rights and health organizations on the continent (Johnson, 2007; p. 3).
While the report did not problematize the Western construction of a heterosexual Africa, it still provided a list of recommendations that aimed to correct this policy and programmatic blind spot. For African governments, the recommendations were to decriminalize consensual same-sex sexual acts, prosecute those who commit violence, harassment, and abuse of same-sex practicing people, establish collaborative relationships with local LGBT and sexual rights groups and increase funds for their HIV-prevention programs, and provide condoms, lubricants, dental dams in prisons. For donor nations and agencies, they recommended an increase in funding opportunities for organizations and programs for men who have sex with men, an end to policies that discriminate against particular groups of vulnerable populations, and evidence based programming, and to not fund programs that openly discriminate against LGBT people. They also highlighted the work of local LGBT and sexual rights organizations in addressing same-sex transmission of HIV. This IGLHRC report was an important development because it was the first major study by an international NGO that highlighted the deficit of research, funding, and programs for Africa’s LGBT population in the international HIV/ADIS response.

Growing Epidemiological Data on HIV among MSM

The lack of adequate global and local funding to address HIV among men who have sex with men in the global South continues despite the reality of high prevalence of HIV among this population. Past and recent studies indicate that HIV disproportionately affects men who have sex with men across the world (Baral et al., 2009; Beyrer, 2008; Beyrer et al., 2010, 2012, 2013; van Griensven, de Lind van Wijngaarden, Baral, & Grulich, 2009). A 2012 review article on the global epidemiology of HIV infection among men who have sex with men reported that internationally, the group has a disproportionate HIV disease burden and that even in many high income settings, the HIV epidemic trends are on the decline except for men who have sex with men (Beyrer et al., 2012). The article reported that the epidemic among this group was expanding in countries regardless of income level and that it was shaped by high HIV burdens
and a clustering of infections within networks. Additionally, the study found that HIV prevalence among MSM was highest among all populations in nearly every context. In terms of HIV prevalence, the study found a range of 3% (95% CI 2.4-3.6) in the Middle Eastern and North African (MENA) region to 25.4% (21.4-29.5) in the Caribbean. Particularly, in South, Central, and North America, South and Southeast Asia, and sub-Saharan Africa, the prevalence was quite consistent, with a range of 14 to 18% (Beyrer et al., 2012). Another recent study on the increase in global HIV epidemics among men who have sex with men portrayed the global burden on a graph, as shown in Figure 1 (Beyrer et al., 2013). In some parts of the global North, HIV incidence is rising, like in the U.K., where HIV incidence among men who have sex with men has increased from 0.33/100 person-years from 1990-1997 to 0.45/100 person-years from 1998-2010 (Phillips et al., 2013). Or in the U.S., where the CDC recently projected that 1 in 6 men who have sex with men will acquire HIV in their lifetime and that for Latino and Black men, it will be 1 in 4 men and 1 in 2 men, respectively (CDC, 2016).

![Figure 1: Pooled HIV prevalence among MSM and among all adults of reproductive age by region (Beyrer et al., 2013)](image-url)
Specifically, in the global South, there is a growing number of studies reporting an alarming epidemic among men who have sex with men (amfAR, 2006; Beyrer et al., 2010; Kerr et al., 2013; Mumtaz et al., 2011; Sabin, Lazarus, Frescura, Gill, & Mahy, 2012; van Griensven, 2007). In fact, data over the past few years indicate that the highest HIV burden among MSM is in the global South (Beyrer et al., 2012, 2013). A 2010 study by Beyrer et al. (2010) argued that the HIV epidemic in low- and middle-income countries could be described by four scenarios in which men who have sex with men are at risk for HIV. The first scenario is described as contexts where the predominant mode of exposure to the population is through men who have sex with men. The second scenario is of contexts where the epidemic is driven by injection drug use transmission. The third scenario is in contexts where the epidemic is driven by heterosexual transmission. Finally, the fourth scenario is in contexts where all these forms of transmissions are significantly driving the epidemic.

Research over the years on the global epidemiological drivers of HIV among men who have sex with men have identified a number of proximal (direct or individual level) and distal (structural) factors that contribute to the high disease burden among men who have sex with men within these different scenarios. Identified sexual behavioral risks include multiple and concurrent sex partners, receptive anal sex, no use or low rate of consistent condom use, low use of lubricants, and sex work (Beyrer et al., 2010, 2012; Mumtaz et al., 2011; van Griensven et al., 2009). Moreover, anal sex and sexual role versatility place men who have sex with men at a higher biological risk and the versatility of sexual roles also means risk of transmission is higher (Beyrer et al., 2012, 2013). Additionally, network-level risks such as large sexual networks increases risk of HIV as well as network risks shaped by structural racism and racist attitudes in gay communities that limit racial minorities’ sexual partners to smaller, more disease burdened networks (Beyrer et al., 2013; Millett et al., 2012). In addition to these, other structural factors have been identified such as poverty, homophobic abuse and violence, sodomy and anti-gay laws, and sociocultural stigma against homosexuality drive male same-sex sexual
transmission (Beyrer, 2014; Poteat et al., 2011; Semugoma, Beyrer, & Baral, 2012). Studies also identified history of sexual abuse and rape and limited access to healthcare as risk factors for men who have sex with men (Beyrer et al., 2012, 2013; Mumtaz et al., 2011).

Specifically, in Africa, which has the highest HIV burden in the world, the expanding epidemic among men who have sex with men is quite alarming. While men who have sex with men might make up a minority of those with HIV, when they are examined as a sub-group, their prevalence indicate a concentrated epidemic. According to Muraguri, Temmerman, and Geibel (2012), the first major publication on MSM HIV risk on the continent was by Niang et al. (2003). This study, which examined the needs, knowledges, attitudes, and behaviors of men who have sex with men in Dakar, Senegal, found that the men had diverse sexual identities and roles, were subjected to immense levels of abuse and stigma (including in clinical settings), had a high burden of sexually transmitted diseases, and engaged in high risk sexual activities. Since then, a growing number of studies have demonstrated that many African men do have sex with men, contrary to the denial of homosexuality by many in society and in spite of social stigma and punitive laws that criminalize it. Moreover, these studies have shown that gay, bisexual, and other men who have sex with men on the continent are at a high risk of transmitting or getting HIV (Baral & Phaswana-Mafuya, 2012; Beyrer et al., 2012; Fay et al., 2011; Millett et al., 2012; Mumtaz et al., 2011; Muraguri et al., 2012; Reddy et al., 2009; Sanders, Jaffe, Musyoki, Muraguri, & Graham, 2015).

Prevalence data from different parts of sub-Saharan Africa between the years 2007 and 2012 indicate that the region has a 17.7% HIV prevalence among MSM. Some cities in South Africa have reported prevalence as high as 25.5 to 49.5% (Beyrer et al., 2012, 2013; Muraguri et al., 2012; Rispel, Metcalf, Cloete, Reddy, & Lombard, 2011). Criminalization of same-sex sexualities and sexual acts, anti-gay social stigma and environment, poverty, and inadequate and limited access to healthcare services are among the structural factors identified as exacerbating biological, network, and individual risk factors for HIV in Africa (Baral & Phaswana-
Mafuya, 2012; Kyomya, Todyrs, & Amon, 2012; Millett et al., 2012; Muraguri et al., 2012; Reddy et al., 2009; Sharma et al., 2008; A. D. Smith et al., 2009; van Griensven, 2007). There are only a few HIV incidence reports from two countries—Kenya and South Africa—for MSM due to limited research on the subject. In Kenya, a study on a sample of men who have sex with men in Mombasa reported an incidence of 20.4 per 100 person-years (Sanders et al., 2007). Five years later, a study by Price et al. (2012) reported an incidence of 6.8 cases per 100 person-years among a sample of men in Kenya and 2.7 cases per 100 person-years among a sample of men in Cape Town, South Africa. In 2016, a cross-sectional study in Gert Sibande in the Mpumalanga province of South Africa found an incidence of 12.5 cases per 100 person-years (Lane et al., 2016). HIV incidence among MSM in most countries within the continent remains unknown.

**Impact of MSM data on prevention and treatment efforts.**

Despite important studies like those referenced above that begin to shed light on the seething MSM HIV crisis on the continent, as well as the previously discussed reports on the need for MSM-specific policies and programs, it is only in the past 5 to 7 years that greater attention has finally been given to this issue in sub-Saharan Africa.

With increasing epidemiological data and advocacy for more funding and policies targeting men who have sex with men, global agencies have responded with important changes. Particularly, international AIDS frameworks now include men who have sex with men as a key population vulnerable to HIV in Africa (Ayala et al., 2011; McKay, 2016). Moreover, as Tara McKay’s (2016) work demonstrates, major international HIV donors such as the Global Fund, UNAIDS, and PEPFAR are now providing funding opportunities for HIV prevention and care efforts that focus on African MSM. These changes have not been immediate but have been occurring slowly over the past decade. In 2008, the two major sources of HIV funding in sub-Saharan Africa—the Global Fund and PEPFAR—developed new policy frameworks that
identified men who have sex with men as a key population (Grosso, Tram, Ryan, & Baral, 2012; Ryan, Macom, & Moses-Eisenstein, 2012). After U.S. President Barack Obama took office in 2009, U.S. Congress voted to renew PEPFAR and included men who have sex with men and injection drug users among its target population—an important shift from the previous, more conservative administration under President George W. Bush (Grosso et al., 2012).

At the Global Fund, the Board of Directors approved a strategy years ago that aimed to address the needs of men who have sex with men and other sexual minorities (Grosso et al., 2012). Additionally, the 2011-2015 UNAIDS strategic framework aimed to reduce the incidence of HIV sexual transmission, including MSM, by half and identified collaborating with major donors to address HIV among MSM as a priority (UNAIDS, 2010). A year prior, UNAIDS had created an Action Framework that provided guidelines on how to address HIV among men who have sex with men and transgender people (Makofane, Gueboguo, Lyons, & Sandfort, 2013; UNAIDS, 2009). This Framework continues to guide the national AIDS policies of many countries. Further, PEPFAR’s 2012 Blueprint, which serves to guide U.S. government funding investments for HIV prevention and care, explicitly mentioned in its five guiding principles the need to end stigma and discrimination against men who have sex with men (PEPFAR, 2012a). While all the ongoing changes in policies are collectively an important step forward, it is important to also note that the overall HIV investments by major international donors towards men who have sex with men were unknown as recently as 2012 (Arreola et al., 2012). However, MSMGF estimates that less than 2% of the global investment in HIV prevention programs is for men who have sex with men in low- and middle-income countries (Ayala et al., 2011). Moreover, analysis of PEPFAR funding allocation found that nations where HIV is concentrated among most-at-risk populations, like men who have sex with men, get disproportionally lower funding than others (Grosso et al., 2012).

Despite these limitations, national AIDS policies in Africa are increasingly acknowledging male same-sex transmission due to the shift in donor policy and funding frameworks that
prioritize MSM as key populations\(^4\) in the global South. An illuminating publication by Keletso Makofane, Charles Gueboguo, Daniel Lyons, and Theo Sandfort (2013) examined how African governments have been responding to the epidemic among MSM. Their analysis found that a large number of national AIDS policies in sub-Saharan Africa identify men who have sex with men as a key at risk population in some shape or form, with 34 out of the 46 NSPs they reviewed recognizing the group as highly vulnerable for HIV. Twenty-four out of those 34 NSPs were within countries that have punitive laws against anal sex between men. Yet, less than half of the 34 NSPs discussed the impact of stigma or criminalization of same-sex sexualities on HIV risk among men who have sex with men and only a few acknowledged that criminalization impedes HIV program implementation and MSM’s access to HIV prevention and care services. Notably, the study also found that several of the NSPs regard men who have sex with men as a public health threat, with some even suggesting that sex work and male same-sex sexualities have the same economic roots, effectively equating homosexuality with sex work. In other words, they believe men have sex with men merely for money or other material gains.

**Gender, Sexuality, Nationalism, and Imperialism**

The momentous shift to include men who have sex with men as a key population in national HIV policies is occurring in local African contexts concurrently to a climate of increasing politicization of homosexuality and hostility towards same-sex sexualities, with disproportionate public attention on homosexual men. Over the past decade in particular, numerous African nations have been in the international spotlight for proposing and enacting stricter laws against homosexuality, often claiming homosexuality is a product of a Western gay agenda and thus, imperialist and un-African. These ongoing debates about same-sex sexualities have been

\(^4\) It should be noted that UNAIDS identifies four main key populations (men who have sex with men, sex workers and their clients, injection drug users, and transgender people) to guide its HIV/AIDS policies, while WHO identifies all those group, minus sex worker clients, but with the addition of people in prisons and other closed settings as key populations.
shaped by Western and local religious forces, politicians and other government officials, traditional leaders, as well as news, print, and broadcast media. Underlying the predominantly anti-gay discourses and environments are a number of complex political, cultural, economic, and historical processes on the international and local levels. These discourses about African sexuality are important to explore to understand the significance and implications of the policy paradigm change in the region. One critical inquiry that my study examines is what ideas about same-sex sexualities inform the policy and programmatic developments as well as the context in which they are taking place. To theoretically ground this inquiry, this study pulls from the literature on the relationship between imperialism, nationalism, gender, and sexuality in the African context.

As African feminists like Sylvia Tamale and Amina Mama have argued, questions of African sexualities and gender cannot be properly examined without understanding the ways in which imperialism—particularly colonialism—has affected the social, cultural, and political fabric of African nations. Europe’s colonial project in sub-Saharan African had a profound impact on gender and sexuality in the region. Laura Ann Stoler (2002) argues in her book, *Carnal Knowledge and Imperial Power*, that sexual control of local subjects was a critical component of how Europe was able to colonize different regions and peoples. In other words, sexual order was necessary for social order and control in European colonial projects. It was a process that simultaneously enforced racist notions of the colonized as well as codes on sexual and gender behavior that were deeply racialized. As Stoler (2002) states, “gender-specific sexual sanctions and prohibitions not only demarcated positions of power but also prescribed the personal and public boundaries of race” (p. 42). For example, to prevent racial miscegenation that would undermine their colonial project, British administrators created the myth of the “black peril” in their colonies to warn White women about the dangers of African male sexuality (Wieringa, 2009). Similarly in Namibia, where the Germans produced a myth of Namibian housemaids as possessing poisonous powers that could be used to kill White settlers through the sexual
seduction of White men—a myth that was used to inform the mass killings of the Nama and Herero populations in the first decade of the 20th Century (Wieringa, 2009). In South Africa, more explicitly, the system of racial apartheid was enforced to systematically keep Black colonial subjects from White settlers (Bhana, Morrell, Hearn, & Moletsane, 2007).

In addition to the racist notions of Africans that informed European perceptions of African sexualities, the influence of European colonialism on African sexualities must also be understood through the lens of the historical changes that were occurring in Europe at the dawn of capitalist development (Foucault, 1978; Stoler, 2002). As Michel Foucault (Foucault, 1978) contends in The History of Sexuality, V. 1, the 18th and 19th century marked a historical change in European norms of sex and sexuality in which individuals’ sexuality became an important characteristic to the emerging political state. This state preoccupation with sexuality took the form of actively monitoring behavior and data related to birth and death, fertility, and public health—a form of governance and population control that Foucault termed “biopower” (Foucault, 1978). Gayle Rubin (1998) expanded on Foucault's theory of sexuality, arguing that sex was a political tool that was used historically to shape social norms in western societies and by extension, their colonies. In these attempts to repress certain types of sexualities, those with power created legal systems that governed every aspect of people’s lives such as sodomy, masturbation, and prostitution laws, producing repressive and unnatural notions of what is sexually moral and what is not.

These European “morality crusades”, as Rubin (1998; p. 143) terms it, were extended into the African colonies and as a consequence, transformed sexual norms in these local contexts. The criminalization of sodomy and forms of same-sex sexual relations was a key mechanism in this transformation that needs to be critically examined. This review of colonial criminalization to legally regulate African sexualities focuses on the English sodomy penal codes because of the legacy these codes have had on the laws of their ex-colonies. However, although France had decriminalized homosexual conduct in 1791, it also subjected a few of its
colonies to sodomy laws as a form of social control, some of which still exist today in some form in nations like Senegal, Benin, and Cameroon (Gupta, 2008). Germany, to a lesser extent, also imposed penal codes that punished same-sex sexual acts between the time span of the Bismarck period to the end of Nazi rule.

The legacy of British colonial sodomy laws, based on the initial Indian Section 377—the first of its kind in any colony—cannot be underestimated. Section 377 of the Indian Penal Code, which was based on Britain’s own Buggery Laws that dated back to the 16th century, stated:

377. Unnatural offences: Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for term which may extend to ten years, and shall also be liable to fine.

Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offense described in this section. (Gupta, 2008; p. 18)

As Marc Epprecht (2008) contends, these penal codes were an attempt to sexually civilize the colonized “savages”. In the process, they have redefined, in gendered ways, what constitutes a sexual norm in different localities and stigmatized gender and sexual non-conforming individuals, while obscuring the history of same-sex relations across the continent.

The notion of a heterosexual Africa is one of the pervasive ideas constructed from the European morality crusades that obscures a diverse history of African sexualities. In addition to the colonial discourse on African sexualities that maintained this myth, the anti-imperialist discourse of prominent anti-colonial, Pan-African figures like Frantz Fanon and Jomo Kenyatta were another key source of this notion of a heterosexual Africa. These leading figures, who were especially preoccupied with male same-sex relations, characterized homosexuality as a European phenomenon in their writing (Epprecht, 2008). Fanon particularly contended that African homosexuality was created by colonial conditions and European racism (Epprecht, 2008). Fanon acknowledged that homosexuality existed, but only because African men were forced into it through activities like prostitution in order to subsist economically. This pathological
model described homosexuality as a result of colonial violence that aimed to feminize and emasculate African men as part of their colonial project (Epprecht, 2008). In African nationalist literature, while there were a few writers who portrayed homosexual characters sympathetically, the majority of writers who discussed homosexuality depicted it negatively, like Chinua Achebe, whose work portrayed homosexuality as a “de-masculinization” of African men that is dangerous to African traditions (Epprecht, 2008).

Even in the rare circumstance when there was an LGBTQ movement as in the case of South Africa, numerous factors affected the ability of non-White members of the movement to openly advocate for LGBTQ rights and resources for HIV and other health needs. Particularly, the pressures to align with the nationalist anti-apartheid movement in the 1980s meant that many LGBTQ members of this movement had to prioritize the anti-colonial struggle over the fight for LGBT rights. This pressure was compounded by the fact that the pre-dominantly white LGBTQ movement was at best accommodating of the racist apartheid system, or at worst, perpetrating and in support of this system. The end result was that non-White LGBTQ South Africans were marginalized in both movements and thus had to compromise their sexual and gender identities in the fight for national liberation. As Zackie Achmat, founder of the Treatment Action Campaign (TAC), explains in Epprecht’s (2008) book:

> In Southern Africa, the taboos [against overt homosexuality] were stronger, the economic and social power and influence of the lgbti community weaker. And, it was further weakened by the moral failure of the white lesbian and gay community with very few exceptions to speak against apartheid and racism. So, when the HIV/AIDS epidemic hit our shores, we all scrambled against direct association with our lgbti communities. We feared association with the racist lgbti communities and we wanted to protect the broader lgbti community from discrimination. (p. 125)

It is little surprise then that, despite the African struggles against the colonial order that successfully ended most European colonial rule from the 1960s to 1980s, colonial sodomy laws continue to exist in the same or modified forms in many of the newly formed nation-states, including 17 ex-British colonies (Gupta, 2008). Moreover, over the past two decades, state and
religious sponsored homophobia in Africa, often dressed in anti-imperialist language, has made international news headlines. Uganda is most infamous for its persecution of those engaged in same-sex relations with its 2009 Anti-homosexual Bill, which sought to give convicted homosexuals the death penalty or long-term imprisonment, as well as imprison anyone who sympathizes with or is aware of homosexuals but does not report them (Kaoma, 2009). Nigeria, Kenya, Zimbabwe, Cameroon, and even South Africa (for “homophobic rape”, commonly referred to as “corrective rape”) are other nations that have received negative international attention for their religious and state-sponsored homophobia.

In response to the hostile environment towards homosexuality, international human and LGBT rights organizations, mostly from the global North, have condemned laws and acts criminalizing same-sex relations. Additionally, Western governments have threatened to impose sanctions or cut international aid to African governments that are actively persecuting homosexuals. These denunciations from the West have further fueled African governments, religious leaders, and traditionalists’ nationalist anti-imperialist justifications of these anti-gay attacks. In fact, the notions that same-sex sexualities are un-African and cultural imports from the West alien to local traditions and a threat to post-colonial sovereignty are common talking points in the modern anti-gay discourse in African.

Many of the arguments against same-sex sexualities in Africa are laden with nationalist rhetoric. Several scholars have argued that this homophobic and heterosexist nationalism serves an ideological purpose in the building of the post-colonial nation state (Currier, 2012; Epprecht, 2008; Wieringa, 2009). Ashley Currier (2012) contends that “gender and sexual dissidents in countries in the global South sometimes become contested subjects in nationalist discourses of cultural and racial authenticity” because such dissidence “disrupts the continuity of national progress” (p. 441). Saskia Wieringa (2009) adds that these depictions of same-sex sexualities as un-African are occurring through a process of a politically convenient historical
amnesia by the post-colonial state in an effort to displace social anxieties and deflect
government accountability from the failures of those states’ post-independence.

The ongoing ideological, legal, and physical attacks against individuals considered
homosexual in Africa have affected public health and sexual rights efforts for same-sex loving
Africans. According to numerous reports, armed mob attacks against human rights groups,
health centers that serve HIV patients, and LGBT advocate groups have been documented in
different African nations (Hanson, 2010). Further, prominent openly gay Africans have been
attacked or murdered, like David Kato of Uganda, over the past few years for their LGBT rights
advocacy work. More recently researchers at MSMGF reported that the further criminalization of
homosexuality in Uganda and Nigeria led to increased vulnerability among LGBT Africans to
blackmail and extortion, physical violence, arrest and detention, loss of employment, and loss of
shelter (Makofane, Beck, Lubensky, & Ayala, 2014).

Gap in Literature

It is in this polarized context of rising anti-homosexuality discourse, persecution, and
violence in sub-Saharan Africa that a growing number of governments on the continent are
simultaneously beginning to address HIV among men who have sex with men—begging the
question, why now? Moreover, this legal and social discrimination of, and violence against
LGBTQ people have implications for the implementation of policies and programs addressing
HIV and other health issues among this population that require examination. Particularly, the
criminalization of anal intercourse between men presents critical challenges to addressing HIV
among gay, bisexual, and other men who have sex with men. As the Global Commission on HIV
and the Law report (2012) indicates, anti-sodomy and anti-gay laws undermine and impede HIV
prevention efforts for men who have sex with men. Moreover, the report finds that such
criminalization drives up risk for HIV as in the example of the Caribbean where 1 in 4 men who
have sex with men in countries in the region with such laws has HIV compared to 1 in 15 men in
countries without such laws (The Global Commission on HIV and the Law, 2012). In Africa, very few studies have examined the recent inclusion of men who have sex with men in national AIDS policies—a gap that my dissertation contributes to addressing.

The past 10 to 15 years has witnessed a growing number of studies on HIV among men who have sex with men in Africa. Many of these have been epidemiological studies that disproportionately focus on prevalence and bio-behavioral risks, most likely because there exists a significant gap in epidemiological data on African MSM that needs to be addressed (Baral & Phaswana-Mafuya, 2012; Baral et al., 2011; Baral et al., 2009; Lane et al., 2011, 2016; Long, Brown, & Cooper, 2003; Mumtaz et al., 2011; Onyango-Ouma, Birungi, & Geibel, 2005; Price et al., 2012; Rispel et al., 2011; Sanders et al., 2007; Smith et al., 2009). Numerous other studies have examined structural risks for HIV, with findings demonstrating that criminalization, stigma, and social persecution of gay, bisexual and other men who have sex with men in Africa affect the group’s access to HIV prevention and care services, drives high risk activities underground, and increases reduces the effectiveness of HIV interventions (Beyrer, 2014; Boyce & Isaacs, 2011; Hanson, 2010; Makofane, Beck, & Ayala, 2014; Masvawure, Sandfort, Reddy, Collier, & Lane, 2015; Muraguri et al., 2012; Niang et al., 2003; Poteat et al., 2011; Reddy et al., 2009; Sullivan et al., 2012; Wakabi, 2007).

In Ghana, specifically, a few scholarly articles have examined HIV among men who have sex with men. One of these publications was based on Ghana’s first study on HIV among sasoi and other MSM in Ghana. Aimed at examining the “MSM situation” in the Accra metropolitan area in order to introduce an STI and HIV intervention, the study provided preliminary data on HIV and STI risks among sasoi and other men who have sex with men. The study also made recommendations to government and other stakeholders for addressing the epidemic among this population (Attipoe, 2004). Two other studies, published years later, assessed efforts to reach MSM on social media and within social networks with HIV prevention activities (Girault et al., 2015; Green et al., 2014). A study last year offered lessons learned in conducting a MSM
population size estimate study in Ghana as part of the Ghana Men’s Study, an integrated bio-behavioral surveillance (IBBS) survey (Quaye et al., 2015). Nelson et al. (2015) published a study on HIV knowledge and stigma on young and adult MSM risk behaviors and a second study examined condom use predictors among networks of men who have sex with men (Nelson, Wilton, Agyarko-Poku, Zhang, Zou, et al., 2015). As these study descriptions indicate, most of the extant literature on HIV among Ghanaian MSM are epidemiological.

In terms of the policy level, a number of studies have evaluated national AIDS policies and efforts on the continent generally and within specific countries. These, however, have mostly focused on mother-to-child transmission, heterosexual transmission, female sex workers, migrant workers and the general population (Allen & Heald, 2004; A. Butler, 2005; Chi, Stringer, & Moodley, 2013; Heald, 2005; Mavedzenge et al., 2016; Parkhurst & Lush, 2004; Stover & Johnston, 1999). Other research on African AIDS policies have focused on AIDS denialism, poverty, and economic development (A. Butler, 2005; Mbali, 2004; Whiteside, 2002). In Ghana, a few articles have examined the country’s AIDS policies, focusing primarily on female sex workers and general population (Aboagye-Sarfo, Mueller, & Cross, 2015; Adjei et al., 2000; Agyei-Mensah, 2001; Fobil & Soyiri, 2006; Porter, 1994). More recently, a study reviewing Ghana’s policy and interventions that focus on female sex workers over the years was published by Peter Wondergem and other state and non-state stakeholders in Ghana’s KP HIV efforts (Wondergem et al., 2015).

Over the past few years, a few articles have been published that touch on or examine MSM HIV policies on the continent. The study by Makofane et al. (2013) on national AIDS policies made an important contribution in the area of MSM HIV research in Africa by drawing attention to which national AIDS policies on the continent are inclusive of men who have sex with men. The study provided a snapshot of the extant policies on the continent for MSM and their scope but it did not focus as much on the sociocultural contexts of these policies or why governments began to include MSM in their policies. A recent article by Eduard Sanders and
colleagues (2015) titled, “Kenyan MSM: No Longer a Hidden Population”, reviews extant literature and epidemiological studies on Kenyan men who have sex with men and highlights the Kenyan Ministry of Health and National AIDS and STI Control Programme’s recognition of MSM as a key population. However, it does not delineate the factors producing the shift nor discuss the efforts, challenges, and successes of these policy and programmatic changes. More recently, a study by Duvall et al. (2015) examined the impact of HIV policies in Burkina Faso and Ivory Coast on men who have sex with men and female sex workers. Of particular interest in this study were how policies were being implemented and the impact of donor support, country leadership, and an enabling environment.

The impact of the “heterosexual Africa” construct on HIV efforts in Africa has also been written about in a number publications, most notably by scholars and researchers like Patton (1990), Lorway (2006), Johnson (2007), and Epprecht (2008). The most influential piece of literature to my research within this body of work is Epprecht’s (2008) seminal work on the heterosexual Africa policy blind spot. The book has especially provided important analysis on what historical and political factors led to early epidemiological constructions of HIV in Africa as heterosexual and how these perceptions and constructions led to policies that ignored male same-sex transmission on the continent. Although the book focuses on challenging the heterosexual Africa construction by providing historical, archeological, and anthropological evidence of diverse same-sex sexualities, intimacies, and desires in sub-Saharan Africa, it does not examine the reversal of this blind spot which is currently occurring, as this change is a recent development. Epprecht’s analysis however, informed the framing of my research questions and aims.

Although Africa is the site of a disproportionate number of HIV studies due to bearing the brunt of the epidemic, a significant gap exists within the area of HIV research on gay, bisexual, and other men who have sex with men. Within the policy area, even less is known about how local governments have treated this population in its national AIDS responses. The study by
Duvall et al. (2015) relates most closely to my research inquiry, particularly in terms of understanding the content, scope, strengths, and challenges within KP HIV policy and programmatic interventions. However, Duvall’s study does not address a gap that still exists within HIV research in Africa, which is to understand the logics, factors, and dynamics causing a policy paradigm shift in Africa to include men who have sex with men in national AIDS policies. No known studies have yet to examine closely this shift in policies and programs on the continent, what factors are driving it, how the process is unfolding, its intended and unintended consequences, and the lived experiences of the population that is being reached out to by state and non-state actors in a backdrop of increasing politicization of homosexuality. Given the decades of silence on and denial and exclusion of same-sex sexualities in HIV efforts on the continent, it is critical to understand these changes and learn the early lessons of these policy and programmatic changes. My study contributes to addressing this gap in the literature by examining these questions in Ghana.

**Conceptual Framework**

HIV policies focusing on men who have sex with men and their implementation do not occur in a vacuum. Rather, they are developed in and shaped by local and international sociocultural contexts. As such, these policy and programmatic efforts can be described as social phenomena due to their significant legal, cultural, political, and moral implications and their production of new norms, subjectivities, and relationships between individuals, groups, and institutions or their maintenance of the status quo (Shore & Wright, 1999). In framing my findings, I employ two conceptual frameworks that speak to these structural factors: The key populations paradigm and health risk construction. These frameworks lie at the juncture of sociomedical scholarship on public policy, local and global health governance, biomedicine and biopolitics, human rights, and health. In the case of my research, they have been informative on
how political, social, and cultural factors on the local and global levels shape the MSM HIV policymaking process and the intended and unintended consequences of these policies.

**The Key Populations Paradigm: A Biopolitical Paradigm**

As an epidemic of signification (Treichler, 1987), HIV has come to symbolize a number of meanings that are informed both by social, political, and cultural beliefs preceding HIV as well as new ones unique to the nature of the virus. One of the key outcomes of this epidemic was the classification of certain social groups as a “high-risk” group for HIV. The populations grouped under this category during the first decade of the epidemic included gay men\(^5\), injection drug users, Haitians, and female sex workers.

Today, nearly all of these social groups remain vulnerable to the disease. In the third decade of the epidemic, *key populations* has become the standard term used to categorize groups at a higher risk of acquiring HIV in global HIV policies. The term, according to definitions offered by the UN, the Global Fund, WHO, and PEPFAR, identifies men who have sex with men, transgender people, sex workers, injection drug users, and—depending on the context—prisoners as key populations at higher risk for HIV. Key populations according to the WHO (2016), are “defined groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context”. UNDP (2016) describes KP as communities of people most vulnerable to HIV infection, due to marginalization and stigmatization. UNAIDS, however, distinguishes KP from vulnerable populations, “which are subject to societal pressures of social circumstances that may make them more vulnerable to exposure to infections, including HIV” (UNAIDS, 2015a; p. 8). They recommend that countries define “specific populations that are key to their epidemic” within their specific social and epidemiological context. The Global Fund also defines KP as “those that experience a high

\(^5\) The first name scientists gave the virus was gay-related immune deficiency (GRID).
epidemiological impact from [HIV, TB, or Malaria] combined with reduced access to services and/or being criminalized or otherwise marginalized” and face human rights abuses that increase their vulnerability (The Global Fund, 2014; p. 5). According to UNAIDS (UNAIDS, 2015):

These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. (p. 31)

Although categorized as key populations, these groups might not be uniformly addressed by their respective country’s national AIDS policies. This might be because the epidemiological patterns in their country may indicate that they are not at a high risk for HIV or it might be because they are oppressed as a population or not acknowledged and thus, not included in state policies and programs. In the case of Ghana and many other African nations, men who have sex with men particularly were not acknowledged in their government’s HIV prevention and care efforts for decades. A central focus of my dissertation thus, was to understand how and why in the past decade, the government of Ghana, in a historic change, has come to include men who have sex with men as a high risk population in their national AIDS policies.

In answering this question, I apply to my analysis Steven Epstein’s concept of inclusion-and-difference paradigm, which he first described in his article, “Sexualizing Governance and Medicalizing Identities: The Emergence of ‘State-Centered’ LGBT Health Politics in the United States” (Epstein, 2003, 2008). In this article, Epstein argues that there has been a growth of “state-centered” LGBT health advocacy in the U.S., whereby researchers and advocates request that state institutions include LBGT populations in biomedical research to understand their unique health needs as a population and in comparison to other social groups. Epstein suggests that by demanding inclusion based on social identity, this approach views identity categories as the foundation of biomedical research and health promotion strategies.
The state-centered efforts by advocates culminated in a number of changes that resulted in a “policy paradigm” change, whereby federal policies and legislation pushed several institutional changes, such as the inclusion of gay and lesbians in key national policy documents, the commissioning of research on lesbians, the inclusion of gays and lesbians in national surveillance studies, and the formation of an Interagency Steering Committee on Health Disparities Related to Sexual Orientation. This policy paradigm change, Epstein argues, was a shift from an old order of health policy, priorities, and practices that didn’t prioritize social minorities like LGBT individuals to an inclusion-and-difference paradigm that did.

Epstein builds on this concept of inclusion-and-difference paradigm years later in his book, *Inclusion: The Politics of Difference in Medical Research* (Epstein, 2008). Here, he argues that the shift to an inclusion-and-difference paradigm was represented by changes in polices, practices, and ideologies and its institutional and procedural manifestations in a context where a growing number of federal health policies have brought group difference and identity into the realm of biomedicine. The paradigm consisted of two goals: the inclusion of members of underrepresented social groups in clinical research and the measurement of differences between the included groups in terms of treatment effect, biological processes, and the progression of disease (Epstein, 2008; p. 6). In exploring this phenomenon, Epstein’s book sought to understand the causes and effects of these new policies, and the political and cultural logic underlying them. This includes how groups are classified, the meanings placed on their differences, and how these changes enable “biopolitical citizenship”, an umbrella term Epstein uses to categorize concepts like “biomedical citizenship” and “biological citizenship” that describe situations where individuals can make claims to the state on the basis of biology.

An important argument that Epstein makes is that the inclusion-and-difference paradigm is an example of what he terms a *biopolitical paradigm*, a concept he defines as “frameworks of ideas, standards, formal procedures, and unarticulated understandings that specify how concerns about health, medicine, and the body are made the simultaneous focus of biomedicine.
and state policy” (Epstein, 2008; p. 17). As part of this biopolitical paradigm, the inclusion-and-difference paradigm conveys that health research is a legitimate entity that should be a subject of state intervention and regulation and that the paradigm not only reflects a politicization of biomedicine but conversely a biomedicalization of politics—that is, the movement of biomedical issues into the political realm. While these inclusion policies are viewed positively, Epstein posits that the process produces unintended consequences such as rendering invisible some social groups by making visible others, conflating biological and social differences and thus essentializing both, implementing biomedical or biological interventions for socially constructed inequalities, and obscuring individual differences by over-emphasizing group differences.

Epstein’s inclusion-and-difference paradigm has been an understudied but useful concept for understanding how health policies shift to become more inclusive of marginalized social groups. Adapting this concept to my analysis, I contend that Ghana’s shift to include sasoi and other men who have sex with men as a key population in the National Strategic Plan signifies a paradigm shift in the country’s AIDS policies. Specifically, I argue that this HIV policy paradigm shift is from a general population paradigm, which frames the epidemic as a generalized heterosexual epidemic, to a key populations paradigm, which frames the epidemic as a generalized, low-level epidemic mixed with a concentrated epidemic among key populations, especially female sex workers and men who have sex with men. Through an analysis of the different variables involved in the paradigm change, I discuss which factors and actors propelled the policy shift towards this key populations paradigm.

Adapting Epstein’s definition, I conceptualize this KP paradigm as a form of biopolitical paradigm: a constellation of policy standards, formal procedures, ideas, and understandings that frame male same-sex sexualities as a matter of biomedical and state intervention—an inherently political process that medicalizes homosexuality. As such, I argue that the recognition and inclusion of sasoi and other MSM in the national AIDS response has constructed this
population as biopolitical citizens—or “therapeutic citizens”⁶ as theorized in Vihn-Kim Nguyen’s (2008) work—with certain rights enshrined within the KP paradigm but limited to the biomedical realm and in conflict with a legal code that criminalizes male homosexual sex. These paradoxical realities coexist in tension, with the potential to cause unintended consequences shaped by biomedical data and discourses within the MSM HIV response as well as local and international sexual politics.

It is worth delineating some key differences between Epstein’s paradigm and my adaption of it. Epstein’s inclusion-and-difference paradigm identifies a shift from an old policy paradigm that did not prioritize group difference, namely sexuality, in biomedical research. However, Ghana’s HIV/AIDS policies, like many other HIV policies, from the start acknowledged that social difference placed certain groups, like women and children, at risk of HIV and thus needed targeted attention. What they, and the global HIV governance institutions did not acknowledge, however, was that gay, bisexual, and other MSM should be among those groups. Another key difference is that while Epstein’s paradigm broadly examines a set of federal policies that govern biomedical research and focuses more on knowledge production and less on health interventions, mine examines specifically biomedical knowledge production and health promotion related to HIV/AIDS policies, research, and interventions. Despite these differences, I am interested in the same underlying processes that Epstein evaluates in the inclusion-and-difference paradigm, namely, “to link an investigation of the causes and consequences of these new policies and practices with a detailed analysis of their associated cultural and political logic, including ways of standardizing and classifying human beings, beliefs about the meaning of difference, and possibilities for establishing ‘biopolitical citizenship’” (Epstein, 2008; p. 11).

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⁶ Nguyen (2008) conceptualizes in her work on PLHIV access to antiretroviral therapy in Burkina Faso, that “therapeutic citizenship” is a form of biopolitical citizenship that “broadens ‘biological’ notions of citizenship” to provide HIV-positive persons a “system of claims and ethical projects” that allow them access to treatment therapy (p. 126).
**Risk Construction and Public Health Governance**

Understanding the ways our social fabric shapes and is shaped by policy change and implementation is another central focus of my research. Within this broader focus, another body of work that my dissertation draws from is that of risk construction in health policies and intervention. Building on the previous section, a key aspect of the inclusion-and-difference paradigm is how certain social identities are constructed as at risk for a particular disease in efforts to include them in public health policies and interventions. The categorization of a social group as “high-risk” is, thus, a key component of the process of inclusion that a number of social scientists have theorized about (Bajos, 1997; Dworkin, 2006; Heyman, 2010; Petersen, 1997; Petersen & Lupton, 1996). Particularly, in the case of HIV research, the concept of “at-risk” or “high-risk” groups, often categorized under “key populations” or “most-at-risk-populations”, is the key construction that informs HIV policies, frameworks, and programmatic interventions and whom these identify as their target populations. In my study, I examine the key role risk construction plays in the inclusion of sasoi and other men who have sex with men in Ghana’s NSP. Moreover, I explore how HIV risk is constructed for sasoi and other MSM in the KP policy paradigm and implementation discourses as well as how the sociocultural context impacts and is impacted by these developments.

Throughout the history of public health, the field has maintained the responsibilities of addressing disease and epidemics, policing space, and establishing boundaries around populations and bodies. However, over the years, the paradigm of public health governance has evolved from quarantine, sanitary science, regime of interpersonal hygiene, and finally the “new public health” (Armstrong, 1993; Lupton, 1995). Sociologist Deborah Lupton, one of the foremost theorists of risk construction, contends that social science theorizing on the concept of risk gained popularity in the 1970s, within the context of a paradigm shift from the regime of interpersonal hygiene of the mid 19th to early 20th centuries to the “new public health” regime of health promotion (Lupton, 1995). Bob Heyman and Mike Titterton additionally argue in the
introduction to the book, *Risk, Safety and Clinical Practice: Health Care Through the Lens of Risk*, that risk thinking in medicine and public health has become increasingly common in the post-World War II era, gaining the attention of social science scholars in the 1990s (Heyman, Alaszewski, Shaw, & Titterton, 2010).

Lupton’s scholarship (1993, 1995, 1999, 2003), including her work with Alan Peterson (1996), has contributed extensively to the conceptualization of risk in medical sociology. In their book, *The New Public Health: Health and Self in the Age of Risk*, Petersen and Lupton (1996) contend that the paradigm of risk as a framework in guiding health research and intervention was a product of “the new health movement”. They argue that since the 1970s, there has been a growth of new programs and knowledge that target the health of populations, with a focus on both lifestyle risks and environmental risks—a shift they say has become ubiquitous in social and personal life. They compare this change to the “old public health” of the 19th century, which was concerned with managing personal hygiene, filth, and contagion that resulted from industrialization and the rapid expansion of an urban working class population living in poor conditions. During this period, public health primarily intervened in infectious diseases that were the source of high mortality rates. However, in the mid-20th century, greater attention was placed on non-infectious diseases like cardiovascular diseases and cancer, as populations grew older and urban sanitation and housing were better managed. “The new public health”, Petersen and Lupton argue, “can be seen as but the most recent of a series of regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and the social body as a whole” (1996; p. 3).

Situating public health as a modernist institution, along with scientific medicine, Petersen and Lupton argue that the field is a progressive entity aimed at applying scientific knowledge and methods as well as advanced technologies to address health issues. As part of its responsibilities, public health monitors and intervenes in population health through the establishment of objectives and measurements to examine efficacy and outcomes for the
common good—all tenets of modernity and utilitarianism. In comparison to modernist public health though, “the new public health” embodies more features of late modernity because of its multi-sectoral and multidisciplinary approaches. Public health now, as Lupton has discussed elsewhere, include health protection, health education, preventative medicine, healthy health policy, and community empowerment. A key issue however, is that as a product of late modernity “the new public health” is also characterized by the individualization caused by neoliberalism. This is exemplified by the medicalization of individual lifestyles or behaviors and the notion that healthiness can be achieved through lifestyle choices or market based solutions—an observation that is very relevant to my analysis. Moreover, to manage the growing medicalization of social conditions or behaviors, a growing number of technologies and experts are used to manage the health of populations “to track down, calculate and eliminate the 'risks' that are seen to pervade all aspects of human life” (Petersen & Lupton, 1996; p. 18).

A notable argument Petersen and Lupton make about “the new public health” is that the paradigm of risk is central to its logic. Risk, they contend, are sociocultural constructs that “are always political in their construction, use and effects; and inevitably include moral judgments of blame” (Petersen & Lupton, 1996; p. 18). This view is not to say that real dangers or threats do not exist in relation to health. Rather, it insists that these risks and their origins and functions can be understood through social, cultural, and political processes; in other words, how things that might produce a particular outcome become a risk. Invoking Castel’s (Castel, 1991) scholarship on risk, Petersen and Lupton argue that risk discourse is intricately connected to social regulation in modern society, shifting regulation of risk from “therapeutic” interventions to calculations of risk. These calculations in turn, legitimize intervention-based assessments of what is a risk by experts responsible for public health policies (Petersen & Lupton, 1996).
Risk as moral danger.

In terms of how risk paradigm is mobilized discursively and practically, Lupton argues in her article, “Risk as Moral Danger: The Social and Political Functions of Risk Discourse in Public Health”, that while “risk” in its mathematical use (i.e. as a measurement of probability) is supposed to be neutral, in the realm of biomedicine and public health, it is an ideologically loaded concept with a variety of meanings (Lupton, 1993). Adopting François Ewald’s argument in “Insurance and Risk”, Lupton (1995) argues that risk is purely a social construction, contending that “nothing is a risk in itself until it is judged to be a risk” (p. 79). Helene Joffe (1999), likewise questions the representation of risk as a neutral paradigm that can be calculated and predictable and thus regulated and prevented. This is of course possible, but a key concern here is that risk is dressed in scientific terms and presented as objective. However, as Joffe contends, “Risk-reduction policies…reveal a more moralistic endeavor, one that routes dangers back to those responsible for them” (Joffe, 1999; p. 4). Risk no longer has a positive meaning and to say something is a “good risk” would be an oxymoron (Lupton, 1995). “In public health” Lupton argues, “the word risk is used as a synonym for danger constantly” (1993; p. 426). To be labeled as at high risk means one is in serious danger of acquiring an illness or disease and, as Joffe adds, is able to make a decision to avoid that danger.

Further, how one is labeled as “at risk” can also play an ideological function. By ideological, I mean the Marxist conception of it expanded by Stuart Hall (1996) as, “The mental frameworks—the language, concepts, categories, imagery of thought and system of representation—which different classes and social groups deploy in order to make sense of, define, figure out and render intelligible the way society works” (p. 26). Risk can serve as an ideological instrument through the different ways it is constructed and operationalized. For example, it can be described as outside the control of the individual such as in the case of environmental hazards, which has been termed external risk (Lupton, 1993, 1995) or involuntary risk (Douglas & Wildavsky, 1983). On the other hand, it can be constructed as an outcome of
individual responsibility, lifestyle decision, or behavior—termed *lifestyle risk* (Lupton, 1993). In the first case, in which the at-risk individual might be considered a “victim” as Constance Nathanson (2007) argues in *Disease Prevention as Social Change*, the public health approach might target institutions. In the latter case, in which the at-risk person might be considered “culpable”, it might target the individual for behavioral change. A third use of risk, Lupton argues, is to identify social groups, instead of individuals as “at risk” due to their social disadvantage, which might be characterized as their fault or due to external factors (Lupton, 1993; p. 77-78).

All these uses of risk have been applied in HIV/AIDS prevention and care efforts, where some risk groups such as women, children, and hemophiliacs have often been depicted as victims due to dominant perceptions of them as socially vulnerable, while others, such as injection drug users, sex workers, and homosexual men have been blamed for being personally responsible for their predicaments. Depending on the time, place, and sociocultural context, however, the labelling of these groups might differ, as in the case of a recent paradigm shift in international HIV and development policies that view African men who have sex with men as not only existing, but also as victims of sexual rights abuses, social stigma, and state violence.

Lupton (1993) further argues that risk discourse is a political tool whose mediators include different bodies of governmentality like the state, media, scientific institutions, medical personnel, and other technical experts. For example, risk might be constructed to distinguish the self from “the other”, with “the other” being a marginalized or stigmatized group. Here, a distinction is made between “those at risk” and “those posing a risk” (Lupton, 1995). Relatedly, the risk paradigm can serve as a political weapon to further repress a marginalized group of people; for example, the history of blaming ethnic minorities for the outbreak of the plague in Europe or more recently, gay men for the AIDS epidemic. In the case of HIV, Lupton argues that the categorization of gay men under “risk groups” led to the oversimplification of social identities, the undermining of intersecting identities, and the obfuscation of who is at risk of HIV and how the virus is transmitted. Lupton (1995) states:
The epidemiological categorization of 'risk groups' and 'risk behaviors' in relation to HIV/AIDS implies that individuals' sexuality and sexual practices are unidimensional and fixed rather than fluid. Such a taxonomy has difficulties dealing with the fact that drug users may also be homosexual and vice versa, that many men who have sex with other men do not identify themselves as either gay or bisexual, that self-identified lesbians sometimes have sex with men, and that men may be the active partner in one experience of anal penetration with a partner, and the receptive partner in another. (p. 88)

Adding to Lupton’s arguments and those of other scholars (Boellstorff, 2011; Khan & Khan, 2006; Young & Meyer, 2005) on the limitations of labeling particular social groups as at risk, Rachel Kaplan, Jae Sevelius, and Kira Ribeiro (2016) more recently argued that existing categories of HIV risk isolate and stigmatize those at higher risk for HIV by constructing misinformed and unspecific notions about gender and sexuality. Relevant here as well is Susan Sontag’s work, AIDS and its Metaphors, in which she contends, “…to get AIDS is precisely to be revealed, in the majority of cases so far, as a member of a certain ‘risk group’, a community of pariahs” (Sontag, 1990; p. 112). Moreover, she adds, it exposes one’s previously hidden identity to family, friends, and the public, and in turn to persecution and harassment.

As I discussed earlier, in public health efforts, terms like “most-at-risk populations”, “key populations”, “risk groups” and “high risk groups” are used to categorize populations “at risk” for certain diseases. While these categories might be useful for the technical managers of risk such as public health professionals and policy makers, these institutional constructions of risk that structurally “other” certain groups of people have the power of constructing or reconstructing the identity of those groups labelled as at risk—a process that scholars such as Robert Padgug and Gerald Oppenheimer (1992) and Dennis Altman (1989) have written about in the case of gay men and HIV. Or in Sandra Hyde’s (2007) work on the case of indigenous ethnic minorities in the Yunnan Province in China who were labelled as carriers of HIV by the Chinese government, leading to further marginalization and stigmatization of this group. Joffe (1999) argues that the construction of certain social groups as “high risk” also fuels a “not me-others” response among
lay people, which facilitates the “othering” of those categorized as “high risk” or those disproportionately affected. As Lupton (1995) argues:

What needs to be brought to light and critically interrogated are the covert political and symbolic dimensions of these institutions; the ways in which the practices and policies of public health and health promotion valorize some groups and individuals and marginalize others, the concepts of subjectivity and rationality they privilege and exclude, the imperatives emerging from other socio-cultural sites that intertwine and compete with those of public health and health promotion, and the discursive processes by which these institutions are constituted and supported. (p. 5)

My dissertation draws on risk construction in HIV policies and interventions—a central component to the key populations paradigm, I argue. Particularly, the concept of “high-risk” groups, usually categorized under “key populations” or “most-at-risk-populations”, is the key construction that has informed Ghana’s HIV policies, frameworks, and programmatic interventions for their key populations. A central component of this construction process is the production of biomedical data that substantiates the inclusion of certain social groups like MSM in AIDS policies and programs. This construction process and the discursive practices at play “take a life of their own” as Sandra Hyde (2007) argues, when they “confront social prejudices” and structural factors informing these prejudices.

Moreover, I demonstrate how certain social identities—in this case saso and other men who have sex with men—are constructed as at risk for HIV to substantiate their inclusion in Ghana’s national AIDS response. I discuss how these constructions are disseminated or discursively represented by policymakers and the media to the public, and to saso and other men who have sex with men. Relatedly, I discuss the meanings these representations and narratives place on HIV risk among men who have sex with men, what ideological functions they may play, and what the social impact and consequences of these processes on the men and on social understandings of homosexuality are. Notably, drawing on Erich Goode and Nachman Ben-Yehuda’s (2010) work on moral panics, I demonstrate how the construction and inclusion of MSM as a high-risk group in Ghana’s national AIDS response has led to moral
panics that have shaped notions and representations of homosexuality as deviant and thus an immoral nuisance that poses dangers to the Ghanaian public.

**Organization of Dissertation**

The dissertation is organized into seven chapters. In Chapter 2, I describe my research methodology and rationale as well as the study setting and sample, data collection and analysis methods, and ethical issues, validity, reliability, and limitations.

In Chapter 3, I explain why and how Ghana’s HIV policies ignored sasoi and other men who have sex with men for over two decades. I also describe the evolution of the country’s HIV policies and the different local and global factors and actors that caused what I argue is a paradigm shift in policies to recognize sasoi and other men who have sex with men in Ghana as a key population at higher risk for HIV. Additionally, I examine the policy objectives and overarching goals for men who have sex with men in the first NSP to include MSM as a KP and some of the challenges and strengths of these efforts. Of particular focus in this chapter are the biomedical and political discourses, attitudes, and beliefs informing these developments and the new social role sasoi and other men who have sex with men occupy as biomedical subjects.

Also in Chapter 3, I argue that Ghana’s policy blind spot was due to 1) the criminalization and stigmatization of same-sex sexualities in the country; 2) a construction of the Ghanaian epidemic as driven by migrant female sex workers; and 3) international AIDS researchers’ categorization of HIV in Africa as heterosexual, which informed donor policies and stipulations. The paradigm shift to correct this blind spot, I suggest, has been catalyzed by growing epidemiological data, local and international NGO and CBO advocacy efforts, and global donor policy changes that now identify MSM as a vulnerable group for HIV in the global South. Moreover, I argue that MSM HIV efforts and the biomedical data and discourses resulting from these activities construct MSM as posing a risk to the public, thus, further marginalizing sasoi Ghanaians.
Also in Chapter 3, I contend that with the construction of sasoi and other MSM as biopolitical citizens with certain rights limited to the biomedical realm, there now exist two parallel and contradictory sets of legal realities: one that recognizes the men in terms of their risk to HIV/AIDS and some of the sociocultural conditions that produce these realities and one that recognizes the men as engaging in “unnatural” and criminal behavior. I also explore the tensions that exist within these strategic efforts given the criminalization and stigmatization of male same-sex sex and intimacies and argue that they present significant barriers to openly, and thus, effectively addressing HIV among this key population. The chapter will discuss these barriers, including the construction of MSM as posing a risk to the public as well as the marginalization of MSM organizations and peers and, in effect, the very efforts the government is leading, resulting in what I argue is an inclusion paradox.

In Chapter 4, I examine the sociocultural context in which sasoi and other men who have sex with men, live, love and survive and in which the KP paradigm shift is occurring, including perceptions and beliefs about homosexuality that circulate in Ghanaian society. Through narratives from sasoi Ghanaians about their lived experiences and perceptions of their sexualities, I illuminate the realities they live under and that shape their risk for HIV and ability to access HIV prevention and care services. I argue that religious leaders and the print and broadcast media play the leading role in the stigmatization of homosexuality in Ghanaian society. Further, I suggest that pressure from these institutions have mobilized and emboldened citizens to speak out against homosexuality while polarizing society around the issue of homosexuality. Likewise, I demonstrate how these local actors as well as international developments around LGBTQ rights have pressured politicians and other government leaders to take a position on homosexuality and thus, further politicized the issue in Ghanaian society.

In Chapter 5, I describe the experiences of key stakeholders, service providers, and other frontline workers in implementing MSM HIV policies and programs. I specifically examine what prevention activities exist and how they are being implemented, and key challenges and
successes of these efforts. I argue that the same sociocultural circumstances that place MSM at risk also present significant barriers to addressing that risk. I also suggest that there are significant gaps between policy and programmatic priorities set by key stakeholders on the highest level and the needs of frontline workers, especially MSM peer educators, who carry out the main prevention and care activities on the ground.

In Chapter 6, I connect the sociocultural realities shaping perceptions of homosexuality to the impact of MSM HIV interventions in Ghana. Particularly, I demonstrate how MSM risk discourse as well as biomedical data are disseminated discursively in the media, to the public, and to men who have sex with men and how these are received and reacted to. Relatedly, I discuss the meanings these representations place on HIV risk among MSM, the ideological functions these representations may play, and the social impact of these processes on the men and on sociocultural understandings of homosexuality. I contend that there have been significant unintended consequences from efforts related to the construction of MSM as at risk for HIV and the subsequent KP paradigm shift, including the leakage of MSM epidemiological data to the media and a backlash resulting from this leakage. These developments have further made visible sasoi and other MSM and is reconstituting the sociocultural landscape, further politicizing homosexuality, and constructing new meanings for what it means to be homosexual. I revisit my argument in Chapter 3 about the inclusion paradox produced by stakeholders’ strategy of not openly implementing MSM HIV prevention policies and programs and suggest that this strategy limits their ability to manage and minimize the impact of these unintended consequences.

In Chapter 7, I conclude with a discussion of the implications of Ghana’s paradigm shift to include MSM in its national AIDS response for sasoi and other MSM, non-state stakeholders, and governments in the broader region engaged in addressing this concentrated epidemic among an increasingly stigmatized group.
CHAPTER 2
METHODOLOGY

Introduction
My study utilized qualitative ethnographic methods to examine: 1) why sasoi and other MSM were not initially acknowledged in Ghana’s national AIDS policies; 2) why and how the government decided to include MSM as a key population in its national AIDS policies and programs; 3) what cultural, social, and political factors have affected the development, implementation, and reception of these policies and programs; 4) how do sasoi and other MSM perceive and experience these policy and programmatic efforts; and 5) how do sasoi and other MSM experience life in a country that criminalizes and stigmatizes same-sex sexual activities. Of particular interest in my inquiry was to understand the underlying discourses, mobilizing metaphors, and the uses and basic ideologies of the HIV policy and programmatic shifts (Wedel et al., 2005).

In this chapter, I provide a description of my research approach and methods and my rationale for employing them. Additionally, I discuss my research setting, sampling methods, data sources, participant characteristics, and data analysis methods. Lastly, I reflect on the study’s validity and reliability along with its limitations and ethical concerns.

Why an Ethnography of HIV Policy?
I applied an ethnographic approach to this study to examine the outlined research questions and aims. As a qualitative study focused on understanding the legal and sociocultural factors underlying and informing national HIV policies on MSM, an ethnographic approach was the most suitable in answering this understudied inquiry. Drawing on Shore and Wright’s work, *Anthropology of Policy*, I conceptualized policy as a “cultural agent”, “political technology”, and “language and power” (Shore & Wright, 1997). Policy particularly produces subjects of institutional power by classifying individuals as “citizen”, “subject”, “criminal”, “deviant”, or in the
case of health policy, “diseased” (Shore & Wright, 1997). Thus, Shore and Wright argue that the examination of policy engages matters at the core of social science inquiries by, for example, studying the relationship between institutions and norms, power and knowledge, the politics of identity and culture, ideology and discourse, and meaning and interpretation.

Sandra Hyde’s (2007) ethnography, *Eating Spring Rice*, on the cultural politics of AIDS prevention in China from a policy lens, was particularly instructive to my study methodologically and conceptually. Hyde argues that a study of the cultural politics of AIDS through an ethnography of policy is necessary because the question of the relationship between the state and minority other is understudied. For my study, this entailed an examination of the cultural politics of state and non-state policy and the programmatic responses to the HIV epidemic among sasoi and other MSM as informed by perceptions of same-sex sexualities and other sociocultural factors. An ethnographic approach, as Hyde rightly points out, is equipped to deconstruct state policies and practices—as this study aimed to do—because of the attention it pays to everyday politics of life, including the contentions, paradoxes, and differing perspectives between and within various actors. Furthermore, an ethnographic approach “draws out how policy aids the state in shaping, controlling, and regulating heterogeneous populations through classificatory schemes that homogenize diversity, render the subject transparent to the state, and implement legal and spatial boundaries between different categories of subjects” (Wedel et al., 2005; p. 35).

**Rational for Research Site**

As discussed in the Introduction, until recently national AIDS policies and programmatic efforts in sub-Saharan Africa had not addressed male same-sex transmission for most of the HIV epidemic. These recent policy shifts are important to examine in order to understand the key drivers and the nature of the processes underlying them. I selected Ghana as a case study of these policy shifts because its national AIDS policy is considered one of the most
comprehensive in the region in terms of MSM HIV prevention and care (Makofane et al., 2013). However, like many other nations in the region, the policy changes are occurring in contexts where the very behaviors being targeted are criminalized and highly stigmatized. Moreover, Ghana has been making international news because of a growing contentious debate on homosexuality in the country that has predominantly focused on male same-sex sexualities. These two phenomena have further politicized homosexuality and added another challenge to HIV prevention efforts for sasoi and other MSM.

Given that Ghana is one of a few countries in the region that has developed HIV policies for men who have sex with men, it provided a good case to examine why and how this historic change is occurring in the region, particularly in contexts that are simultaneously hostile towards homosexuality. Additionally, the legal and political realities for LGBTQ people in the country were similar to those in other parts of the region, but the social situation was not so charged that it would be precarious or impractical to study my research questions as it would be in countries such as Cameroon or Uganda. Another key factor in choosing Ghana as my research site was that I had previous experience working in there on LGBT rights and MSM HIV prevention. During the summer of 2011, I volunteered as a research assistant at the Center for Popular Education and Human Rights Ghana (CEPEHRG)—a gay-led Ghanaian NGO that does LGBT advocacy work as well as provides HIV and STI prevention services to sasoi and other MSM. Through this experience and my continued correspondence with the organization, I established rapport with the director, staff, and a few other key stakeholders who were directly or marginally involved in MSM HIV policy and programmatic efforts. These connections helped to broker my access to the site.

With Ghana’s policies as the focus of my research, I narrowed my data collection site to its capital and largest city, Accra. Accra is located in the Greater Accra Region, which is the second largest region in the country with a population of 4,010,054 people (Ghana Statistical Service, 2013). Accra is also the political capital of the country and home to its three
governmental branches: Executive, Judicial, and Legislative. Additionally, the Ghana AIDS Commission (GAC), the governmental agency responsible for developing the country’s AIDS policies and implementing and coordinating programs nationally, operates from Accra. Thus, the policymaking bodies that are responsible for HIV and key population policies are based and meet in Accra. Another deciding factor was that while there are a few MSM HIV prevention programs in other major cities, Accra is home to CEPEHRG, which has run MSM HIV prevention and care programs for the longest in Ghana. Finally, the vast majority of conferences and meetings related to HIV prevention and care take place in the Greater Accra region.

A Profile of Ghana

Ghana is a West African country that borders the Gulf of Guinea to the South, Togo to the East, Ivory Coast to the West, and Burkina Faso to the North (see Figure 2 for a map of Ghana). A country of approximately 27.4 million people, on March 6, 1957 it became the first sub-Saharan African nation to win its independence from European colonialism. Ghana consists of 10 administrative regions: Eastern, Western, Central, Northern, Volta, Greater Accra, Ashanti, Brong Ahafo, Upper East, and Upper West.

Although currently a representative democracy, Ghana was politically unstable in the decades following its independence with the political terrain characterized by single party rule and military coups (Austin, 1985; Chazan, 1982; Rothchild, 1980). In 1992, the country transitioned to a democratic republic after a 12-year-long military dictatorship under Lt. Jerry John Rawlings and his populist party, the Provisional National Defense Council (PNDC). The end of single-party rule was also marked by the creation of a new Constitution, which has been renewed twice over the past 20 years. Although there was a shift to multi-party elections, Rawlings ruled for another two terms until John Kufuor won the presidential elections in 2001 under the New Patriotic Party (NPP), a center-right party. Despite the history of military coups, Ghana is considered one of the most politically stable nations in West Africa, with very few
incidents of ethnic and political conflicts in the past 25 years. Politically, it is a multi-party democracy that holds presidential and parliamentary elections every four years. Presidents are limited to two 4-year terms although two main political parties—NDC and NPP—dominate elected positions.

![Map of Ghana & Research Sites, Google Maps 2016](image)

International financial and economic development institutions consider Ghana a post-colonial success story. Its recently acquired status as lower middle-income nation is perhaps the best marker of this success (D. Johnson, 2016). Ghana boasts a gross domestic product (GDP) of $37.54 billion, and a GDP per capita of about $1,369.7 (World Bank, 2016a). While the
agricultural industry was the largest contributor to the GDP in the past, today the industry and
service sectors contribute the most (Ghana Statistical Service, Ghana Health Service, & ICF
International, 2015). In terms of employment and occupation, 43.9% of the population is
economically active based on the last census and 42% of the population age 15 years and older
is employed (Ghana Statistical Service, 2013). About 60% of the workforce is self-employed
without employees. For the population of economically active people that are 15 years and
older, 41.7% of them work as skilled fishery, forestry, and agriculture laborers. Another 21% of
the population work in service and sale, and 15.2% work as trade and craft workers. Despite
Ghana’s economic growth, there are currently 3,650,000 children (28.3%) living in poverty and
1.2 million (10%) living in extreme poverty (Cooke, Hague, & McKay, 2016).

According to the most recent comprehensive census data (Ghana Statistical Service,
2013), there are nine ethnic groups in Ghana: the Akan (47.5%), Mole-Dagbani (16.6%), Ewe
(13.9%), Ga-Dangme (7.4%), Gurma (5.7%), Guan (3.7%), Grusi (2.5%), other (1.4%) and
Mande (1.1%). Each of these groups consist of multiple sub-groups that share a common
history, language, origin, and culture. There are nine government sponsored and 26 non-
government sponsored languages, with English designated as the national language and Twi as
the most commonly spoken native language. Ghana is not religiously diverse. Christians
account for 70% of the population (Pentecostal/Charismatic 28.3%, Protestant 18.4%, Catholic
13.1%, other Christian 11.4%), followed by Muslims (17.6%), people with no religious
identification (5.3%), and Traditionalists (5.2%).

Ghana’s population is young, with about 48.9% under the age of 20 years (Ghana
Statistical Service, 2013). The country has a life expectancy at birth of 61.03 years, which ranks
170th in the world (UN DESA Population Division, 2015). Its birth rate is 33 births per 1,000
people (World Bank, 2016a). The infant mortality rate is high, with 43 deaths per 1,000 live
births, and the general mortality rate is nine deaths per 1,000 people. In terms of mortality, the
following five diseases are the top causes of death in Ghana: lower respiratory infections
(10.7%), stroke (8.7%), malaria (8.3%), ischemic heart disease (5.8%), HIV/AIDS (4.9%), and pre-term birth complications (3.7%) (World Health Organization, 2015).

In terms of education, about 74% of the population age 11 years and older are literate in at least one language (Ghana Statistical Service, 2013). Additionally, 45.8% are literate in English and a Ghanaian language. Seven percent of the population are literate in a Ghanaian language only, while a fifth of the population are literate in English only. According to census data (Ghana Statistical Service, 2013), in terms of educational attainment, 23.5% of the population have no formal education. Out of the population with formal education, 26.6% of them have a primary level education, 29.7% at middle or Junior High School/Junior Secondary level, and 10.2% at a high school level. Only 1.8% has a bachelor degree.

Ghana’s economic growth over the past decade, although elevating the country’s status to lower-middle income, parallels its growing economic inequality since 1992 (Cooke et al., 2016). The country has made important progress on poverty reduction since the 1990s but inequality is widening between the richest and the poorest within the following four indicators: 1) income, 2) under-five mortality, 3) skilled birth attendance, and 4) access to improved water (UNDP, 2014). Inequality is also widening, especially between women and men, and between Northern and Southern Ghana (UNDP, 2014).

**Data Collection Methods**

I conducted field research over the course of 12 months, from December 2013 to December 2014. I entered the field as a Fulbright student researcher and was hosted as a visiting scholar by the Center for Gender Studies and Advocacy and the Sociology Department at the University of Ghana, Legon. As Emerson, Fretz, and Shaw (1995) contend, ethnography is a recursive and iterative process in which interaction with informants and research sites may transform research inquiries and assumptions. In the case of my dissertation, the boundaries of my fieldwork evolved as new questions developed from my fieldwork and as my research
protocol was consequently modified. The section below details the specific data collection methods and instruments I used, and the fieldwork sites where I conducted my study.

**Participant Observations**

Participant observation (PO) is a key ethnographic research method through which researchers can examine and take note of cultural patterns, political processes, organizational structures and hierarchies, and other structural patterns that are not easily observed through other methods. Through PO, researchers, engaging in different levels of participation over a long-term period, can observe how cultural, social, and political beliefs and practices shape processes, and specific to my case, the development and implementation of HIV policies. Moreover, the researcher can gain an emic understanding of how groups and individuals make sense of different sociocultural phenomena, such as same-sex sexualities and rights, HIV risk, and HIV prevention efforts (Hyde, 2007; Parker & Ehrhardt, 2001).

Over the course of my field research, I conducted participant observations, recorded field notes, and collected relevant materials from the following sites and activities:

1) Key populations Technical Work Group Steering Committee (KP TWG) meetings
2) Two local NGOs engaged in HIV and rights advocacy work for LGBT populations (CEPEHRG and Human Rights Advocacy Center)
3) HIV service providers during their testing and counseling outreach to MSM
4) Peer educator meetings and field outreach
5) HIV-related and sexual rights-related conferences, meetings, and events
6) Social settings like restaurants, bars, public transportation, social events, etc.

My primary focus as a PO of the KP TWG was to collect data on how its policy work group functions and the scope of its work. I sought to learn which actors are involved in the process; the policy, research and materials produced by the work group; and the political, social, and cultural factors that informed their work. I observed five work group meetings from
March 2014 to December 2014. As part of my PO activities, I was particularly interested in how often the work group met, the focus on its meetings, how decisions get made, intra-group relationships and dynamics, and debates within the group about the scope of their work. I was also interested in the cultural meanings these policymakers place on same-sex sexualities and if these meanings inform the development and implementation of HIV prevention policies. Relatedly, I was interested in what social, political, and cultural factors inform the group’s discourse on sexuality, MSM HIV risk construction, and health promotion. In regards to implementation, I examined what initiatives the work group was undertaking to operationalize policies as well as which parts of the policies were not acted on, and why. Additionally, I was interested in which actors participate in and influence the groups and how, and which actors are missing and why. I contextualized the functioning of the group within other underlying international and local processes that might have affected the development and implementation of these policies.

In addition to observing the KP TWG, I conducted participant observations of CEPEHRG and HRAC as an intern with both organizations for 8 months. Starting in March 2014, I interned at CEPEHRG once a week, which was also on the only day its HIV/STI drop-in center (DIC) for testing and counseling was open. There, I assisted the organization with editing research proposals and reports as well as provided a training for staff members on writing research abstracts. At CEPEHRG, I was particularly interested in the organization’s MSM HIV prevention and care work. I chose CEPEHRG because it was the first organization to provide HIV services and LGBT rights training to sasoi and other MSM. While a few other organizations now provide HIV services to MSM, CEPEHRG has been providing these services the longest, has been led by people from the local LGBTQ community, and has close relationships with members of this community. Moreover, the organization has the largest number of peer educators. Also critical, I had established rapport with its Director and a number of its staff and volunteers. At CEPEHRG, I was interested in observing the types of services they provide to sasoi and other MSM, and in
learning about their experiences working long-term in this area, including their challenges and successes, if and how their work is informed by policies targeting MSM, and what political, social, and cultural factors shape their work.

During my twice a week internship with HRAC, I assisted them with conducting literature reviews and research (they had been commissioned to conduct in and outside of Accra) and writing reports based on this research. I chose HRAC because it is the only mainstream human rights organization in Ghana that advocates for human rights for LGBT Ghanaians. Moreover, the organization receives a significant amount of funding and support from Western and international HIV donors. At HRAC, I was interested in examining the rights advocacy work that was done on behalf of the LGBT population, particularly sasoi and other men who have sex with men. My work at HRAC provided me with numerous opportunities to participate and observe, including two LGBT rights-themed events at the U.S. Embassy; six research dissemination, program development, and advocacy meetings; and two focus group discussions and workshops with peer educators and other MSM on matters related to rights abuse.

I additionally conducted observations of peer education outreach to MSM. I observed two peer educator-led testing, counseling, and group education events. At these events, I examined which clients attended, who led the event, what information was shared, what questions and concerns were raised, and whether these efforts were informed by policies. While I was hoping to observe more examples of group education and other outreach by peer educators, I was unable to because of time limitations.

Lastly, I collected participant observation data at social settings such as restaurants, salons, bars, clubs, church, and at social events, including a few gatherings within the LGBTQ community. From these sites, I observed discourses, social interactions, and perceptions

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7 HRAC does not advocate for LGBT-specific rights. Rather, they advocate for human rights for LGBT people, meaning they insist that the government and other institutions should ensure that all rights enshrined in the constitution for Ghanaians should be ensured for LGBT people as well.
related to same-sex sexualities and HIV. Specifically, I examined the representation and circulation of stories about homosexuality and of HIV/AIDS, as well as if and how people relate the two. I also observed how LGBTQ Ghanaians live their social lives in a context that is highly stigmatizing of them. These observations were informative on cultural and social perceptions of homosexuality, MSM, and HIV/AIDS underlying the ongoing policy shifts and programmatic efforts.

In-depth Interviews

Another key source of data came from the in-depth interviews I conducted. During the data collection period, I conducted 43 in-depth interviews with policymakers, HIV prevention service providers, key informants, and sasoi and other MSM. In terms of policymakers, I conducted interviews with 11 stakeholders from the KP TWG and MSM sub-work group members. The interviewed stakeholders were composed of members of: local and international implementing NGOs (5), GAC (2), National AIDS/STI Control Programme (NACP), (1), the Ghana Police Service (1), and USAID/PEPFAR (2). Interview protocols solicited information about the factors that motivated the work group to include MSM as a key at risk population in its National Strategic Plan, and if and why the interviewee sees this work as important. The interviewees were asked to reflect on the policymaking process, what factors have informed it, what challenges they encountered and what they viewed as successes. I also asked how they think donor priorities, funding stipulations, and recommended best practices affect policymaking and implementation processes. Finally, during the interview, I inquired about points of contention between the policies and what participants viewed as cultural and political barriers to implementing the policies.

I also conducted in-depth interviews with nine individuals having varying levels of training and experience in MSM HIV/AIDS work, and from numerous sites that provide services to sasoi and other MSM. These workers were asked about their views on the MSM HIV
prevention policymaking and implementation process. They were also asked to discuss if and how policy priorities are both communicated to their organization and inform their work. Lastly, the participants were asked to discuss what impact criminalization, discrimination, and stigma of same-sex behavior have on their work and how prevention policies might address this.

Another group of people I interviewed were the men who are targeted by the policy and programmatic efforts. During my time in the field, I was able to conduct in-depth interviews with 15 men about their awareness and knowledge, attitudes, and perceptions of MSM HIV prevention policies and services. These participants were asked to discuss how they perceived and experienced this policy change and the services being provided in order to understand what factors are facilitating or limiting their ability to benefit from these resources. They were also asked to share their life experiences as men who are involved in same-sex intimacies.

The last group of in-depth interviews was conducted with five key informants from HIV-service and academic organizations and civil society who had unique insights on a number of different inquiries related to my research questions and aims.

Focus Group Interviews

Another method of data collection was focus group interviews with MSM peer educators. I conducted three group interviews with a total of 18 participants: the first two interviews were with CEPEHRG peer educators representing various communities in Accra and the third interview was with peer educators in the city of Takoradi, who work for Maritime Life Precious Foundation, another non-profit that has been providing HIV prevention and care services to MSM since 2006. Purposive sampling was used to recruit participants to ensure that the participants have varying levels of experience in HIV/AIDS work that focus of sasoi and other men who have sex with men. Peer educators were interviewed about how and why they got involved with peer education work and about their experiences doing HIV and sexual health outreach to the men in their respective communities. I also asked them about if and how policy
priorities are communicated to them and whether these inform their work and if so how. The participants were additionally interviewed about what impact criminalization and social stigma of male same-sex sexualities and sexual activities have had on their work and how prevention policies can address these.

Archival Research: Print and Online News Media

Another source of data was from archival research of media coverage of homosexuality since 2010, when the explosion of anti-gay media coverage began in Ghana. This analysis provided insights on the socio-cultural context in which MSM HIV prevention and care were being addressed. I reviewed media articles to evaluate how homosexuality is represented and how these representations are circulated, discussed, and repeated publicly. Additionally, I examined the cultural, social, and political factors shaping the representations; what prompts coverage of same-sex sexualities in the media; how different organizations/institutions and individual actors talk about same-sex sexualities; and what trends can be observed in media coverage of same-sex sexualities. Preliminary analysis of these sources informed the in-depth and focus group interviews.

For this part of my research, I searched for articles on www.Ghanaweb.com, which archives as well as aggregate articles from major Ghanaian print and online news media sources as well as publish its own original news. To find relevant articles, I used the following search terms: ‘homosexuality’, ‘homosexual’, ‘gay’, and ‘lesbian’. I limited the search to the ‘News’ and ‘Opinion” categories of the search engine. I also restricted the search to articles published from 2011 up to the end of my fieldwork in December 2014. I selected 2011 as the starting point because a series of events in Ghana and internationally brought the question of homosexuality into the limelight in 2011 in an unparalleled way after U.K. Prime Minister, David Cameron threatened to withhold aid from Ghana if the country did not reform anti-gay legislation (see Chapter 4 for a fuller discussion of this development). Additionally, I focused my analysis
on this four-year period to examine the evolution of media coverage of homosexuality over the period that the 2011-2015 key populations National Strategic Plan covered. While the bulk of the articles I analyzed for this component of my study were between 2011 and 2014, my analysis also includes media coverage of homosexuality before and after that time period.

My search on Ghanaweb.com using the cited key terms produced the following results over the four-year period:

- In 2011, 228 articles mentioned “gay(s/ism)”, 372 mentioned “homosexual(s)”, 305 mentioned “homosexuality”, and 176 mentioned “lesbian(s/ism)”.  
- In 2012, 86 articles mentioned “gay(s/ism)”, 109 mentioned “homosexual(s)”, 73 articles mentioned “homosexuality”; and 52 mentioned “lesbian(s/ism)”.  
- In 2013, 245 articles mentioned “gay(s/ism)”, 238 mentioned “homosexual(s)”, 199 mentioned “homosexuality”, and 109 mentioned “lesbian(s/ism)”.  
- In 2014, 112 articles mentioned ‘gay(s)’, 96 mentioned ‘homosexual(s)’, 61 mentioned ‘homosexuality’, and 49 mentioned ‘lesbian(s/ism)’.

It is important to note that more than one term appeared in the same article, as might be expected, thus some of the articles that resulted from each search term overlap. The articles were published by various online and print news sources: Ghana News Agency; Daily Graphic and Daily Guide newspapers; news summaries from radio stations such as My Joy FM (myjoyonline.com), Citi FM (citifmonline.com), Peace FM (peacefmonline.com), and XYZ FM (radioxyzonline.com); a few foreign news sources such as the BBC; and opinion pieces by columnists and readers of Ghanaweb.com, public figures or personalities, and other civil society members.

These articles do not represent all media coverage of same-sex sexualities in Ghana, thus, there are limitations to the findings regarding the media analysis. The articles that are
archived on Ghanaweb.com, however, are published in many of the prominent news publications in Ghana and thus, constitute much of most circulated media coverage in Ghana.

Archival Research: Field and Research Documents and Materials

In addition to the media analysis, while conducting participant observations, interviews and other fieldwork, I collected various materials that informed my research questions. These included: 1) HIV policy documents and reports; 2) public health promotion materials focused on HIV prevention and care among men who have sex with men; 3) conference and research materials such as handouts, presentations, and reports; and 4) meeting/workshop agendas, handouts, and documents. These were analyzed to inform a description of how HIV policies and programmatic efforts in Ghana, particularly those focused on men who have sex with men, have evolved, the current policy and programmatic efforts, the written and illustrated content of health promotion materials, and the discourses embedded in these materials.

Study Population and Sampling Characteristics and Methods

Study Population and Sample Composition

The study population consisted of: 1) HIV policymakers from the Ghana AIDS Commission and the MARPS Technical Work Group Steering Committee; 2) HIV prevention personnel who serve MSM, including peer educators; 3) men who identify as gay, bisexual, saso, or as having sex with men; and 4) key informants who had unique or expert knowledge on the research inquiry. I conducted a total of 61 interviews with a sample size of 59 participants. Please refer to Table 1 for more information on the sample composition.
Table 1: Sample Composition

<table>
<thead>
<tr>
<th>Participants</th>
<th>In-depth Interviews</th>
<th>Focus group Interviews</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policymakers</td>
<td>11</td>
<td>X</td>
<td>11</td>
</tr>
<tr>
<td>HIV service providers</td>
<td>9</td>
<td>X</td>
<td>9</td>
</tr>
<tr>
<td>MSM</td>
<td>15</td>
<td>X</td>
<td>15</td>
</tr>
<tr>
<td>Peer educators</td>
<td>3</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Key Informants</td>
<td>5</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>18</td>
<td>61</td>
</tr>
</tbody>
</table>

Sample characteristics.

Out of the 59 people that were interviewed, 55 were Black and out of that, 53 of were Ghanaian. Two of the participants were White Europeans and one of them was African American. Fifty-three were men and six were women. I did not collect additional demographic information for my informants—with the exception of sasoi and other MSM—because it was not relevant to the research questions.

The sample of sasoi and other MSM participants I interviewed ranged from 20 years to 31 years and averaged 25.6 years. They represented ethnic groups from almost every region of Ghana, including Northern, Eastern, Volta, Central, Western, Ashanti, Brong-Ahafo, and Greater Accra. A majority of them identified as feminine or both masculine and feminine. Additionally, nine identified as saso, gay, or homosexual, some of whom also identified as MSM. One person identified as MSM only and three identified as bisexual. Two people did not identify as anything. The group was highly educated; most of them had taken post-graduate courses and a few had college degrees or were in college. One person did not share their educational status and
another person had some high school education. Seven people were employed while the rest worked as unpaid interns/volunteers or were unemployed.

**Sampling Methods: Purposive and Chain Referrals Sampling**

I used two different sampling methods to recruit participants for my in-depth interviews. For the recruitment of policymakers, non-peer educator HIV service providers, and key informants, I used purposive sampling. This method was the most suitable for my research questions because it allowed for targeted recruitment of individuals who hold particular historical knowledge of the evolution of MSM HIV policies in Ghana, and/or who had first-hand experience working on HIV prevention initiatives focusing on key populations like MSM. Additionally, it allowed me to seek individuals who could fill the gaps in my data as the study progressed. Purposive sampling also produced a diverse and representative pool, with participation from newer and more experienced policymakers, representatives from different organizations engaged in the key population programmatic and policy efforts, and key informants from different but intersecting areas of work.

I also used purposive sampling to recruit participant for my focus group discussions. I specifically recruited peer educators from two different organizations that have been doing peer education with men who have sex with men for the longest period in Ghana: CEPEHRG and Maritime. For the CEPEHRG peer educators, I announced my research study at a peer educators meeting that the organization hosts each month. I described to participants the scope of the study, the requirements for participation, and the interview content and process. After informing them about the study, I asked those who were potentially interested in participating to provide me with their contact information. With the help of one of the peer educators, I organized two focus group discussions at a gay-friendly private social space that was familiar to many of the men.
For the Maritime peer educators, I met them during a training workshop by Human Rights Advocacy Center that Maritime co-hosted in Takoradi, a coastal city in the Western Region of Ghana. During this workshop, I informed the peer educators of my interest in interviewing them as a group and gave them a similar orientation to my study as I did with the CEPEHRG peer educators. In this situation, all four peer educators agreed to participate in a focus group interview, and it was conducted in a private office at the site of their workplace.

Sasoi and other men who have sex with men were recruited for in-depth interviews using a chain referral sampling method. I used this method because of its effectiveness in recruiting hard to reach populations, like men who have sex with men, while maintaining confidentiality and privacy (Penrod, Preston, Cain, & Starks, 2003). During my time working with peer educators in participant observation work and conducting group discussions, I developed rapport with the men. In the process, I established good relationships, especially with some of the peer educators who were very enthusiastic about the study and interested in helping me find participants for the in-depth interviews. I therefore asked the peer educators I interviewed in the group discussions to identify other MSM in their networks who might be interested in participating in the study. I specifically asked them to inform the prospective participants of my study and to get their consent to share their contact information with me. If the prospective friend was not interested in giving their contact information, I asked the peer educators to share my phone number with them and have them contact me if interested. With the assistance of three peer educators and participants they referred, I was able to interview about eight men. The other seven men I interviewed were men I met during participant observations of workshops, trainings, and social events. Throughout this process, I attempted to access multiple networks of MSM to ensure that the sample reflected different experiences and age groups. However, the vast majority of the men were between ages 20 and 31 years, and thus, my data does not reflect the lived experiences of older saso men.
Ethical Approval and Informed Consent

Prior to commencing field research, I submitted two Institutional Review Board (IRB) applications for my study to be reviewed for ethical approval. An application was submitted to the Columbia University Medical Campus IRB and another was submitted to the Institute for Statistical, Social, and Economic Research (ISSER) Ethics Committee for the Humanities at the University of Ghana, Legon in Accra. Once ethical clearance was granted by both of these institutions, I began the human subjects and participant observation component of my data collection.

To be eligible to participate, prospective participants had to be from the identified populations, 18 years of age or older, and speak English. Race and gender were not part of the eligibility criteria. Although in the United States individuals between ages 18-21 years are legally considered minors, in Ghana the legal age of consent is 18 years old. Thus, individuals in my study were considered emancipated adults and therefore capable of giving informed consent. Before being able to participate in the interviews, individuals who met the criteria underwent oral consent procedures that informed them about the objectives of the study, what participation entailed, and the risks and benefits of participating in the study. While they were not asked to sign the consent form due to confidentiality, they were given a copy of an oral consent form with my contact information as well as that of the institutional ethical review boards. Key staff who worked at each of the participant observation sites were also informed about the study, and approval was received from the appropriate representative.

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Data Analysis Methods

Grounded Theory

The collected data were analyzed using a grounded theory approach. This iterative and inductive analysis process coincided with data collection, although the majority of the analysis was conducted after completing field research. A majority of the interviews and recordings were transcribed by a graduate student at the University of Ghana, Legon. However, I also transcribed or re-transcribed most of the transcripts. Once all of the interviews were transcribed, I reviewed them for errors, then logged and indexed all collected data (field notes, transcribed interviews, documents).

In terms of data coding, I used a three-phase coding process of: 1) open coding whereby substantive codes from conceptual categories are created; 2) axial coding to look for emerging themes and categories, and to connect these with theoretical codes; and 3) selective coding, which involves a higher level of conceptualization where theory is generated (Creswell, 2007). Half of my analysis was conducted using Atlas.ti software to organize interview transcripts, notes, and some of the research reports. I also used Atlas.ti to code interview transcripts. However, since a good portion of the archival data source were hard copies of research reports, policy documents, health promotional material, I also conducted my analysis manually.

During my analysis, I triangulated interview, observational, and archival data to ensure that different codes/themes and voices are represented, as well as to ensure validity of the findings. I utilized memoing to theorize from the data and codes and to reflect on analytical thoughts simultaneously as I conducted the analysis. These memos were theoretical and personal (Creswell, 2007). Memos attempted to be attentive to what participants said and did, as well as what they did not say or do (Charmaz, 2003). These memos connected different concepts and informed my writing process. In an effort to vividly and accurately portray the views attained and the contexts underlying them, I provide detailed descriptions of participants’
accounts. In a few instances, I conducted member checking by contacting key participants to verify my analysis.

My write up identified interviewees by name except in instances where the information they shared was sensitive or off the record. With the exception of peer educators, I used pseudonyms for all my sasoi and other MSM informants.

**Validity and Reliability**

There were numerous measures that were taken in the study to ensure its reliability and validity. In quantitative studies, reliability deals with how consistent over time data collection, and how accurate the representation of a study sample are (Golafshani, 2003; Joppe, 2000). It is also concerned with how replicable and repeatable a study is using similar methodology, and thus, whether it is reliable. Also in quantitative studies, validity addresses whether a study indeed measures what it aimed to measure and how “truthful” the findings are (Golafshani, 2003; Joppe, 2000). The measurement of a study’s validity involves asking numerous questions including comparing it to the results of other studies in the extant literature. In qualitative studies, however, especially ethnographic ones where the researcher is considered the instrument of data collection, measurements of validity and reliability are slightly modified to measure the credibility, transferability, and dependability of the research and findings (Golafshani, 2003). Thus, my discussion of validity and reliability engages with measures taken to assure these three factors.

In terms of dependability, to ensure that I was collecting data that accurately answered my research inquiries, I developed a unique semi-structured in-depth interview instrument for each of the populations I was interviewing: policymakers, HIV service providers, peer educators, and sasoi and other MSM. For my key informants, I created for each participant a unique instrument that was comprised of different questions from my other instruments I developed in order to adapt the instrument to the informant’s area of expertise. Also in terms of reliability,
major measure in my methodology that enhanced the accuracy of my data collection was my use of an audio-recording to accurately capture interview responses.

A feature of my research that enhanced validity was the long-term nature of the study and the ethnographic methods I employed. As Creswell argues, "Prolonged engagement and persistent observation in the field [allows for] building trust with participants, learning the culture, and checking for misinformation that stems from distortions introduced by the researcher or informants" (Creswell, 2007: p. 207). I also took steps to debrief with my dissertation sponsor every two or three weeks about the progress of my research, ethical and other research questions that emerged, modifications to my methodology while in the field, and preliminary findings. His feedback on these matters helped check bias that would affect validity and reliability of the study.

In my analysis of the interviews with each study sub-population, I discovered that when discussing the same events, I usually found informant’s recollection of stories or events to be consistent with each other. However, since participants have differing perspectives in recounting events and different experiences in their areas of work, there were differences in the breadth and content of the interviews that might affect study validity. To address these issues, I triangulated my data to ensure it was valid and reliable and that I was not over-representing one experience or perspective. I did this by comparing stories from different participants and examining them against research reports, policy documents, field notes and observations to confirm or disconfirm what was shared. For example, one informant’s recollection of how Ghana’s policy shift to include sasoi and other MSM emphasized his role in catalyzing the shift. If I considered his view as the most authoritative, Ghana’s shift would have single-handedly been due to the role he played. However, analysis of other informants’ responses to this question, which were more consistent with each other, disconfirmed his recollection of events.
Limitations and Delimitations

There are a few limitations to the study that are worth noting. First, my study examines government policies on HIV/AIDS. A study of policy is necessarily a study of state power, which is difficult to engage in social science research due to the sensitive nature of politics and political decisions. What I might discover in my research could have far-reaching implications for the government stakeholders I interviewed. Thus, some informants seemed to have censored some of their responses in order to not implicate themselves or others with sensitive information. For example, in my questions about the challenges in MSM HIV research, very few policymakers openly talked about the extent of homophobia among stakeholders and implementing partners in HIV research. Even those who did touch on the issue did not extensively discuss the nature of homophobia in the country’s MSM HIV response. Being sensitive to the lack of open discussion, I reacted by not asking as many probes as I could have. I was instead able to gather more extensive answers from other informants. Nonetheless, policymakers’ assessment of homophobia surrounding the MSM HIV response were limited.

As Howard Becker (2008) has argued, in social science, researchers often value the knowledge and insights of experts or those with authority as more valuable. However, he warned that this “hierarchy of credibility” can blind social scientist from information these experts leave out. And given their positions of power, this might mean especially omitting the voices of those who are more socially vulnerable. In my research, I attempted to examine all levels of the response, however due to time limitation, the views of lay health care workers and MSM living with HIV were underrepresented. Additionally, I was unable to interview other government officials outside of the MARPs/KP TWG for insights and other government perspectives on Ghana’s MSM HIV policy efforts.

Another key limitation is that my study examines the evolution of HIV policies to include men who have sex with men. It is however not a comprehensive history of Ghana’s HIV prevention and care efforts since the global onset of the epidemic. Although, it does present part
of this history in the process of describing the evolution of MSM HIV policies in the country. Similarly, while I interviewed key policymakers who are currently or have historically been involved with key populations and MSM specific HIV work, I was unable to interview some other key stakeholders that played a central role in the process. As is often the case with field research, some key informants had moved, were difficult to reach, or were not interested in being interviewed.

Another limitation of my study is that since I utilized an ethnographic approach, the findings are not generalizable. However, the findings are transferable, meaning it can be applied to contexts or settings that are similar. In my research, Ghana is used as a case study for understanding the ongoing paradigmatic shift in HIV prevention in sub-Saharan Africa and the sociocultural context in which its occurring. While the study examines Ghana as a case study of the larger policy trend, my findings indicate that there are unique sociocultural factors at play that place Ghana in the position it holds as a model country in MSM HIV prevention work. As such, the findings from Ghana may not be generalizable to other parts of sub-Saharan Africa, however by understanding the evolution of MSM HIV policies and the underlying factors and consequences of the shift, readers can transfer this knowledge to the ongoing shifts in other parts of the region.

**Reflection on Ethics and Positionality**

When one studies policies, it increases their proximity to power and how it operates. Sometimes this proximity reveals a number of processes and activities that may raise ethical questions for the researcher. During my fieldwork, there were a few ethical issues I encountered. In this section, I discuss these issues, how they affected my research and how I addressed them.

One of the most challenging issues I encountered during my fieldwork was my research participants’ curiosity about why I was interested in researching men who have sex with men.
Why, they wondered, would a young Ghanaian-American woman be interested in studying homosexuality, a highly taboo topic. One person followed this initial question with another, more personal one: Are you a lesbian? In response to questions of this nature, I avoided disclosing personal information or my own views on homosexuality. Rather, I usually explained that I arrived at my research question after observing social and media discussions of homosexuality in Ghana and how this observation, combined with my interests in sexual health and rights, peaked my interest in how Ghana was responding to HIV among MSM. Or I would explain how Ghana’s status as a model country in MSM HIV efforts drew me to the topic. Usually, these responses would suffice although I continued to sense some skepticism about my intentions.

Another key issue I faced in the field was sexual harassment by one of the policymakers, who despite having a reputation as a government personnel well-trained in rights abuses against women, PLHIV, and LGBTQ people, did not in fact practice what he assumedly knew. The incidence of harassment, in fact, happened after a theatre performance and workshop led by female sex workers on police sexual abuse, rights violations, and violence against female sex workers. Immediately following the harassment, I avoided all contact with him. And after consulting with a mentor, I initially maintained my distance from him until deciding that conducting an interview with him would be useful since he was the only representative from his field among policymakers. Thus, towards the end of my fieldwork, I requested an interview with him and explicitly conveyed that I wanted to ensure it was professional.

In addition to these issues, I encountered what appeared to be a lead stakeholder organization’s fabrication of data—what some in Ghana refer to as “data cooking”—from an MSM intervention. I did not discover this based on any extensive research or probing. It was quite transparent to any person who was paying close attention. The implementing organization behind this intervention reported reaching tens of thousands of MSM through this intervention. Due to this outcome, it was lauded as innovative and successful in reaching hard-to-reach MSM. However, an examination of the public site of the intervention indicates that messages
posted on the site were in fact not reflective of what was described in program reports, nor was it possible that they reached the reported number of men given that this number was half of the estimated population size of MSM across Ghana. If the report was accurate, this would mean they had reached 50% of all MSM in Ghana. I was further puzzled the study’s funder did not question how the organization reached that many people during private and public research dissemination meetings, given how obvious the fabrication seemed. This implied that perhaps they did not want to touch on the issue. As a researcher, I observed these issues but did not raise my concerns to the organizations or the funding agency. I did however ask a few key informants and MSM peer educators what they thought about the estimated reach of the intervention.

Despite the identified limitations and challenges, my methodology proved to be successful in helping me effectively address my research problem.
As a nation, we have not stopped to ask whether men are having sex with men in Ghana and if so what the potential contribution to the HIV/AIDS epidemic could be. Our national response to the epidemic failed to recognize MSM as a vulnerable group and does not include programs to curtail any potential threat from MSM. Recent developments in the country as captured by the media rather bring to the fore the level of intolerability of the system to homosexuality and the obstacles that would have to be overcome in introducing an intervention for MSM.

-Dr. Dela Attipoe, Greater Accra NACP Regional HIV/AIDS Coordinator, Revealing the Pandora Box or Playing the Ostrich? A Situational Appraisal of Men Having Sex with Men in the Accra Metropolitan Area and its Environs – Ghana, 2004

Introduction

In 2004, nearly two decades after Ghana discovered its first HIV case, the first study on HIV risk among sasoi and other men who have sex with men in Ghana was released. The report, titled Revealing the Pandora Box or Playing the Ostrich? A Situational Appraisal of Men Having Sex with Men in The Accra Metropolitan Area and its Environs-Ghana, was authored by the late Dr. Dela Attipoe, a medical doctor who worked for Ghana’s National AIDS Control Program (NACP) as the Greater Accra Regional HIV/AIDS Coordinator. The study was commissioned by West African Project to Combat HIV/AIDS and STIs (WAPCAS), a regional NGO, with funding from the Canadian International Development Agency (CIDA). The study conducted with the assistance of Ghana’s first LGBT rights organization, the Centre for Popular Education and Human Rights Ghana (CEPEHRG).

The aim of the Attipoe study—as a number of my policymaker and other key informants referred to it—was to “assess the MSM situation in and around Accra, Ghana so as to make recommendations for the introduction of an intervention to control sexually transmitted infections (STI) including HIV/AIDS among MSM in support of the national response to the HIV/AIDS menace” (Attipoe, 2004; p. 5). As reflected in the epigraph, the report strongly argued the government of Ghana had failed to recognize that many Ghanaian men do indeed have sex with
men and thus, may be a vulnerable group for HIV. More importantly, Attipoe hoped that, “this study will be an eye opener to many, including decision-makers, as it was to me and bring about a radical shift in our perceptions and bring about a better health status for all Ghanaians” (Attipoe, 2004; p. 3).

The Attipoe study was groundbreaking for numerous reasons. One, it was the first empirical study on HIV risk among Ghanaian men who have sex with men and one of the first in Africa. Two, it openly challenged the government to acknowledge male same-sex sexualities in Ghana and related health issues. Three, it argued for a strategic response to the epidemic among this group that addressed the criminalization and social stigmatization of same-sex sexualities and suggested pragmatic interventions. And four, it garnered the attention of state and non-state key stakeholders engaged in Ghana’s HIV response, who had the power to meaningfully transform the national response to the epidemic among the group. The study, in fact, was marked by several long-standing policymakers and other key stakeholders that I interviewed as a significant turning point in the country’s national response. Particularly, for USAID, it was one of the key studies that informed the agency’s shift to include men who have sex with men in their new bilateral HIV prevention and services program for MARPs (Robertson, 2009; p. 5). Despite the findings and recommendations from the Attipoe study, it took another seven years before Ghana finally released its first National HIV/AIDS policies to include men who have sex with men.

How Ghana excluded male same-sex transmission in their HIV efforts for nearly two decades of its epidemic and why and how the government finally came to include this population in its policies is an important history that offers instructive insights on the ongoing paradigm shift in Africa to include MSM as key populations in national AIDS polices. In this chapter, I describe the evolution of HIV polices in Ghana, why and how the government ignored sasoi and other men who have sex in its national AIDS polices, what actors and factors played a role in this critical blind spot, what local and international factors contributed to this blind spot,
and how the government has been correcting for the blind spot with a new set of national AIDS policies in the third decade of the country’s epidemic.

I make four key arguments in this chapter. First, I contend that Ghana’s policy blind spot—described with Attipoe’s metaphor of “the Ostrich” with its head buried—was a product of three related and mutually reinforcing factors: 1) the criminalization and stigmatization of same-sex sexualities in Ghana, 2) the construction of the local epidemic as driven by female sex workers, and 3) Western researchers and donors’ categorization of HIV in Africa as “heterosexual”, which in turn informed donor policies and funding stipulations that functioned within the political economy of HIV aid.

Second, I argue that the shift to include MSM as a key population—described with Attipoe’s other metaphor of “opening Pandora’s Box”—signifies a paradigm shift in Ghana’s HIV policies that has been catalyzed by growing epidemiological data, local and international NGO and CBO advocacy efforts, and international HIV donor policy changes that identified MSM as a vulnerable group for HIV in the global South. Moreover, I argue that this policy paradigm shift is from a general population paradigm, which frames the epidemic as a generalized heterosexual epidemic, to a key populations paradigm, a biopolitical paradigm, which frames the epidemic as a generalized, low-level epidemic mixed with a concentrated epidemic among key populations, with a focus on female sex workers and men who have sex with men.

Third, I argue that a central component of the key populations paradigm is the construction of sasoi and other MSM as at risk for HIV. In arguing this, I demonstrate how growing epidemiological data informed part of the construction of MSM as at high-risk for HIV/AIDS to substantiate their inclusion as a KP in Ghana’s national AIDS response.

Fourth, I suggest that the KP paradigm shift is a historic step, but one that has taken a strategically discreet form. This strategy is significantly shaped and limited by the continual criminalization of unnatural carnal knowledge and social stigma against sasoi and other men who have sex with men. Thus, the efforts by the government to reach sasoi and other MSM with
HIV services strategically function outside the radar of sections of the government, the healthcare system, and society at large. In effect, these efforts tow a fine line between visibility to its target audience and invisibility to the society they live in. Moreover, these discreet efforts further marginalize MSM peers and organizations and subsequently, the very efforts the government is leading, causing an *inclusion paradox*.

The chapter is divided into two sections. The first section discusses Ghana’s early responses to its HIV epidemic, particularly the causes of their policy blind spot. The second section reviews factors and developments that led to the Inclusion of MSM in national AIDS policies.

**Ghana’s Early Responses to its HIV/AIDS Epidemic**

**A “Unique” Epidemic**

Ghana discovered its first HIV case in March 1986, 5 years after the disease was identified in the United States. During that period, government and other health officials characterized the Ghanaian epidemic as “unique” compared to other parts of the region (Antwi & Oppong, 2006). In the early 1990s, Ghana had a relatively low prevalence, ranging from 1 to 4%, compared to its neighboring country Cote d’Ivoire and Southern African nations (Porter, 1994). In addition, other parts of the continent had a nearly 1:1 ratio of female to male prevalence, whereas data on HIV in Ghana indicated that over 80% of the cases were women (Anarfi, 1993; Antwi & Oppong, 2006). In fact, at the First International Conference on the Global Impact of AIDS, Dr. Alfred Neequaye, Director of Ghana’s first HIV response body, the National Technical Committee on AIDS (NTCA) and his colleagues reported that the female to male prevalence ratio in 1986 was 11:1, which narrowed to 7.6:1 by the end of 1987 based on the 276 total cases they had identified. Based on these early observations, Neequaye et al. (1988) attributed the growing epidemic in the country to female sex worker returnees who had traveled outside the country during economically and politically turbulent times in Ghana:
Many Ghanaians, both professional and unskilled, left the country during the economic crisis in the late 1970s. During this period of exodus to neighboring countries, many young Ghanaian women traveled to Cote d'Ivoire. When they found no other means of support, many resorted to prostitution, and many are returning with Acquired Immune Deficiency Syndrome.

This narrative informed Ghana’s early response to HIV, which primarily targeted female sex workers and any women perceived to be one (Antwi & Oppong, 2006; Patterson & Haven, 2005; Porter, 1994). In essence, HIV was something foreign to Ghana, imported into the country by immigrants and returnees.

Robert Porter (1994) referred to this characterization of the epidemic as “the prostitute model”. This model, he argued, had three interrelated assumptions: 1) that HIV/AIDS is a disease of female prostitutes who were 2) originally infected elsewhere, returned home, and then 3) began infecting men who had traveled abroad (Porter, 1994; p. 98). The government and health sector thus profiled women who had traveled outside the country and were either poorer and less educated as a high-risk group for HIV and more critically, as the source of the growing epidemic in the country. This narrative particularly emphasized the disproportionate number of HIV cases among young women from the Krobo ethnic group in the Northeastern region of Ghana. These women had travelled to Cote d'Ivoire due to the economic challenges that followed the construction of the Akosombo hydroelectric dam in their region during the 1960s. As a journal article by key HIV policymakers in Ghana explained, “Countless young Krobo women left Ghana in the following 3 decades [after the 1960s] to seek work in Cote d'Ivoire and other neighboring countries—all of which had a higher prevalence of HIV than did Ghana” (Wondergem et al., 2015; p. S138).

This narrative as well as limited resources within the government informed policy on who to prioritize for testing. Porter (1994) argued that this risk profile “of women with a history of foreign travel” constructed a very narrow category of who was at risk for HIV/AIDS (p. 100). Moreover, since Ghana had to ration its very limited testing kits and funding, health workers prioritized those who fit this profile, as well as symptomatic patients, blood donors, those
applying for travel clearance, and those who used services at sero-surveillance sites like military, antenatal, and STD clinics for testing.

This epidemiological model was problematic for numerous reasons according to Porter. First, it assumed that sex workers were driving the general epidemic by spreading HIV to their clients, when the opposite explanation made more sense: that a small group of men with HIV/AIDS were spreading the virus to multiple sex workers and sex partners. Sex workers were a vulnerable group for HIV. However, instead of including male clients and partners of sex workers as part of the “core-group transmitters”, stakeholders overlooked this population. Second, due to the narrow risk profile from which the government based their prevention policies, the prevalence data quality was tenuous given that there was a selection bias in testing. Moreover, the data on sex workers was questionable and did not support the theory that sex workers were driving the epidemic according to Porter (1994). Rather, it appears that, stigma against sex workers was the key factor that informed the narrative that Ghanaian sex worker returnees, rather than other migrant workers for example, were bringing HIV to the country.

**Reasons for Ghana’s HIV Policy Blind Spot**

Despite these glaring limitations, the characterization of the epidemic as predominantly driven by women, particularly female sex workers, informed the early testing and prevention policies for over a decade, even after the gap between HIV female and male prevalence decreased (Porter, 1994). Notably, this early construction of Ghana’s epidemic, I argue, played a key role in producing a blind spot on male same-sex transmission as a feature of the epidemic. By focusing its limited resources predominantly on women, particularly female sex workers, government health officials rendered men, and especially sasoi and other MSM, as an invisible and unrecognized population in the country’s national response.
This blind spot, I suggest, was not solely the doing of the Ghanaian government. Rather, it was a product of three mutually reinforcing factors: 1) the criminalization and sociocultural stigmatization of same-sex sexualities locally; 2) the construction of the local epidemic as driven by female sex workers as discussed above; and 3) Western researchers and donors' categorization of HIV in Africa as “heterosexual”; a construction that informed donor policies and funding guidelines that narrowed the scope of Ghana’s HIV/AIDS response.

The Ostrich and Pandora’s Box: Denial of same-sex transmission.

To elaborate on this argument, it is instructive to go back to the Attipoe report. One of the notable aspects of the report was its utilization of two metaphors in its title—that of the Ostrich and that of Pandora’s Box. These metaphors have been particularly useful in describing why and how both state and non-state actors failed to address male same-sex transmission of HIV in Ghana. My policymaker and key informants’ repeated reference to and use of the Ostrich and Pandora’s Box metaphor in interviews reflected the usefulness of the metaphors as well as the impact of the Attipoe study on key stakeholders in Ghana’s HIV response.

The Ostrich metaphor as used by my participants symbolizes the Ghanaian government response as well as officials, particularly those tasked with addressing the epidemic, from the President to the health officials and agencies responsible for the national response. The Ostrich conjures up the image of an animal burying its head in the sand, thus it is either unable or intentionally refusing to see what is around it. It is a symbol of ignorance or denial connected to the cultural perception of homosexuality as immoral and alien to the Ghanaian culture. For those stakeholders who might have been aware of male same-sex sex but refused to acknowledge it, the Ostrich represents cowardliness for failing to examine the impact of such marginalized sexualities on the HIV/AIDS epidemic in Ghana. Moreover, the Ostrich’s denial and cowardliness are reinforced by its environment—a stigmatizing sociocultural context and the legal provisions that criminalized that which it did not, could not, or would not acknowledge. The Ostrich, thus, was used in the Attipoe report, as well as by my participants, as a metaphor
for health and policy key stakeholders (and their actions) turning a blind eye on, or denying the existence of same-sex sexualities or same-sex transmission of HIV.

One of my key informants, Emmanuel Essandoh, a Ghanaian Program Management Specialist at USAID, shared his observations of this denial on display during a U.S.-sponsored African Key Populations conference as recently as 2011, “My take home message was that, here in Africa, we’re all behaving like ostriches and thinking that we didn’t have key populations in the country, in our respective countries.” This belief is what Attipoe (2004) was challenging when he argued that Ghana’s lack of recognition of men having sex with men was a threat to the progress of its HIV efforts. Attipoe (2004) stated:

Another aspect of our social lives that has either not been recognized or is being denied but which could reverse any gain made in the fight against HIV/AIDS is ‘same-sex-sex’ particularly ‘men having sex with men’ (MSM) since sex is the commonest mode of transmission of HIV. (p. 5)

The notion that homosexuality is a “practice” foreign to Ghana is a pervasive idea in the country today, but this belief was also quite common during the early days of the country’s HIV epidemic. In Neil McKenna’s (1996) report on HIV research on MSM in developing countries, he cites an excerpt from a 1994 STEP magazine article titled “Men Marrying Men”, in which the Ghanaian author described this cultural perception of same-sex sexualities:

Some people are of the opinion that homosexuality is not part of our culture but was brought in by foreigners. The Ghanaian culture actually ridicules and considers it a disgrace for anybody to engage in it. Perhaps that explains why the people who practice it do it in secret. (p. 14)

As the quote suggests, beliefs like these forced those who engaged in same-sex sexual relations to do so privately, erasing sasoi and other men who have sex with men from public view and into more subversive spaces. Moreover, as Kyeremeh Atuahene, the Director of Research, Monitoring, and Evaluation at GAC and the Chair of The MARPS Technical Work Group Steering Committee, shared in an interview, Ghanaian policymakers were aware of female sex worker returnees from Cote d’Ivoire but the idea of men who have sex with men was
“an alien” thing to them; male same-sex transmission was something that they recognized in the West, but not in their own backyard:

At that time, there wasn’t sufficient knowledge on the epidemic. We knew that in America, for example, infections started among men who have sex with men, but in our part of the world, that wasn’t even in our terminology: men having sex with men. It was quite an alien thing to us. What we knew was that people who were infected were those who had, especially women…who were returnees from Cote d’Ivoire, and those women were found to have been engaged in prostitution in Cote d’Ivoire.

Post-colonial economic and political conditions.

In addition to these cultural perceptions of homosexuality, it is important to note that HIV entered Ghana in the midst of a nearly two-decades long economic and political crisis that affected its ability to adequately assess and respond to the epidemic or other social crises during the first decade of HIV, irrespective of which groups might have been affected. Like other African governments during the middle to late 1980s, Ghana was in a period of political transition from British colonial rule. While the young country was the first sub-Saharan colony to gain its independence from colonial rule in 1957, it nonetheless experienced decades of political and economic unrest due to a series of coups in addition to the realities of the global capitalist market that was making a paradigm shift towards neoliberalism.

The first decade following Ghanaian independence is considered the country’s first republic (1960-1966) out of four republics where there were civilian governments. This period witnessed a one-party rule under the leadership of social democratic Prime Minister, Dr. Kwame Nkrumah, and was characterized by state attempts to establish social reforms such as universal health care and education and development of infrastructure. Political tensions between the ruling party and oppositional political forces however culminated in a military and police coup that brought into power the National Liberation Council (NLC) in 1966. A few years later, the NLC allowed a general election that brought Dr. Kofi Busia of the Progress Party into power—a period that was categorized as the second republic (1969-1972).
A few years after Busia assumed leadership, another coup led by Colonel I.K. Acheampong, ousted Busia and his administration from power in 1972. This would be followed by a period of military rule for 7 years until another coup in 1979 led by Jerry John (JJ) Rawlings—then a Flight Lieutenant in the Ghana Air Force—brought into power Dr. Hilla Limann, marking Ghana’s third republic (1979-1981). Two years into the civilian government, Rawlings led another coup in 1981 with the backing of a number of youth and workers’ organizations, commencing 11 years of military rule under his Provisional National Defense Council (PNDC) Party. The series of coups that Ghana experienced were catalyzed by economic turmoil the young country had been experiencing for years that led to high rates of unemployment, food shortages, and currency devaluation and subsequently, mass migration of Ghanaians to Europe and other parts of Africa.

None of these coups resolved the tensions and the ongoing crisis further pushed the Rawlings’ regime to undergo trade liberalization under the Economic Recovery Program of 1983, despite the regime’s attempts to enact populist reforms in its first few years in power. The recovery program along with Ghana’s adoption of structural adjustment programs consisted of trade liberalization, reduction of public subsidies, introduction of user fees, currency devaluation, and rationalization and privatization of state services and industries (Gyimah-Boadi, 1990). Ghana’s economic situation continued to be unstable despite these reforms, leading to the political alienation of the PNDC and subsequent authoritarian rule and human rights abuses (Gyimah-Boadi, 1990). While these economic issues alone do not explain the lack of inclusions of male same-sex transmission in Ghana’s HIV policies, I am suggesting that the socioeconomic conditions in Ghana meant that most citizens in Ghana, whether homosexual or not, were not prioritized in state policies or efforts during this period.
The heterosexual African AIDS construction in the global AIDS response.

Apart from the local stakeholders who failed to recognize male same-sex activities and HIV transmission and the wider socioeconomic conditions that underlay this blind spot, I argue that the Ostrich also represents Western researchers, as well as bilateral and multilateral HIV and development agencies that characterized the epidemic in Africa as heterosexual. As Michael Barnett and Martha Finnemore (1999) suggest and as Tara McKay (2016) examines in her work on the global HIV response to men who have men with men, these actors have the power to define “international tasks” like disease eradication, construct and define new subjects like “female sex workers or “men who have sex with men” and “transfer models of political organization” like “democracy” (p. 699). These formations are then the basis from which these international organizations establish objectives and funding opportunities for recipient nations flowing from those objectives.

Due to the primacy of international aid in driving government policies and programs in sub-Saharan Africa and especially given Ghana’s economic difficulties described above, these actors have arguably played a larger role than Ghanaian officials in the historical exclusion of men who have sex with men from HIV/AIDS policies. International agencies in the global HIV response, particularly the Global Programme on AIDS (GPA)—the World Health Organization founded program from 1986 to 1996 that was the first and main international governing body created to respond to the epidemic—and its successor, UNAIDS, played a leading role in setting policy and funding priorities. These priorities were, however, were largely shaped by their regional characterization of the epidemic as heterosexual in Africa and homosexual in the West. Namely, for a majority of the HIV/AIDS epidemic, there was a consensus by leading international donors, researcher, policymakers, and development organizations that the epidemic was mainly homosexual in the global North and heterosexual in the global South (Epprecht, 2008, 2013; C. A. Johnson, 2007; Lorway, 2006; Muraguri et al., 2012). This early discourse on the epidemic, although reflective of an epidemiological reality, also helped cement
the notion that same-sex transmission was not a reality in other parts of the world outside of North America and Western Europe—a notion that has had significant implications for the response to the epidemic.

The characterization of HIV in Africa as heterosexual was constructed very early on in the epidemic. In 1983, two years after the discovery of AIDS in the United States, one of first scientific reports written on HIV/AIDS epidemic in Africa argued:

Acquired immune deficiency syndrome (AIDS) has been described in homosexual or bisexual men, in drug addicts, in haemophiliacs, and in Haitian immigrants. To our knowledge there is no report of AIDS and opportunistic infections in previously healthy Black Africans with [a] history of homosexuality or drug abuse. (Clumeck, Mascart-Lemone, De Mauberge, Brenez, & Marcelis, 1983; p. 642).

In the same year, a team of European researchers, led by Belgian epidemiologist Peter Piot—the future first executive director of UNAIDS—discovered cases of HIV in then Zaire, Africa that had been reportedly heterosexually transmitted (Piot, Taelman, Quinn, Feinsod, & Minlangu et al., 1984). From their findings, they concluded that “the situation in Africa presented a new epidemiological setting for this worldwide disease—that of significant transmission in a large heterosexual sample” (Piot et al., 1984; p. 65-66). It should be noted that the report was careful to state that “none of the patients or controls admitted to homosexuality” (Piot et al., 1984; p. 67), thus allowing room to question whether the lack of admission meant same-sex transmission could be ruled out.

Despite this framing that patients did not admit to same-sex sexual activities, the report did not discuss same-sex sexual activities as an alternative transmission route nor did it critically assess the sociocultural environment in Zaire that may cause some HIV-positive patients to not report same-sex sexual activities. Rather, it concluded that these cases revealed that HIV could indeed be transmitted heterosexually and that this was a different epidemiological pattern than

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8 The original statements states “with no history of homosexuality”, however it seems that this is double negative typo given the syntax and the arguments in the paper. It is more likely the authors meant “with a history of homosexuality”, which I have corrected in the quote.
that observed in North America and Western Europe. The significance of this growing evidence of “heterosexual AIDS” in Africa during this period cannot be underestimated. Up until that point, researchers understood AIDS as a disease that only affected gay men, injection drug user, hemophiliacs, and Haitian immigrants (Clumeck et al., 1983). To now have evidence that the virus spread through heterosexual sex—understood as the dominant and natural form of human sexuality—completely transformed not only the biomedical knowledge of the disease, but also the social and policy implications of it.

After a few more years of accumulating more data from different parts of the world, leading AIDS researchers argued in a highly cited article on the epidemiologic paradigm of AIDS in Africa that HIV was predominantly transmitted on the continent through “heterosexual activity”, exposure to infected blood transfusions and needles, and mother-to-child transmission (Quinn, Mann, Curran, & Piot, 1986; p. 956). Referencing the report by Piot et al. (1984), they added that “while it may be difficult to ascertain homosexual and drug history because of cultural differences, it is evident from the multiple studies performed in Africa by both national and international experts in sexually transmitted diseases that these two risk factors do not play a major role in HIV transmission in Africa” (Quinn et al., 1986; p. 958). To substantiate this claim of a heterosexual AIDS in Africa, the authors referenced research indicating that female to male ratio of HIV cases in Africa was 1:1. Another set of evidence they referenced from case-control studies was that seropositive men had more sex with female sex workers and that single women had more heterosexual partners.

It should be noted that while these notions went mostly unchallenged, there were a few voices in the minority that contested the idea of a heterosexual African epidemic. One such voice was that of Dr. Felix Konotey-Ahulu, a notable Ghanaian-born, British-based physician who conducted much research on HIV in many parts Africa in the early days of the epidemic. Dr. Konotey-Ahulu wrote a number of letters to the editors of major medical journals like The Lancet and Journal of the Royal Society of Medicine (JRSM) in response to articles that
uncritically described the sub-Saharan African epidemic as heterosexual. In one such letter to JRSM he problematized the reductive manner in which the authors of an article on HIV in Africa described the role of sexual intercourse in the epidemic. He argued:

The very first report on AIDS to come from Uganda (in a region the world press loved to describe as heterosexual) mentioned that traders who were found to be HTLV-III seropositive “admitted to both heterosexual and homosexual casual contacts”, and one AIDS patient had a high recto-vaginal fistula of recent onset. (Konotey-Ahulu, 1987; p. 720)

For Dr. Konotey-Ahulu, the causal factors could not be distinguished between heterosexual and homosexual sex, but rather “normal” (penovaginal) sex and “abnormal” sex (non-penovaginal sex, such as anal sex that cause perineal trauma), itself a loaded distinction he adopted from descriptions used by sex workers he interviewed. In another letter to The Lancet, he made a related argument worth quoting in length that problematized The Lancet’s editorial on June 4, 1988:

Sir: In contrast with your editorial earlier this year, which hit the nail on the head regarding sexual practice and AIDS, your one of June 4 (p 1260), wide-ranging though it appears, does not reflect adequately what is happening in sub-Saharan Africa, which comprises forty-seven countries with a population of 483 million. The editorial repeats certain statements that are not entirely correct. For example, you say that in sub-Saharan Africa sexually active men and women are affected in almost equal proportions, but we know that there is a preponderance of females with AIDS in Ghana. Your reference to “predominance of heterosexual transmission in sub-Saharan Africa” seems to imply a counterbalance of homosexuality in Europe with heterosexuality in Africa but even before Lorian pertinently stated (reinforcing your earlier editorial) that "HIV transmission has more to do with sexual practice than sexual orientation", I tried to show that abnormal sex, qualitative and quantitative, rather than homosexuality or heterosexuality, was mainly to blame for sexually transmitted AIDS. (Konotey-Ahulu, 1988; p. 164)

Despite believing that Ghana’s epidemic was largely driven by a “preponderance of females with AIDS”, as professed by leading Ghanaian health officials, he contended that same-sex sex (abnormal sex) could not be ruled out as a mode of transmission in the African epidemic.

Despite such criticisms, admittedly a drop in the ocean compared to the dominant discourse, these distinctions became more entrenched as attempts were made to better understand the global face of the epidemic and consolidate a global response to it. Particularly,
as referenced in the introduction, in 1988, in a major article written on global patterns and prevalence of HIV, the authors, Drs. James Chin and Jonathan Mann, two key figures in the global response to HIV/AIDS, described three distinct patterns of HIV based on observed risk behaviors globally (Chin & Mann, 1988). The analysis informing the three patterns, illustrated on a map (Figure 3), was based on data reported to the WHO between 1980 to 1987. In the article, the authors described Pattern I as characterized by homosexual, bisexual, and intravenous drug transmission, with small but increasing incidence among heterosexuals. This pattern, they suggested, was common in industrialized nations such as those in North America, parts of Latin America, Western Europe, Australia, and New Zealand. Pattern II, found in less industrialized countries like those in Southern, East, and Central Africa and increasingly in the Caribbean, was characterized by heterosexual transmission, with the authors stating that “intravenous drug use and homosexual transmission are either absent or occur at a very low level” (Chin & Mann, 1988; p. S250). Pattern III was described as an emerging epidemic consisting of small but growing cases of heterosexual and homosexual transmission among people who had travelled to regions where pattern one and two were dominant. The regions that fell within this pattern were North Africa, Eastern Europe, most of the Pacific, and the Middle East.
The global epidemiological patterns described by Chin and Mann in this highly referenced article, although necessary in addressing a complicated and overwhelming global health crisis, drew too firmly distinctions between the regional differences in an epidemic that was quickly spreading and expanding its reach. The characterization in the report was also reflected in other analyses at the time of global trends of the epidemic and informed the research and programmatic responses to HIV/AIDS internationally. Specifically, these epidemiological profiles informed the guidelines and policy efforts of the World Health Organization's GPA (J. M. Mann & Kay, 1991). As McKay (2016) argues in her recent work, "From Marginal to Marginalised: The Inclusion of Men who have Sex with Men in Global and National AIDS Programmes and Policy", the WHO's Global AIDS Strategy "fell back on its widely disseminated conceptions of the epidemic that emphasized a divide between North
America, Europe, and Australia from developing contexts, especially sub-Saharan Africa” (McKay, 2016; p. 7). McKay (2016) portrays the extent to which the international response, as she argues, made same-sex transmission a marginal issue in the global South by quoting from the WHO’s 1992 *Strategy*:

> Although the first reported cases were among homosexual men in a few industrialized countries, it soon became clear that this was an epidemic of much greater scope…In the world as a whole, heterosexual intercourse has rapidly become the dominant mode of transmission of the virus…Homosexual transmission, on the other hand, has remained significant in North America, Australasia and northern Europe, although even in these areas, heterosexual transmission is showing the fastest rate of increase. (As cited in Mckay, 2016; p. 7)

In 1989, the WHO had commissioned a set of studies in seven nations—five in the global North and two in the global South—titled “The Homosexual Response Studies” to ascertain knowledge on HIV among gay men and how they were making efforts towards safer sex (McKay, 2016; McKenna, 1996). Years later, in 1992 another working group was formed to examine studies on bisexuality and HIV and to inform policy guidelines with their findings (McKay, 2016). Despite these efforts, the WHO did not produce a report specific to these Homosexual Response Studies that detailed their findings and policy recommendations, with the exception of some journal articles, conference presentations, and a GPA progress report that discussed or referenced some of the findings (McKay, 2016). Moreover, due to the limited number of studies conducted on same-sex sexual transmission in the global South, the GPA did not provide any policy guidelines to governments on addressing HIV among men who have sex with men in their National AIDS Policies. As cited in McKenna’s (1996) report, the GPA working group on homosexuality and HIV conceded on the limitations of their efforts:

> It has always been a regret of the Working Group that it has not been able to include sites representative of other significant areas where the AIDS pandemic is at an earlier, but dangerously increasing stage of development (such as the Far East) or where cultural factors make the form of homosexuality very different or socially even less visible or accepted (such as the Islamic and African countries).
In addition to these limitations, the GPA had been caught in a political struggle within the WHO that presented challenges to their efforts, particularly those of the Social and Behavioral Research Unit of the Program, which led much of the efforts on sexuality and HIV. As a result of these factors, their strategy at best provided vague guidelines on male bisexuality and HIV or resorted to a general recommendation of sexual transmission (McKay, 2016). Even when strategies were recommended, the GPA could not enforce them to individual nations due to the importance the WHO placed on nations’ autonomy in developing national policies they felt were most appropriate for them. As McKay (2016) states in her article, overall, despite mounting evidence of high HIV risk and rates among men who have sex with men in the global South, “GPA ultimately avoided taking a formal policy stance on HIV prevention among homosexual and behaviorally bisexual men throughout the late 1980s and early 1990s” (p. 8).

Researchers and policymakers’ classification of sexual transmission of HIV as between a binary of heterosexual or homosexual sex and therefore categorizing whole epidemics in countries, regions, and continents as one or the other seems short-sighted in hindsight and reflected biomedicine’s shallow understanding of human sexuality as well as the repressive legal social conditions facing those with same-sex sexualities. Even as gay and lesbian communities and activists challenged these narrow ideas about sexuality after the onset of HIV, policymakers and researchers continued to base the response to the epidemic on such distinctions. A key consequence of these rigid epidemiological and regional distinctions was that less research and surveillance focused on same-sex transmission in highly affected regions of the global South, like sub-Saharan Africa (Epprecht, 2008, 2013; C. A. Johnson, 2007; McKenna, 1996). As a result, very little to no data was collected or monitored on same-sex HIV transmission in this part of the world by major global AIDS organizations or local governments for decades in the epidemic (C. A. Johnson, 2007; McKay, 2016; McKenna, 1996; Parker et al., 1998). As Parker, Khan, and Aggleton (1998) have argued, the construction of the epidemic outside of the West as heterosexual and therefore affecting the ‘general population,’ rather than
morally reprehensible groups such as gay and bisexual men or injecting drug users, [became] a mantra justifying efforts aimed at prevention and control-efforts that presumably would not be justified were the perceived victims of the epidemic drawn from more questionable or expendable populations” (p. 330). It was politically safer.

It is ironic that during the early days of the epidemic, researchers did not believe heterosexual transmission of HIV was possible as new data from other parts of the world emerged. As Lindsey Knight (2008) stated in UNAIDS’ 10-year anniversary report, at the First International Conference on AIDS in 1985, when the only three African doctors present at the conference reported on heterosexual transmission from their region of the world, many of the Western doctors present at the conference did not believe them:

Some participants aggressively refused to accept that HIV could be transmitted through heterosexual intercourse. ‘In a non-scientific way they were saying …these men must be closet gays, and transmission from women to men is impossible’, Piot recalled. Other participants presented estimates of incidence in African countries that Piot knew from his own experience were wildly exaggerated. (Knight, 2008; p. 13)

It is surprising then that the narrative flipped so quickly after that the reverse, a homosexual epidemic on the continent was not realistic. This swift shift could only be a testament to the impact policy can have on perceptions and attitudes and in obscuring certain realities. Moreover, it reflected the pervasiveness of pre-existing notions of people and places and how these inform what we believe and don’t believe or how we make sense of our observations. So powerful were these factors that in less than five years, HIV went from a gay disease solely to one that is gay in the global North but heterosexual elsewhere.

The legacy of this heterosexual Africa construction by Western researchers and donors cannot be underestimated. For Ghana, like many other global South nations, the ability to develop a national response to HIV was directly linked to funding from international agencies that categorized Africa’s epidemic as heterosexual. As such, Ghana’s interpretation of their data, as well as the policies developed from this data, was informed by these constructions of
the African epidemic. It is no surprise then that leading health officials from Ghana’s HIV/AIDS response argued while at the First International Conference on the Global Impact of AIDS in 1988 that “homosexuality and intravenous drug abuse are important risk factors in America and other developed countries, whereas heterosexual spread and spread by prostitution are more important risk factors in many African countries” (Neequaye et al., 1988; p. 9). This distinction was repeated so often and so authoritatively by Western donors and researchers that it became the narrative about HIV/AIDS in the country. In fact the only studies referenced in the paper were the publications by Clumeck et al. (1983) and Piot et al. (1984) on HIV in Africa.

**Ghana’s First HIV Policy Responses: 1985-1995**

The government of Ghana has demonstrated commitment to addressing HIV from the very beginning of its epidemic, unlike other governments both in the global North and South. The country’s early responses were very limited due to inadequate funding and an international response body that was still underdeveloped. Even the few national initiatives that did exist were limited in scope. Nevertheless, the government took important steps in an attempt to minimize the impact of HIV/AIDS in its population. From 1985 to 1995, the government launched a number of initiatives to address a burgeoning epidemic that was spreading to the general population (see Figure 4 for a timeline of the country’s HIV response evolution; see Appendix A for a larger version). Peter Wondergem et al. (2015) marked this period as the first phase of the country’s HIV response, characterized by experimentation with interventions. The key focus of these early efforts was on female sex workers, blood donors and recipients, pregnant mothers, and people who had a recent history of travel. Beginning in 1985, the government of Ghana, concerned about the global impact of HIV, proactively created the National Technical Committee on AIDS (NTCA), notably, a year before the country discovered its first HIV case. This body was tasked with advising the government about HIV prevention after assessing the nature of the epidemic in the country (Pellow, 1994). Later that year, the
Noguchi Memorial Institute for Medical Research created a testing center at the University of Ghana, Legon, through a partnership with Tokyo University (Neequaye et al., 1988). Over the next few years, more testing sites were established to reduce the risk of transmission through blood transfusions at four regional hospitals in the country’s major cities: Korle-bu in Accra, Kumasi, Sekondi-Takoradi, and Tamale (Neequaye et al., 1988).

The NTCA carried out these modest efforts for nearly two years before the Ministry of Health established the National AIDS Control Program (NACP) in 1987 to replace NTCA as the coordinating body for Ghana’s national response to HIV/AIDS. The Government of Ghana’s establishment of the NACP and its subsequent development of short and medium term plans were the product of the WHO’s GPA efforts to help global South countries develop a national response to the spreading epidemic (Knight, 2008; Lisk, 2009). As cited in Knight’s review of UNAIDS’ HIV response, Alan Whiteside argued that, “The WHO adopted a series of ‘Short- and Medium-Term Programmes’ in a laudable effort to contain the spread of the epidemic. These packages were all more or less the same, as they were manufactured and exported from Geneva to the countries of Africa, Asia and Latin America” (Knight, 2008; p. 18). Flowing from this initiative, the NACP—located within the Disease Control Unit of the Ministry of Health—developed a Short Term Plan (STP), which operated from 1987 to 1988. The program oversaw a health promotion campaign implemented on television and the radio, to make safer blood transfusions, and to improve the capabilities of local and regional efforts (Antwi & Oppong, 2006). It also helped lay the ground work for the development of future policies.

During this period, a couple of female sex worker-focused programs were being implemented. In May 1987, Dr. Neequaye, the lead figure in the country’s response efforts, acted as the Principle Investigator for the first intervention in Africa to include peer education for sex workers (Wondergem et al., 2015). Initiatives like these were few and far between in those days due to very limited funding that mostly came from small foundations like the American Foundation for AIDS Research (AmFAR). AmFAR provided funds to Family Health International
(FHI) 360, an international NGO that was the main organization that carried out some of the first interventions for female sex workers. The pilot program by FHI trained 16 sex workers about HIV. These women then educated their peers about HIV and its prevention (Asamoah-Adu et al., 1994). Despite being designed as a four year program, due to a loss of external funding, the program limited its scope in 1988 (Asamoah-Adu et al., 1994). A couple of other small programs were launched up until 1990 that focused on Ghana’s sex workers, as well as increasing HIV knowledge and testing. From 1987 to 1989, USAID also funded an HIV education program through FHI for female sex workers and their clients to increase their condom use (Pellow, 1994). However, after 1990, there was virtually no active sex worker interventions and HIV efforts had shifted to more programs targeting the general public (Wondergem et al., 2015).

In 1989, the NACP with the Ministry of Health launched a major program to succeed the STP. This program—the Medium Term Plan (MTP-1) for the Prevention and Control of AIDS—was a five-year policy plan from 1989 to 1993 developed in collaboration with the WHO’s Global Program on AIDS. The MTP-1 marked an important milestone in Ghana’s HIV response because it was the country’s first successful attempt to create a comprehensive policy that consolidated and strengthened the capacity of the national response infrastructure and interventions. It specified two general objectives: 1) to prevent further transmission and spread of human immunodeficiency infection; and 2) to reduce the impact of AIDS on affected individuals, families, groups and communities at large (Antwi & Oppong, 2006; NACP & MOH, 2001; Pellow, 1994). The plan was supported by donations from Britain, the European Economic Community, West Germany, and France (Pellow, 1994).

To coordinate the program, the government established a National Advisory Council on AIDS consisting of key stakeholders, a Program Management Unit, and Regional and District committees (Antwi & Oppong, 2006). MTP-1, which aimed to improve Ghana’s HIV surveillance, involved programs such as blood bank screening, workshops on AIDS, and laboratory services. It specifically employed the following strategies: 1) surveillance to determine the extent and
pattern of distribution of HIV infection and sexually transmitted diseases in the country (which was marginal in the Ministry of Health until the onset of HIV); 2) assuring the safety of blood transfusion; 3) providing adequate laboratory services for the detection of HIV infection and diagnosis of AIDS and STD’s; 4) providing adequate clinical management to AIDS and STD patients; 5) providing psychosocial support to both affected individuals, families, and their communities; and 6) providing information and education to the general public and various target groups on the dangers of HIV (Antwi & Oppong, 2006).

![Timeline of Ghana’s HIV Policy Evolution](image)

**Figure 4: Timeline of Ghana’s HIV Policy Evolution**

After 1993, there was an attempt to establish a second MTP, which aimed to better integrate the work of all ministries in the response to HIV in light of a shift to treating HIV as not just a disease, but as an economic *development* issue. This shift was informed by changes the GPA was attempting to make in light of criticisms of its overly biomedical approach to its global strategy under the leadership of the new WHO Director-General, Dr. Hiroshi Nakajima (Lisk,
2009). In response to these criticisms, the GPA encouraged recipient nations to develop a multi-sectorial approach to their HIV response, rather than having their efforts be coordinated solely by their Ministry of Health (Lisk, 2009).

Decentralizing and Strengthening the National Response: 1996-2010

The mid to late 1990s was a transitional period for Ghana as it entered its fourth republic. This period was characterized by attempts to transition into democratic, multiparty rule due to mounting local and international pressure against President JJ Rawlings’ 11 years of quasi-military rule. In 1992, Rawlings and his National Democratic Party developed a liberal constitution and held open elections in which multiple parties were eligible to run, although opposition parties boycotted it (Kwasi, 2015; Patterson & Haven, 2005). Rawlings would be elected for two terms, in 1992 and 1996, until he reached his term limits as mandated by the new constitution. Amy Patterson and Bernard (2005) have has argued that this political transition created more space for the government to address HIV in the country, although still relatively less space than was given to other political issues. In 2000, a new administration took office under the leadership of newly elected president, John Kufuor of the New Patriotic Party (NPP). Unlike Rawlings, who only publically made a statement about AIDS in 2000—15 years into the epidemic—Kufuor addressed HIV in his first state of the union address (Patterson & Haven, 2005).

This period also marked a time of growing discussions between the Ghanaian government and international development agencies, like UNAIDS and the World Bank, on establishing a National Strategic Framework on HIV/AIDS and a government agency that could coordinate a multi-sectorial response to the epidemic. These conversations were in light of a shift by global development institutions, namely the WHO and UN agencies, to handle the epidemic as a development issue and thus in need of a response that involved government multiple agencies (Knight, 2008; Lisk, 2009).
Notably, towards the end of the decade, the government and its non-state partners conducted a major assessment of the state of the country’s national response to HIV/AIDS—the most comprehensive evaluation of its response history at that point. The assessment, which was sponsored by UNAIDS and the UK Department for International Development (DFID-UK), was part of a major process to restructure Ghana’s HIV response towards this new development/multi-sectorial paradigm. The resulting report, *Ghana HIV/AIDS Response Analysis*, released in 2000, argued the following:

Ghana has reached a critical stage in the growth of the HIV/AIDS epidemic beyond which point the epidemic will be difficult to control…Faced with this alarming situation, the need for urgent multi-sectorial action has been recognized by government and her partners, and the need was identified for the development of a National Strategic Plan that will guide multi-sectorial action in the medium term (Adjei et al., 2000; p. 5).

Of particular concern in the report was how Ghana could make improvements in the following thematic areas: promoting safer sex, the clinical response, community and district response, the legal response, and the stakeholder response and response management. Of note, despite a detailed discussion of safer sex as part of its key thematic areas of focus, there was no mention of same-sex sexual transmission as a probable characteristic of the country’s epidemic profile. Rather, the report maintained that “evidence in Ghana indicates that heterosexual contact is the predominant mode of HIV transmission” and suggested that Abstinence, Be faithful, and Condom Use (ABC) was the appropriate strategy for promoting safer sex, presumably for heterosexuals (Adjei et al., 2000; p. v).

Informed by this epidemiological assessment, the report identified youth, commercial sex workers, migrant and mobile populations (refugees, tourists, fishermen, students, traders, and long distance truck drivers), PLWHA, and civil society as “key vulnerable groups” ((Adjei et al., 2000; p. 9). These vulnerable groups were then the focus of analysis and calls to stakeholder action, response management, and interventions, “In all discussions, attention is placed on the fact that all action must translated into impact on the vulnerable population. The target
population is therefore the focus of the analyses and remains the central theme” (Adjei et al., 2000; p. 8).

Despite an epidemic that had expanded and transformed significantly over the years, the government of Ghana and its partners continued to insist that the only type of sexual transmission of HIV in Ghana was heterosexual in their assessment of the HIV response. There are two possible conclusions that one could make from such a statement: that same-sex sexual expression did not exist in the country or that same-sex sexual activities were safe from HIV. While sasoi and other men who have sex with men could fall within one of the key vulnerable groups, by distinguishing the epidemic as heterosexual, these key stakeholders were suggesting the latter conclusion that same-sex sexual expression was non-existent. Thus, although the country was undoing a major restructuring of its national response policies and programs, one thing remained constant, the notion that same-sex sexual transmission did not exist in Ghana and thus, not worthy of its focus and resources. In the meantime, an unknown number of sasoi and other men who have sex with men continued to lose their lives to HIV/AIDS.

The assessments and efforts on how to restructure Ghana’s HIV response culminated in efforts by the government to train all government departments and Ministries on the centrality of a multi-sectorial approach in the country’s HIV response (Antwi & Oppong, 2006). Additionally, it led to the creation of the Ghana AIDS Commission (GAC) in 2000 (officially approved by Parliament in 2002; Act 613), which was located under the Office of the President—a move that would prove later to have significant implications for the inclusion of men who have sex with men in the county’s NSP. The GAC—Ghana’s highest policy making body on HIV/AIDS mandated to provide leadership, support, and guidance on the national response—was formed in response to international donors’ suggestion for Ghana to establish a central body that could “decentralize” and coordinate the country’s HIV/AIDS policies and programmatic efforts through a multi-sectorial approach. In fact, GAC was established to facilitate the shift towards this
development framework in Ghana’s approach. This was because, as explained in a 2007 World Bank document on the Ghana AIDS Response Project (World Bank, 2007), the NACP—a body limited to the Ministry of Health—was handling HIV narrowly as a medical issue and was functioning without enough support or capacity with only five full-time and four part-time staff at the time (Adjei et al., 2000; p. 47).

As described in the *Ghana AIDS Commission Act of 2002*, GAC was established “to formulate a national HIV/AIDS policy; to develop programs for the implementation of the policy and direct and co-ordinate the programs and activities in the fight against HIV/AIDS and to provide for related purposes”. GAC policies serve as directives for ministries, departments, and agencies (MDA), development partners, the private sector, and civil society groups. Membership of the GAC consists of all government ministries, NGO representation, Christian and Muslim groups, PLWHA, traditional leaders, health professional associations, and the student union, among others. The Commission is chaired by the Vice President of Ghana and the Director General of the GAC is appointed by the president.

**2001-2005 National HIV/AIDS Strategic Framework.**

Around the same time that the GAC was being conceived, Ghana’s first National Strategic Framework, a document that was recommended by the *Ghana HIV/AIDS Analysis* report, was released. *The National HIV/AIDS Strategic Framework, 2001-2005*, was developed and disseminated by a technical team of key stakeholders from different government sectors, NGO, donors, and CBOs. Notably, the framework marked what I argue was a *paradigm shift* in Ghana’s HIV response from one that viewed *HIV as a disease* to one that viewed *HIV as an economic development issue*. As the framework stated, “HIV/AIDS in Ghana was first managed as a disease rather than as a developmental issue. The national response has, consequently, been medically-oriented and directed by the Ministry of Health” (GAC, 2001; p. 9). The policy document, then, was “formulated in recognition of the developmental relevance of the disease”
as specified in its Preface. Kyeremeh Atuahene of the GAC summarized well this shift in Ghana’s policy during this period:

_HIV response in Ghana goes way back. Even before we had any case in Ghana, the government had setup a committee to plan and develop a framework for HIV response so that was…in 1985. We saw the first case in 1986. And at that time, the committee came up with a National Action Plan that was health sector centered so…it was handled as a medical issue. It was only institutional care that was given attention so far as HIV is concerned in the country and that continued until the late 90’s, when the world became aware of the successes achieved in Uganda, which had used a multi-sectorial approach in tackling the epidemic, which was actually showing good dividends in terms of reduction in the new infections. So, the World Bank came up with a model, which they call multi-country IEC [information, education, communication] response, MAP program. So, Ghana was brought onboard in 2000. That is when we had the multi-sectorial approach to the response which means that it was not going to be just a medical issue, but more of a developmental issue which required all stakeholders to work together or work in concert to address [HIV].

Flowing from this development paradigm, the framework had the following goal: to prevent and mitigate the socioeconomic impact of HIV/AIDS on individuals, communities, and the nation (GAC, 2001; p. 16). Its key objectives were to 1) reduce new HIV infections among the 15-49 age-group and other vulnerable groups, especially the youth, by 30 percent by the year 2005; 2) improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and the communities by the year 2005; 3) reduce individual and societal vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the implementation of the national response; and 4) establish a well-managed multi-sectorial and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programs in the country. The principles guiding the implementation of the framework were rooted in the idea that Ghana’s HIV response needed a multi-sectorial partnership approach; respect for fundamental human rights; access to information and comprehensive services; decentralization, community participation and individual responsibility in all HIV/AIDS programs; and adequate financial and human resources mobilization to implement framework (GAC, 2001; p. 16).
Notably, despite the shifts that were being made during this period, the 2001-2005 framework still made no mention of homosexuality or same-sex transmission of HIV as part of Ghana’s epidemic. Rather, beginning with the introduction of the framework, the government maintained that the epidemic in Ghana was predominantly characterized by heterosexual transmission, vertical transmission, and contaminated blood (see Figure 5 for the original graph of the MoT from the NSF I). As the introduction to the document asserts, “Heterosexual transmission of HIV accounts for 75-80% of all HIV/AIDS infection. Vertical transmission (from mother to child) accounts for 15% while transmission through blood and blood products accounts for 5%” (GAC, 2001; p. 1).

![Fig. 2: Modes of HIV Transmission in Ghana](image)

**Figure 5: Modes of HIV Transmission in Ghana, Ghana HIV/AIDS Strategic Framework, 2001-2005**

This was in line with Ghana’s approach to the epidemic since the 1980s. As Atuahene from the GAC explained, the policies in the 2001-2005 strategic framework focused on the general population, particularly with an emphasis on strong institutional care of HIVs. It also emphasized community mobilization and education of HIV through the Information, Education, and Communication (IEC) strategy:

*It [GAC’s first national HIV and AIDS Strategic Framework] focused on the general population but it had a very strong component on institutional care. The other aspects of the response were played down but they recognized multi-sectorial approach and all that and the community mobilization, IEC and those things. I know you understand IEC:*
Information, Education and Communication on the epidemic. Those things were given prominence in the strategic framework, the first one.

In addition to its focus on the general population based on its perception of the epidemic as a generalized one, the framework also identified vulnerable populations as targets of its strategies. At this point in the global response, the framework of vulnerability was used in shaping policies (this was before key populations was a category of risk used to frame policies and interventions). Those the policy identified as vulnerable were youth, women, commercial sex workers and their male clients, migrant and mobile populations, and uninformed personnel. However, “the general public” was also included in this category, rendering inoperative the concept of vulnerable groups, whom are understood to be categorically at a higher risk for HIV due to their social status. The policies did however delineate that the lack of respect for the rights of women and children, to information and education, for freedom of expression and association, for liberty and security, for freedom from inhuman or degrading treatment, and for privacy and confidentiality affected increased people’s vulnerability to HIV and that ensuring these rights can create an enabling environment for HIV prevention.

Consistent with Ghana’s HIV response history, and particularly the assessment in the Ghana HIV/AIDS Response Analysis, the strategic framework made no mention of homosexuality, same-sex transmission, or men who have sex with men. As one key informant from USAID stated, “At that time, even though we were implementing a national response, there was no mention of MSM in the National Strategic Framework. Clearly, they didn’t want to hear anything about MARPs”. Peter Wondergem, a Senior HIV Adviser at USAID, who consulted on the 2001-2005 Framework, described these first five years of Ghana’s strategic response as a “period of ignorance”, by which he meant, ignorance of male same-sex sexualities and transmission of HIV in Ghana. Moreover, he shared that when he attempted to include men who have sex with men in the Framework, a consultant on the team deleted it. During this time,
according to him, key stakeholders did not know that MSM existed in Ghana or that they were at risk for HIV:

_When we started in 2000, nobody had an idea that there were MSM in Ghana and that they were a risk group…. In those days we were really thinking that we were just behind Southern and Eastern Africa and that we would see the same increase that we saw there. And so we were thinking really that we would go up 15-20% [prevalence] here as well. So we were worried about general knowledge, youth, social marketing of condoms, that type of thing._

Thus, 15 years into its epidemic, the Ghanaian government, external donors, and other key stakeholders in its national response had yet to acknowledge male same-sex transmission as a feature of its epidemic. A number of the policymakers who were interviewed maintained that this lack of recognition was due to not having data demonstrating HIV risk among men who have sex with men in the country. Without the evidence, they contended, policymakers could not get political buy-in to develop policies and interventions that focus on MSM as an at-risk population in national polices. As Essandoh of USAID explained, “No matter whichever target which you are targeting in development, you always need the evidence to prove your case. That justifies why you are doings what you are doing”. He added, “There should be some evidence when you talk to the government. What are you going to tell them? That you think that there are MSMs in the country, so we should address their needs using a public health approach, when you don’t have numbers?”

**Ghana’s HIV Policy Paradigm Shift: From General Population to Key Populations**

**Unburying the Ostrich’s Head: The Attipoe Report**

If a lack of evidence were the source of Ghana’s policy blind spot on HIV among MSM, like some of my informants suggested, then developments in 2004 would start to fill that gap. This year marked the first time a study assessing MSM HIV risk—the Attipoe study referred to in the beginning of the chapter—was conducted and published in Ghana. This event would
become a significant turning point in the country’s eventual shift to recognize HIV among men who have sex with men in its HIV response. The exploratory study conducted semi-structured interviews and surveys with 156 people. The questions inquired about when the men were introduced to “MSM”, what their sexual identity is, what type of sex they engage in, how many sexual partners they have, whether these partners are male or female, their sexual practices, their marital status, whether they engage in sex work or drug use, and their knowledge of STIs/HIV.

The Attipoe report read as a polemic against the government’s HIV response blind spot. The report in fact discussed very explicitly that the government’s lack of recognition of same-sex transmission was problematic and a significant barrier to adequately responding to the epidemic:

Currently all working documents of the country on HIV/AIDS recognize only heterosexual transmission of HIV. The National HIV/AIDS Response Analysis and the Ghana HIV/AIDS Strategic Framework 2001-2005 list a number of vulnerable groups but failed to identify MSM as a potential mode of transmission of HIV. The contribution of MSM to HIV transmission in Ghana is also not highlighted in the AIDS Impact Modules…Facts available at the international level also indicate zero transmission of HIV by homosexual and bisexual groups in Ghana. (Attipoe, 2004; p. 11)

It was the study’s hope that government officials would be moved to action by demonstrating that men who have sex with men were indeed a real population in Ghana with immense structural challenges that put them at a higher risk for HIV.

The Attipoe study did not proceed without significant challenges due to the harsh realities of stigma against same-sex sexualities. Notably, around the time of data collection, the Ghanaian news media was amidst one of its moral panics on homosexuality that it has become known for over the past ten to fifteen years. Additionally, the criminalization of unnatural carnal knowledge, as well as the arrest of four young men around the same period as the data collection based on this very law, created a difficult environment for the men and researchers ("Is Ghana Ready for Gay Rights?," 2004). Thus, to gain rapport with and access to the
community of sasoi and other men who have sex with men, the study employed the services of Ghana’s first LGBT rights and health organization, CEPEHRG, to recruit participants. The role of CEPEHRG in shaping Ghana’s turning point in the national HIV response is an important point that I will return to later.

The findings from the study were telling. Particularly, the study found that overall the men: 1) were sexually active with multiple sex partners, some of whom were sex clients, yet were highly trusting of them; 2) had poor knowledge of STIs, outside of HIV and gonorrhea; 3) believed that anal sex was safer than vaginal sex and that STIs could not be transmitted through anal sex; 4) were at high risk for HIV due to other health issues, 5) low use of condom and belief that spirituality and herbal potions could protect them; and 6) were bridging between their male partners and their female partners. Of note, many of the men who were interviewed had intimate relationships with both men and women, which the study viewed as the men bridging their risks as men who have sex with men with the women they are sexually intimate with—a cause for concern to stakeholders as it was repeatedly discussed by a number of my informants and a key argument in the later construction of MSM risk by HIV policymakers.

Although it was a polemic against the Ghanaian government’s response to HIV, the Attipoe study itself reflected some of the sociocultural biases and misconceptions about homosexuality that should be noted. For example, the survey asked questions such as “How were you introduced to MSM?”, “How long have you been involved in MSM?”, “Reasons for MSM: Money? Pleasure?”, and “Do you know a lot of men involved in MSM”? And stated in their key findings that, “there are many prevailing factors that make MSM attractive particularly to the youth including adventure seeking, poverty, ignorance, lure of older gays looking for partners and the belief that anal sex is safer than vaginal sex” (Attipoe, 2004; p. 5). These questions and statements treated male same-sex sexualities as a practice young men are “lured” into by older men, as something one does rather than is, and as merely a means to an end, of either financial gain or sexual pleasure. It had some shortcomings, including several confused notions of how
and why people come to adopt same-sex sexual intimacies, expressions, and identities. This
too is important to account for because as the first study to contribute to epidemiological
knowledge of male same-sex sexualities in Ghana, it constructed homosexuality in ways that
might have reinforced the negative perceptions of it, which in turn were being pitched to
policymakers to inform a response for MSM.

Yet, despite these limitations, the study was quite a radical development that would
begin a shift in the country’s HIV/AIDS response. In a country where sex and sexuality is treated
with silence or discussed through metaphors and where homosexuality is spoken of in a
language of allusion, as Serena Owusua Dankwa (2009) terms it, it was very significant that a
major research study would not only explicitly discuss homosexuality in Ghana, but argue that it
was “real in Ghana with Ghanaians fully involved. It is not a recent phenomenon being visited
on Ghana and Ghanaians by ‘whites’ or foreigners” (Attipoe, 2004; p. 5). It was also significant
that a study “proved” that there were sasoi and other MSM throughout the country, cutting
across religious, ethnic, marital status, and class backgrounds. The report ended with a call for
the government and its partners to develop pragmatic solutions that recognized and intervened
on HIV among MSM, including working with the media, the judiciary, and the public:

HIV/AIDS is taking its toll on the socio-economic lives of many in sub-Saharan Africa
and it is possible that MSM is contributing significantly to the statistics. Without any
health intervention targeting MSM, the struggle against HIV/AIDS cannot succeed. The
Ministry of Health/ Ghana Health Service (MoH/GHS) in accordance with its mission,
vision and code of ethics and the Health Partners owe it a duty to the nation and to
posterity to improve the overall health status and reduced inequalities in health
outcomes of all people living in Ghana including men having sex with men. (Attipoe,
2004; p. 6)

For the government and other stakeholders in Ghana’s HIV/AIDS response, the Attipoe
study was a sobering reality check and for some, even a shock or, as one participant stated, a
“wow”! For years, those responsible for setting the country’s HIV/AIDS policies had been
burying their heads, completely ignorant of, or unable to see a crisis that was happening right
under their noses. As one of the leading GAC policymakers, Atuahene, stated:
Prior to developing a new one [2006-2010 National Strategic Framework], we had a study first by Attipoe, which kind of skimmed the surface of MSM activities in the country...People didn’t know about them: who they were, where they were, and what they were doing. The study...it wasn’t HIV-oriented study as such. It was more of looking at who they are, where they are, what they do, the issues affecting them and that kind of thing. So, when the report came out, it was ‘WOW! So, we have a lot of this thing happening in the country and most of them were young people and that kind of thing’.

The government’s shock at the findings was a bit surprising. Given that Ghana’s news media had been panicking over homosexuality for at least since the liberalization of the media after the fourth republic in 1992 (Dankwa, 2013), it is difficult to understand how stakeholders in national HIV response could have been this oblivious to same-sex sexualities in Ghana. While conducting my research on news media representations of homosexuality, I found a number of articles during the early 2000s that discussed the topic of homosexuality, including “sex scandal” at an all female boarding school, whereby a male teacher was luring students to have sex with him to cure “lesbianism” (Sena, 2001). Additionally, there was the aforementioned 2003 Daily Graphic article that reported four young men getting arrested for “unnatural carnal knowledge” and “indecent exposure”.

Regardless of whether this shock was genuine, the findings had a significant impact on policymakers and donors. Like Attipoe’s second metaphor suggests, it was like opening Pandora’s Box to reveal all these secrets that had been hidden or suppressed for years. Moreover, it exposed the taboos, struggles, and realities of a hidden population with immense HIV risk and burden. As Attipoe (2004) argued, anti-gay public perceptions and reactions had driven homosexuality “underground creating a safe haven for people to practice and making it difficult for services to be rendered to them” (p.5). Moreover, the report showed that “heterosexual” men, whether married or single, were having sex with other men and that certain homosocial spaces, like prisons and labor camps, were sites of same-sex sexual relations.

Attipoe and the other advocates behind the study hoped that the government would be moved to action by the evidence the study presented, rather than “wishing it away”.

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AED/SHARP program.

The revelation from the Attipoe report was the beginning of a long process to take on the deeply seated ideas about homosexuality that served as barriers to including sasoi and other MSM in Ghana’s HIV/AIDS response. As Attipoe warned in his report, the social and cultural stigma against homosexuality, as well as the legal environment that enabled it, presented significant obstacles to translating the findings into policies and interventions. In fact, according to Wondergem, the team and organizations behind the Attipoe study thought long and hard about whether or not to come out with the study data due to stigma against sasoi men in Ghana. When they did decide to share it, they experienced significant barriers to presenting the data to government officials, who eventually were presented the data but were still in shock of what they were hearing.

The period after the Attipoe study would mark a turn from a period of ignorance to a period of confusion, as Wondergem described it. During this period, stakeholders were presented with at least some evidence of same-sex sexualities, but they did not know what to do with the information about same-sex risks and vulnerabilities to HIV and were also in denial. As Wondergem recalled,

Period one was a period of ignorance. That somewhat stopped with the Attipoe report. But then let’s say, there was a period of confusion following that. What can we do? What should we do? How do we do it? ... The confusion was after the Attipoe study. Because we didn’t know really how to handle the information. You know, we didn’t want to stigmatize and others were in denial. The Ghana AIDS Commission was in denial.

Those who were advocating for the inclusion of men who have sex with men in the national response were in a difficult position—in order to gain political buy-in for this shift, they needed to make men who have sex with men visible, but this also meant that this would increase public
attention and scrutiny towards the men and thus increase the burden of stigma. To reduce this risk of increased stigma, Nana Fosua Clement of FHI 360 stated that there was an attempt to disseminate findings in this period through in person meetings and written reports.

With the foundation of the Attipoe study in place, USAID, one of the main donor organizations to Ghana’s HIV response since 2000, made a swift shift to fund more studies on most-at-risk populations (MARPs). In 2004, they funded Ghana’s first MARPs intervention, which targeted female sex workers, non-paying partners of female sex workers (NPP), men who have sex with men, and people living with HIV (PLHIV). The project was called the Academy for Educational Development’s Strengthening HIV/AIDS Response Partnerships (AED/SHARP) program. The Academy of Education Development was a 501(c)(3) NGO that provided services related to education, economic development, and health in the U.S. and in the global South that received most of its funding from the U.S. government. In 2011, the NGO shut down and transferred all its USAID-funded programs and employees to FHI 360 after it was found guilty of false claims, misconduct, and mismanagement of funding.

The AED/SHARP program was a five-year, USAID-funded project with the aim of reducing new HIV infections and lessening the impact of HIV in Ghana (AED, 2009). Over the five years, it purported to have reached over 25,000 FSWs, 16,000 NPPs, 7,500 MSM and over 6,500 PLHIV with their services and communications interventions on behavior change and services. These achievements were reached through five key goals which were to: 1) build the capacity of local NGOs (they trained 12 NGO implementing partners, 243 peer educators, and 28 NGO staff on HIV/STI interventions); 2) develop an enabling environment in Ghana (formed a national MARP working group to develop policies for MARPs), 3) create performance-based feedback and funding system (to enable transparency and accountability and enhance strategic decision making); 4) implement a package of prevention services (established 8 NGO drop-in centers with and 21 Ghana Health Services STI clinics where HIV/STI services were provided to over 50,000 of their population of focus); and 5) conduct pertinent research (conducted
behavioral and bio-behavioral surveillance surveys with FSW, MSM, long distance truck drivers, and informal miners).

The SHARP program was important for a number of reasons. First, it helped put on the map of Ghana’s HIV/AIDS response small, marginalized NGOs that were working with stigmatized populations like sasoi and other MSM and FSWs. Organizations like CEPEHRG and Maritime Life Precious Foundation were able to develop their capacity by receiving modest funding that allowed them to enlist peer educators to do outreach to their respective constituencies. Moreover, their staff and peer educators received trainings to develop competencies in providing HIV/STI services to their peers. Second, it was the first bio-behavioral study in Ghana and the first to provide an estimate of MSM HIV prevalence—a statistic that proved that there was a concentrated epidemic among MSM. Third, CBOs, NGOs, and other advocacy groups were able to use the data generated by the project to legitimize their proposals for funding and demonstrate that there was a serious unmet need for interventions for men who have sex with men in the country’s HIV response. Fourth, the interventions built the foundation for the country’s current HIV services and interventions for MSM and established the first drop-in center specifically for MARPs (further discussed in Chapter 5). Fifth, at the end of the project, SHARP had generated enough evidence to substantiate their call for a specific GAC technical working group for MARPs.

One of the most important achievements of the SHARP projects was the conduct of a bio-behavioral survey with MSM in 2006, in collaboration with CEPEHRG and other partners. The study was an attempt to collect more data on MSM risks to HIV and to get an estimate of MSM HIV prevalence in Ghana. It was their hope that the study findings would “assist the National AIDS/STI Control Program, the Ghana AIDS Commission and other partners in Ghana’s response to HIV and AIDS in making informed decisions in designing effective interventions for and by men who have sex with men” (AED/SHARP, 2007; p. 2). The study had many similar findings as the Attipoe report: that there were many men who have sex with men in
Ghana; they had multiple, concurrent sex partners, both men and women; and they were knowledgeable about HIV but not knowledgeable about which sexual activities put them at risk of acquiring it. What was however significant about the study is that it generated a preliminary prevalence of HIV among MSM in Ghana, which was an astounding 25.3%, based on tests of 269 men from the Accra metropolitan area. In the 2007 report on findings, it stated, “With an overall HIV prevalence of 25% among the sample interviewed, MSM in the Greater Accra area should be classified as a most-at-risk population (MARP), with the resulting program interventions, policies, and resources allocated to support this MARP” (AED/SHARP, 2007; p. 16). The SHARP project itself did not proceed without pushback from other staff within AED at the time. As a CEPEHRG member recalled:

*I remember there were times where he [head of the AED team] had challenges with the Ghanaian counterparts in terms of rolling of the MSM component after the pilot phase, like people think “Oh, MSM are not correct⁹”, so not to start the program. “MSM are not ready for the program and MSM program cannot be organized” and there’s the back and forth in terms of whether we can do it, it’s possible or it can be done or not be I remember...*

Despite the challenges, an important legacy of the SHARP project is that it consciously built on the momentum set by the Attipoe study and refused to let the Pandora’s Box close. By doing so, it kept pressure on stakeholders, who claimed to not know of MSM HIV risk, to respond to the emerging evidence. Despite the findings from the SHARP project and those of the Attipoe study, it was still difficult to get political buy-in from the government. Even with evidence, there were other cultural and political factors that served as obstacles to addressing the blind spot in HIV policies. As Wondergem contends, the lack of political will from Ghanaian stakeholders at this point seemed to be an excuse, because the evidence was clear by then but resistance to change remained with the Ghana AIDS Commission refusing to accept or even acknowledge the report. As he recalled:

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⁹ When a Ghanaian states that a person or a group is “not correct”, it is a colloquialism for crazy, not mentally stable, or “not right in the head”.
With that [SHARP] information we went to the Ghana AIDS Commission. We were in a very difficult situation because on the one hand, MSM were so stigmatized. And on the other hand, there was this high prevalence. But making that widely known would even stigmatize them more. But we felt that the right people needed to know the information. We didn’t want to get it to the newspapers and that type of stuff. The Ghana AIDS Commission did not want to acknowledge…not even accept the report. I remember standing in the corridor and trying to hand the report over to the Director General…the then Director General of Ghana AIDS Commission and he just didn’t accept it.

One possible reason for this lack of acknowledgement was that the ruling party at the time of the study report, the National Patriotic Party (NPP), was afraid of the political blowback of acknowledging and including homosexuals in health programming. Wondergem recalls standing in the hallway of the GAC, attempting to hand the MSM BBSS report to Professor Frederick Torgbor Sai, the Chairman of the GAC and adviser to President Kufuor at the time, who refused to take the report. Prof. Sai is a well-known medical doctor with expertise in reproductive health with decades of experience working with different government administrations in Ghana. According to Wondergem, Prof. Sai understood that there was a problem but could not address them due to political pressures to avoid any backlash from the oppositional party, the NDC. He feared that the data on homosexuality and any action based on it would “taint” the NPP, the party he was working under. The public health issue was clear but the political conditions and tensions did not allow for a resolution.

**2006-2010 National HIV/AIDS Strategic Framework.**

At the same time that the data from SHARP was being disseminated to key policy stakeholders, Ghana was developing its second National HIV/AIDS Strategic Framework (NSF II). As Atuahene recounted, the AED/SHARP bio-behavioral study report was an “eye opener” for the government and its partners because it revealed evidence of a concentrated epidemic among FSWs and MSM. This compelled them to “fully address” female sex workers in the national framework that year. But for MSM, the policy did not yet recognize their vulnerability to
HIV and offer any interventions focused on them as recommended by the SHARP report. As Atuahene of the GAC recalled:

[SHARP] was the first bio-behavioral study among MSM in Ghana and it was among about three hundred MSM. A little more than 300 MSM and 25% of them were found to be HIV positive. That was an eye opener, and based on that study, strong advocacy ensued and people were saying ‘Okay, now we need to pay attention because HIV prevalence among that population is very, very high’. That was about the time that we were going to actually prepare a second national strategy. So, the idea was to include that in the national strategy but there was no consensus on that. As for sex workers, their program had been running for more than a decade earlier and that one started in 1995 and they had done a series of studies so the necessary data were available to actually inform decision…Strategies to address the needs of sex workers so far as HIV was concerned was fully addressed in the national strategy from 2006 to 2010. An attempt was made to include some components on MSM but we didn’t know much about them so, the idea was to support the ongoing activities, which SHARP was leading. So that is how it went.

For the NSF II, a number of the advocates behind the AED/SHARP project, namely USAID, were working to persuade other policymakers to prioritize men who have sex with men in national HIV/AIDS policies. The previously discussed political issues and tensions, however, were obstacles to including the men in the second national framework. In fact, Wondergem had attempted multiple times to get fellow policymakers to include MSM in the national policies, however the lead consultant for the framework, who was actually hired by USAID, kept deleting any references to men who have sex with men. However, in the final version of the policy, there was one parenthetical reference to “MSM”, in which the group was listed with children, displaced persons, refugees, prisoners, and sex workers as vulnerable groups within PLWHA who are not protected due to a lack of anti-discrimination laws for them (Ghana AIDS Commision, 2005; p. 48). This reference, according to my USAID informants, was accidental. In his efforts to delete any mention of MSM, the consultant missed one of the mentions. Thus, the first time MSM was mentioned in the country’s national AIDS policies, it was unintentional.

By that time, we were also writing the second National Strategic Framework…The lead consultant was paid for by USAID, and each time, we tried to get information into the report and then a week later, it was all erased again. And that went on and on, and finally in the version, they forget to delete a footnote, and that is why in the second Strategic Plan there is one footnote on MSM.
Wondergem described this period as a transition from confusion to neglect, and he also argued that this neglect also describes the current national response. Essandoh added:

*Too, now, I thought that, ‘Well, even though it’s (MSM) not there, the fact that it has now appeared as a footnote, I’m sure that we are making some kind of a progress’. You see, in a country that is so sensitive about sexuality issues about MSM and so forth, there’s a limit to how far and how fast you can push the MSMS. You can only push if you have the data.*

While Atuahene suggested in his statement that the lack of inclusion was because they “didn’t know much about them”, it seems that what was more likely the reason was that there were significant disagreements and tensions in the GAC and other parts of the government on whether to include MSM in the national policies, what the political blowback of such an action would be, whether there was even enough data to substantiate this, and less explicitly whether the group deserved any attention and help.

So despite the mounting evidence of a concentrated epidemic among sasoi and other men who have sex with men, the government continued to treat its epidemic like a generalized one. By this point of the country’s epidemic. As Essandoh stated, the first two NSFs had planned for a generalized epidemic.

> For as long as the Ghana government did not see the epidemic as a mass epidemic or a concentrated epidemic, there was no way to move to alter their strategies. You looked through all the—okay, the first two documents were a strategic framework for the table of National Strategic Plan. When you looked through the first two frameworks, it is very clear that they were looking at a generalized epidemic. For a generalized epidemic, you plan for virtually everything.

The NSF II had similar objectives as the first NSF. As the policy document stated, the NSF was “designed to provide an overall planning guide for a vastly expanded effort to deal with the epidemic including improvements to the supporting environment, preventing infections, targeted behavior change programs to the general population, as well as specific vulnerable groups, treatment, care and support, and combating stigma and discrimination” (GAC, 2005; p. 6). The framework was to operate using the “Three Ones” Principles, which had been adopted by the
UN, developing nations, and donor agencies in 2004, as a framework to better improve the coordination of the scale up of national AIDS responses. The “Three Ones” principles were, 1) one HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; 2) one national AIDS coordinating authority with a broad based multi-sectorial mandate for HIV/AIDS overall policy and co-ordination; and 3) one agreed country level monitoring and evaluation system.

The NSF II focused on seven key interventions which were 1) Policy, advocacy and enabling environment, with a focus on advocating for a legal environment that reduces stigma and discrimination against PLWHA; 2) Coordination and management of the decentralized response, with a focus on better coordinating a decentralized, multi-sectorial response; 3) Mitigating the social, cultural, legal, and economic impacts of HIV/AIDS, with an emphasis on poverty reduction and ensuring the rights of vulnerable populations like women and PLWHA; 4) Prevention and behavioral change communication (BCC), with a focus on changing “individual risky sexual behavior as well as community perceptions and attitudes about HIV/AIDS and PLWHA”; 5) Treatment, care, and support, with a focus on scaling up ARV therapy and meeting the treatment needs of all PLWHA; 6) Research, surveillance, monitoring, and evaluation, with an emphasis on strengthening institutional mechanism to facilitate the timely and consistent conduct of these activities and of the dissemination of data; and 7) Mobilization of resources of funding arrangements, with a focus on pooling all resources for the HIV/AIDS response in an integrated system.

Like the NSF I, there was no mention of homosexuality or same-sex sexualities as a marker or risk—with the exception of the accidental mention of MSM. When vulnerable populations were identified, the groups mentioned were sex workers and their clients, STI clinic attendees, migratory populations, youth and orphans, itinerant traders, and women. Notably, however, there was also no mention of heterosexual transmission or even the term
“heterosexual” as part of the framework. Clearly, the new data on men who have sex with men had an impact on how the Ghanaian epidemic was being framed by policy makers. They might not have been ready to include the men as a vulnerable group but it was now clear to them that the construction of a heterosexual epidemic was not reflective of reality and could not continue to describe the epidemic as such.

Ghana’s NSF I and NSF II were important steps in coordinating, decentralizing, and strengthening their national response, particularly for its general population, but they had failed to seriously address the concentrated epidemic among sasoi and other MSM. As a 2009 UNAIDS Review and Analysis of the Application of the “Three Ones” Principles in Ghana assessed:

The first NSF was not based on strategic information and was based mainly on perception of the epidemic and international projection. The second NSF saw some improvement. There are differences of opinion as to the nature of the epidemic and its diving force, and hence misunderstanding as to the emphasis on strategies relation to Most at-Risk Populations. (Aryee, 2009; no page)

Paradigm Shift to Include MSM as a Key Population

Key population policies as biopolitical paradigm.

After 2010, significant steps were taken to ensure that the next set of national AIDS policies identified MSM as a high-risk group to be prioritized in Ghana’s HIV policies. Particularly, the 2011-2015 National Strategic Plan (NSP) marked the first time Ghana’s HIV policies included MSM as a key population (originally referred to as a most-at-risk populations). It was also the first time the government developed a specific document that detailed an NSP for each key population.

This shift to include MSM as a KP in national HIV policies, I argue, signifies a paradigm shift in Ghana’s HIV response from a general population paradigm that constructed the epidemic as heterosexual to a key populations paradigm that acknowledges male same-sex transmission. Drawing on Epstein’s (2008) concept of the inclusion-and-difference paradigm, I
conceptualize this KP paradigm as a type of biopolitical paradigm: a constellation of policy standards, formal procedures, ideas, and understandings that frame male same-sex sexualities and sexual behavior (along with sex work, prisoners, and injection drug use) as matters of biomedical and state intervention. Moreover, the operationalization of this paradigm is a political process that medicalizes homosexuality. As such, I argue that the recognition and inclusion of sasoi and other MSM in the national AIDS response has constructed sasoi and other MSM as *biopolitical citizens* (a concept I will return to in chapter 6) with certain rights preserved within the KP paradigm but limited to the biomedical realm and in conflict with a legal code that criminalizes male same-sex sexual activities.

**Factors catalyzing the paradigm shift.**

This historic shift was in part a product of the previously discussed epidemiological data from the Attipoe and AED/SHARP studies that indicated that MSM not only existed, but were highly stigmatized, and had a high prevalence and risk of HIV/AIDS. This production of biomedical data is a critical part of deciding whether the inclusion of MSM as a priority group is substantiated by scientific evidence. Are they indeed at a higher risk than the general population? This process is a central component of the key population paradigm and informs the construction of MSM as a high-risk group in HIV policies and interventions.

In addition to the production of epidemiological data suggesting MSM as high-risk, the shift was also due to changes in bilateral and multilateral donors’ AIDS funding frameworks to include a sexual rights framework and men who have sex with men as a key population in the global South (McKay, 2016). Particularly the Global Fund, around 2008 started pushing the government to address HIV among the MSM due to changes to its own funding framework. They had also begun to prioritize a rights based approach to HIV interventions that was inclusive of men who have sex with men in its 2010 Partnership Strategy (Ayala et al., 2011). Given Ghana’s dependence on foreign aid to address its epidemic, with 80% of its national
HIV/AIDS funding coming from external sources (Dutta, Paxton, & Kallarakal, 2015), and the downstream nature of international aid, the policy changes by these donors directly affected and were the key determining factor in changing their framing of the epidemic. Likewise, PEPFAR was also changing its tone, from the previous set of AIDS policies under President George W. Bush, to increase attention on MSM and other KPs in its 2008 and 2009 Country Operational Plans in Ghana. This change was informed by the new data from SHARP, which PEPFAR funded via USAID.

The shift in the late 2000s also coincided with a change in leadership in the Ghana AIDS Commission that was more open to addressing HIV among key populations, including MSM. Moreover, the fact that the GAC was under the Office of the President provided the political cover needed for stakeholders to prioritize MSM in the national response. As one of my informants recalled:

_But the important part is that at some stage we had so much information that there was no doubt we should do MSM interventions. And very slowly, the leadership changed and the Ghana AIDS Commission and actually I don’t know the year. But Dr. Richard Armenia became the Technical Director; he was open. Angela El-Adas became the Director-General. That might have been 2007, 2008. And they were more open to considering MSM interventions. Then the Global Fund came in and they started saying, ‘Hey, why are you not doing anything there?’_

_I do think that we need to give some praise to the President [John Mahama], who when he was Vice [President], in a meeting was kind of shocked when he learned what the general opinion was on MSM. And you know probably the [media] story that he was found to have homosexual friends in the U.S., who were bringing up children and that type of thing. So, the guy is just way, way more open and ahead of the pack._

A notable point made by my informant here is that Mahama’s support gave El-Adas, the new Director-General, “more confidence in doing what she was doing because she was somehow backed, if that’s possible in politics, by the Vice. And that the President at that time did maybe the more general cover-up for the general population but still allowing the Ghana AIDS Commission to do what they are doing. I think that support at the very highest place is
probably the reason why they feel comfortable writing strategic plans, like we have the best in Africa.”

In addition to support from the new presidential administration, Samuel Owiredu of CEPEHRG emphasized the role external donor agencies have played in ensuring that MSM are included as a KP in Ghana’s efforts:

“Yeah, it’s (MSM) a priority group, so including MSM in the NSP, it’s helping Ghana in this HIV prevention…and then I think that is even one of the key factors. That is why Ghana has been getting funding to do HIV work in Ghana because these donors look at whether you have priority for key populations when you are applying for HIV funding. The Global Fund, USAID, if you don’t place priority on key populations, they will never give you [funding].

Essandoh added that agencies like the National AIDS Control Program were “favorably disposed towards MSM program…especially now that they see the Global Fund tilting towards key populations”. He added, “All across the world, there’s a push for targeting people, so maybe they see themselves as ‘we have no option other than supporting the key population agenda. Otherwise, we don’t get any funding’”.

Also, importantly, the shift was due to advocacy efforts by CEPEHRG, without whom data collection and peer education outreach to sasoi and other men who have sex with men would not have been impossible. As one of my USAID informants shared,

CEPEHRG I think needs some special mention because they were working in a total vacuum, but they were there. MacDarling, from CEPEHRG…He was the one that could help Attipoe find enough respondents. And could help start up some of the first interventions and the discussions of the SHARPER project. So yea, there are a bunch of individuals that somehow found each other and each kept pushing. So, it’s a small group that can do quite something.

In addition to these actors, Ghana had conducted a Modes of Transmission analysis in 2009 using a WHO/USAID software that indicated that about 8% of new adult infections were MSM (PEPFAR, 2012b). The findings in this report signaled to stakeholders that not only were MSM at risk, but they were significantly contributing to the general epidemic. This increased the urgency of addressing HIV/AIDS among the men in future policies. As Atuahene explained:
The result of that modeling showed that the key population that is MSM, sex workers and their partners were contributing substantially to HIV new infections and MSM was the population with the highest probability of transmission. So if MSM had the highest probability of transmission, then obviously, we needed to ensure that we have favorable policies that actually uses public health approach to responding to HIV among MSM and that we use rights based approach to ensure that…access to and utilization of services by MSM is unimpeded, it’s unhindered and that services are provided in a non-stigmatizing environment for them.

Thus, with key GAC officials now more open to prioritizing MSM as an at-risk group, USAID’s AED/SHARP project and its partner organizations formed the MARP Technical Work Group—now known as Key Populations Technical Work Group (KP TWG)—in close collaboration with the GAC. The KP TWG’s goal has been “to guide an effective and efficient coordination of the different interventions targeted at KP within the national HIV and AIDS response” and “have advisory, coordinating and advocacy functions to promote KP prevention-to-care continuum interventions in Ghana” (KP TWG, 2013). In addition to MSM, other key populations the group focuses on are female sex workers, prisoners, and people who inject drugs (PWID). Their work is guided by the for following principles: 1) protection and promotion of the rights of KPs to HIV related services; 2) Active involvement of KPs in prevention, treatment and care programs; 3) reduction of HIV related stigma and discrimination towards KPs; 4) safeguarding the human rights of KPs including equal access to quality care.

The KP TWG is composed of multiple state and non-state stakeholder members from: the GAC and the Ministry of Health/Ghana Health Services (NACP), both of who are co-Chairs of the TWG; FHI 360; bilateral donors (currently US government and GIZ-German Corporation for International Cooperation); multilateral donors (the UN system); the Country Coordinating Mechanism (CCM) of the Global Fund; Academia (University of Ghana’s School of Public Health and the Institute of Statistical, Social, and Economic Research); KP implementing partners (WAPCAS, ADRA, ProLink); representatives of KP (CEPEHRG); USAID SHARPER Project (successor of AED/SHARP); Ministry of Gender, Children, and Social Protection), NAP+, Security services (Ghana Prisons and Police Service); Narcotics Control Board (NACOB);
human rights organization (Commission of Human Rights and Administrative Justice-CHRAJ); and Federation of Women Lawyers. There are also three sub-committees that have been established for each of the KPs. These are an MSM sub-committee, an SW sub-committee, and a prisoners/PWID sub-committee.

The National Strategic Plan for MARPs: 2011-2015

One of the key projects the KP TWG has completed since its formation is the development of *The National Strategic Plan for Most at Risk Populations, 2011-2015*. This strategy, now referred to as the KP NSP, was developed with the central goal of reaching 80% of all identified MARPs\(^1\), including non-paying partners of FSW, with comprehensive and evidence-based package of HIV prevention, protection, treatment, care and support services. The Plan identified four Strategic Objectives (SO) which aimed to reduce stigma and discrimination, improve access to services by creating an enabling environment, enhance organizational capacity, and strengthen data on MARPs:

SO1: Develop and implement evidence-based, comprehensive HIV prevention, protection, treatment, care and support services for MARPs

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

SO3: Strengthen coordination among stakeholders and enhance organizational capacity to effectively deliver comprehensive services for MARPs

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

For MSM, specifically, the KP NSP identified the following factors that make sasoi and other men who have sex with men vulnerable to HIV/AIDS: punitive laws, widespread and entrenched

\(^{10}\) MARPs was the original category used to identity at risk groups in the policy document, so I retained the term MARPS in the quotes from the policy. However, the GAC has since started using key populations instead of MARPs.
stigma, sex work, harassment/arrest by police, drug use, elevated sexual risk taking, and gender-based violence. Some of the needs they identified for MSM beyond prevention services were legal and social protection, social acceptance, and post exposure prophylaxis services (See Figure 6 for full MSM Typology). These policies and interventions for MSM were informed by frameworks from FHI 360, World Bank, UNAIDS, USAID/AIDSTAR-One, and WHO.

- **Men who have Sex with Men**

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

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

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

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

| Key Needs | • Gender-based violence  
• **Integrated** HIV prevention services (e.g. condoms and lubricant, STI screening and treatment, HIV counseling and testing)  
• Continuum of Care and treatment including ART  
• Sexual health services  
• Post exposure prophylaxis (PEP) services and post -violence/rape care  
• Legal & social protection  
• Alternative income and economic independence activities  
• Empowerment and personal development  
• Psycho-social/Peer support  
• Social acceptance |

*Figure 6: MARP Typology for MSM in MARP NSP, 2011-2015*
The KP NSP demonstrated state and non-state stakeholders’ newly found commitment to reduce the impact of HIV/AIDS on sasoi and other MSM in Ghana. In the Forward to the document, the Director-General of the GAC, Dr. Angela El-Adas, wrote:

We must all work together to fight the stigma and discrimination that hinders the efforts being made and which significantly prevents access to available HIV services. Let us move forward in the delivery of these critical services to MARP and making strides in keeping all of Ghana healthy. (KP TWG, 2011; p. 6)

Despite using vague language, her statement and the framework as a whole are a testament to how far Ghana had come since its NSF II, despite an increasingly politicized local and international debate on homosexuality and sexual rights that presented challenges to the shift (see Chapter 4 for a longer discussion). In fact, around this period, the media was undergoing another moment of moral panic on homosexuality because of threats U.K. Prime Minister, David Cameron, had made on withholding aid from Ghana due to it criminalization of unnatural carnal knowledge—a statement to which the then President, John Atta Mills replied that he would never legalize homosexuality in Ghana (Joy News, 2011b). In fact, one of the proponents of reforming the unnatural carnal knowledge criminal code was Prof. Sai, who years ago refused to include MSM in the country’s HIV/AIDS response, was now in public defending gay rights to privacy:

There are Constitutional provisions also which talks about autonomy. Meaning a human being given freedom to do with his own body what he wants provided his freedom and the expression of that freedom does injure somebody. So why should what two people do in their privacy without confronting anybody, be subject to the law when the law itself has got all of these provisions. (Citifmonline, 2011b).

**National HIV & AIDS Strategic Plan, 2011-2015**

Developed on the heels of the aforementioned local and international changes to prioritize men who have sex with men as a key population in the global and national AIDS responses, Ghana’s 2011-2015 NSP then was a complete break from its past framing of its epidemic and its policies to address it. Notably, the epidemic was described with a lot more nuance, reflecting the progress that has been made in acquiring improved data on the epidemic
and in better and honestly grappling with the realities of it. The policies introduction framed the epidemic in this way, “Ghana is among countries with a low prevalence 1.9%... in spite of the generalized low epidemic, there are pockets of high prevalence in specific locations and among some sub-population. Additionally, there is a typically young population with high-risk sexual behaviors, thus requiring a mix of strategies” (Ghana AIDS Commision, 2010; p. 10). Based on this assessment and the goal of achieving universal access for all those in need of treatment and prevention services, the introduction stated “this plan guides the prioritization and targeting of key populations and regions in the country to ensure HIV services are provided where most needed. It takes into account the nature of the HIV epidemic in Ghana by: ensuring HIV interventions are evidence based and results oriented; ensuring the relevant gaps in the national response are addressed in order to deliver effective HIV services; and building the capacity of institutions coordinating, managing and implementing the national response (Ghana AIDS Commision, 2010).

Unlike past NSPs, Ghana’s most recent NSP identified men who have sex with men as a priority and discusses sexuality—albeit mostly heterosexuality—in much more detail than ever before. It also recognizes that while there might be a general epidemic, there also exist concentrated ones that require attention and state resources. The 168-pages long document is an impressive strategic plan that grapples with how to respond to its epidemic rather than simply try to repeat what it perceives donors want it to say, although there is some of that. Specifically, for MARPs, there are a couple of sections that speak of their needs in more detail, including a section that discusses the epidemiological profile of each of the MARPs group. Notably, in the main section dedicated to MARPS on preventing new infections (Section 4.8), there is recognition that the Ghanaian constitution criminalizes MARPs and that there aren’t public health services that address the needs of these groups, “There are laws, regulation, or policies that present obstacles to access to prevention, treatment, care and support for these vulnerable
sub-populations. There are laws that criminalize same-sex sexual activities between consenting adults and laws deeming sex work to be illegal” (Ghana AIDS Commission, 2010; p. 69).

**Successes and Challenges in Ghana’s MSM HIV Efforts**

**A model country, relatively.**

As the efforts by the KP TWG and the KP NSP demonstrate, the past 5 years has seen increased strategic effort from Ghanaian state key stakeholders as well as non-state key stakeholders to address a concentrated epidemic among sasoi and other MSM in Ghana. These efforts have gained Ghana the status of a model country in sub-Saharan African in regards to key populations. During my time in Ghana, I was able to attend a USAID-sponsored conference titled, *Stakeholders Technical Workshop for Key Populations in West and Central Africa*, held from May 27 to May 29, 2014, in Accra. The conference brought together key stakeholders from about 14 countries in the West and Central Africa (WCA) region who work with KPs with the goal of sharing experiences, strategies, and practices to make improvements towards HIV prevention, treatment, and care in the region. Anecdotally, I heard numerous times that Accra was chosen as the site for this conference because of the good progress it had made in addressing KPs in its national AIDS response. Compared to other countries in the area, like Cameroun where the government refuses to address HIV among men who have sex with men, Ghana’s efforts are exemplar.

This achievement by Ghana is commendable. On the other hand, the standard by which they are ranked is currently low due to how much the region is lagging behind in terms of MSM interventions, a legacy of the policy blind spot. As one USAID stakeholder stated in response to how Ghana compares to other countries in the region, Ghana is doing well in terms of its overall work on HIV/AIDS among KP, and perhaps for MSM as well *in relation* to other countries in the region, but it is not so clear how much of a model Ghana is when judged alone. As they stated, “Ghana supposedly is leading. Other countries are not as advanced… Ghana has really set up
a model programming around KP. I don’t know about MSM, but around KP…other countries want to visit them.” They added regarding the regional KP conference:

There was a recent KP conference here. Supposedly several countries already put it on their map that they want to come visit, not recognizing that it could be a disruption to the program, either...The MSM portion, I don’t know. KP, yes. I’m thinking if it is, if we are doing better at MSM than other countries, it’s not because we specifically targeted MSM. It’s just because the general KP [work] that we do has benefitted MSM and maybe other people. Other countries may not have such comprehensive KP programming that we can actually encapsulate the MSM as a group. That’s what I’m thinking…Yes, that’s what I’ve been told, that we’re the lead. By all accounts that’s what I seem to see when people—the accolades come our way. I’ve never heard anything specific for the MSM.

Strong multi-sectoral collaboration, unequal representation.

In addition to its model country status, another strength of Ghana’s MSM HIV efforts that policymakers and service providers identified was the multi-sectorial nature of the KP TWG and how it has been able to engage other sectors of the government that were less friendly to the efforts. As one of the FHI 360 representatives on the KP TWG stated:

What is going well? I would say that the various key stakeholders that we have in terms of our objectives, which is focusing on service provision, access to key services, commodities to reduce new infections of HIV...that one is good in the sense that we are having Ghana Health Service come on board, not as fast as we want but then what is required is the change in perception and attitude, which is really habit in people. So, you can’t change that quickly.

While some thought the work was collaborative, others felt that smaller NGOs representing men who have sex with men were marginalized in the policy and programming efforts for KPs. A TWG member from one such group shared that they felt tokenized at the policy table. MSM organizations are invited to represent their constituency, but the people who have the most influential voice are those outside of the KP groups. Thus, they felt their representation was mostly symbolic.

I think the challenge is that we have the same champions you know…We have the same champions [in that] the same people who run the show are the same people running the show. They would say ‘Oh MSM are part of it’ but they don’t listen to what you say. They
would say ‘Oh, let’s bring them on the table’ but just to sit on the table and not listened to and that is what we have. And it’s the same technocrats who know how to do everything, they are the same people who think [things should be done] the same way they used to do it. Just that this time [around] the MSM is on the table to listen or to know that this is what they are doing [whereas] previously, you didn’t know.

As part of my field research, I attended five meetings of the KP TWG over the course of 9 months in 2014. Three of those meetings were regularly scheduled meetings and two of them were special meetings called for to report the findings of the mid-term evaluation of the MARP NSP and another meeting in response to coordinated police attacks on sex workers in Accra. I observed some of the work the group does to address HIV among key populations and my observations reflected both these views. On the one hand, there is representation of diverse organizations and agencies on the technical work group as previously described. These actors meet together to discuss strategies or policies and programs for prevention and care of KPs. On the other hand, it was clear that some members, particularly those from the GAC, major donor agencies, and implementing partners had more space to air their views and more influence on the discussions and direction of the group efforts. If collaboration meant not just a seat at the table, but equal representation and incorporation of views, concerns, and needs of all stakeholders, the KP TWG did not yet reflect that.

Homophobia among key stakeholder organizations.

In addition to the aforementioned issues, there are other challenges that my informants raised. One of the key issues that came up with multiple KP TWG members is the issue of stigma and discrimination against homosexuality and how they affect their efforts to address HIV among sasoi and other men who have sex with men. In my interviews, I would hear repeatedly the idea that “MSM is a no go area” due to social, religious, legal, and cultural factors. As the key populations point person for NACP and co-Chair of the KP TWG shared:
Well MSM in Ghana is a no go area. It is a no go area at all. People say Ghana is a Christian society, so people are quoting things from the bible. People are relating it to Sodomy and Gomorrah because of MSM activities that is why...I mean so many issues. The Islamic group is saying they should be arrested and killed. It's a whole lot of...so MSM in Ghana is it's a no go, it's a no go area, yeah.

Essandoh of USAID added that some—both people within and outside the HIV/AIDS response—view the inclusion of MSM as sanctioning homosexuality, which they view as wrong. While some who work in the national response would not admit to it, he argues that these beliefs operate beneath the surface:

Yes, you talk to some people who do not think that we should be targeting MSMs because Ghana is a religious country. We shouldn't sanction MSM, so some people...view the outreach as giving credence to what MSMs are doing, and why should that happen, when, in the Bible, God doesn't sanction homosexuality? Sometimes you hear this from even program people. Of course, officially, they will not say that, yeah. Also, at a policy level, people still do not agree that it is a right lifestyle.

In essence, there is a discrepancy between the MSM-friendly language in policies and the institutional reality these policies operate in. This discrepancy was articulated well by another policymaker, who explained having to constantly argue with government officials about the importance of including MSM:

Well in the first place, it is really difficult to agree on the importance of MSM interventions. And the statistical models are just statistical and then we can start fighting about parameters, small details. But small details can change an entire model. [But] authorities like to underestimate the importance of the contribution of MSM to the overall epidemic. And another example is the size of MSM in Ghana. ‘Wow, are they a few hundred or are we talking about a few percent of the entire population?’ That’s a huge difference. So, it is not acceptable [for MSM-proponents] to talk about bigger numbers. The smaller [the numbers], the better to keep it a bit under the carpet.

Although he claimed to understand why officials were hesitant, he indicated that he gets “angry” occasionally with them, “We start debating. I’ve been debating for a decade and maybe things slowly changed. It is understandable. Its just difficult to handle authorities.”

A “rights” vs. public health approach: A contentious debate.
At the Stakeholders Technical Workshop for Key Populations in WCA that I attended, one of the most contentious issues raised was the question of whether governments’ response to HIV among key populations, particularly men who have sex with men, should take a rights approach or a public health approach. Specifically, during the session “KP-Donor and Stakeholder Synergies with Regional Strategies in WCA”, a Gambian representative raised a concern from the floor to the Global Fund about its new funding model that emphasizes rights, which they treated as different from a public health approach. He stated:

The new funding model has the questions of rights, but it is different with MSM in Africa. We need to give ourselves time to allow public health to drive the perspective so that we do not lose resources and support. Even in a difficult context, it is possible to ensure access to health services as a right rather than talking about other human rights. (Stakeholders Technical Workshop for Key Populations in West and Central Africa, 2014; p. 29)

In response, the Global Fund speaker stated:

We have worked this way in Gambia, and the question is always ‘Should we push for a human rights perspective, or a public health perspective?’ The Global Fund is not a human rights organization, but human rights are part of the enabling environment.

The concern was echoed by other nations like Cameroon, which was experiencing a politically charged backlash against homosexuality that stifled the policy and programming efforts. In a context of polarized global and local debates on decriminalizing unnatural carnal knowledge and legislating sexual rights for LGBTQ people in African contexts, the concerns and anxieties of these policymakers in taking a rights approach to enable MSM to have better access to services are critical, even if they are sometimes embedded in homophobic beliefs. It is a source of tension that remains unresolved and continues to shape the landscape of KP efforts on the continent.

In Ghana specifically, while the paradigm shift being supported from the highest levels, with human rights emphasized, there is a debate among stakeholders about whether a rights approach is a feasible or reasonable one to take, given how morally and politically charged homosexuality is. This concern is widespread and the perspectives I heard during interviews on
whether the country’s KP policies should take a rights approach or a public health approach varied immensely. What was clear from people’s answers were that: 1) there was no shared understanding of what exactly a “rights approach” meant, 2) there was no shared understanding of what “rights” specifically were being discussed in the approach (Is it sexual rights? Right to health care? Right to treatment? Decriminalization of homosexuality? Legalization of homosexuality? And 3) there was not clarity on how a rights approach, however it was being defined, related to a public health approach.

The main proponents of the rights approach tended to be those representing MSM led groups. Those who were against it shared various concerns about the dangers and limitations of the rights approach. One policymaker viewed it as asking for special treatment of gay Ghanaians and since most Ghanaians “don’t really enjoy rights” and “homosexuality is criminalized” asking for “special rights” for MSM “would cause an uproar.”

A notable point was that policymakers were not necessarily against a rights approach, except when it comes to gay and other men who have sex with men. As one stakeholder from an MSM CBO shared, in policy and programmatic efforts, he’s found that people are more receptive to a rights approach for sex workers and other groups than for men who have sex with men. He explained:

> When you go to the meetings and you talking about rights, most people listen if you talking about female sex workers. Yes, people would at least say yes. If you’re talking about other rights. But we talk about LGBTI rights, forget it. No one supports you, no one. That’s it and that’s been a very difficult area. Most of the programs, for instance Global Fund says ‘Yes, we promote some rights as part of our funding’ but then when you go to the CCM and you try to discuss that here in Ghana, everybody tells you ‘No, human rights is not part [of it]...it’s about services, HIV services, TB services and these services’.

According to him, “MSM rights has not been on the discussion and it only comes up when someone has been abused or there is a news article then you hear some partners say ‘Oh can
we meet to discuss it and know the way forward?’ But it has not been on the table like, let’s look at LGBT rights and how to protect it.”

Many of my informants, however, held some view that in order for the public health approach to work, they would need to include some kind of rights approach, whether it is right to health or right to services (but not gay rights). One policymaker took a sexuality-blind approach, whereby she primarily sees MSM as human beings deserving of rights afforded to all other human beings. For her, they are should not be “something special for them because they are a special group” because that would rather stigmatize them. She explained:

*The first thing we have to see is that the MSM is a human being and we want to reach them with health and prevent HIV…If we see the person like [a human being] whatever approach we have used in the general population to reach them with HIV messages and prevent HIV amongst them, why can’t we do it for this population? What is special, what is special about them? Because they have same sex? Let’s see them as human beings for the first time…it doesn’t matter the sexual orientation. Look at all the strategies, rights and public health approach, everything that we have done in Ghana for our prevalence to be this low, everything that we have done to reach the general population about information on HIV, prevention of HIV.*

An interesting observation from the responses on this rights vs public health approach question was that there seemed to be a contradiction in the responses, whereby numerous policymakers perceive their acknowledgment of MSM as treating them like everyone else—they are not different from everyone else who need HIV services. This view treats the men in a “sexuality-blind” manner where their sexuality is not a factor in how stakeholders regard them, yet policies and programs are targeting the men with MSM-specific safer sex messages, condoms, and lubricants. Moreover, as the last quote states, the men are “human beings” like everyone else but by recognizing them as special—that is as sasoi, gay, bisexual, or homosexual—stakeholders would be stigmatizing them. The contradiction or tension here is that this view seems to not regard a specific policy for MSM such as the KP NSP as treating MSM as a special group in need of targeted policies and efforts in correcting the past blind spot on same-sex transmission.
The inability of some stakeholders to recognize that what they are doing indeed is a special intervention aimed at addressing a sub-population with much higher prevalence than the general population was astounding. Moreover, my informant’s responses demonstrated that key stakeholders involved in these efforts are unsure, unwilling or limited in their ability to apply a sexual rights framework to Ghana’s HIV/AIDS policies focusing on men who have sex with men, partly because of fear of a backlash if the Ghanaian public learns about these efforts and in part because of the acute homophobia within the government and society at large. As biomedical citizens, saso and other MSM are restricted to rights specific to interventions for their sexual behaviors and risks (the public health approach) and associated interventions but not rights related to their sexual identities as non-heterosexuals (the sexual rights approach). The blind spot in this logic—namely that sexual risks and sexual identity are intricately linked—however, is lost on many stakeholders. Without protection of rights as homosexuals, HIV prevention efforts among saso and other MSM will be limited in making meaningful progress.

**The operationalization and function of key populations in Ghana’s response.**

I suggest that given the homophobic sociocultural context, an impact of the non-standard application of a rights framework in Ghana’s MSM HIV efforts, is that these efforts tow a fine line between visibility to its target audience and invisibility to the society they live in. One example of this in the policy efforts is the packaging of MSM efforts under “key populations” in ways that obscures the visibility and needs of this population. To elaborate on this point, it is important to examine some of the politics of the key population category and its operationalization in Ghana. One notable aspect of Ghana’s HIV/AIDS response is the shift in framework used to identify groups at a higher risk for HIV. When Ghana made its paradigm shift in 2011, it started using the language of key populations simultaneously with MARPs, to categorize marginalized populations with a concentrated epidemic, primarily because there was a transition
internationally to use MARPs less as a category. In fact, the 2015 UNAIDS Terminology Guidelines discourages readers from using MARPs in HIV/AIDS efforts (UNAIDS, 2015). According to UNAIDS, “Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context” (UNAIDS, 2015). The term could also be used for other high-risk groups such as sero-negative partners, mobile populations, and long-distance truck drivers—groups that Ghana has historically identified as vulnerable to HIV in its policies.

Notably, the 2011-2015 KP NSP defined MARPs as “those subpopulations, within a defined and recognized epidemiological context that have significantly higher levels of HIV risk, mortality and/or morbidity; and whose access to or uptake of relevant services is significantly lower than the rest of the population” (KP TWG, 2011; p. 14). One of the key tensions apparent in KP HIV efforts in the country was the simultaneous application of both KP and MARPs in ways that were not clear on where they intersected and diverged, and how this shaped policies and interventions. A key issue here is that because much of Ghana’s policies are directly informed by donor frameworks and global AIDS policies which are constantly changing, it seems recipient governments, like Ghana, are always playing catch-up. If they don’t move quickly, they lose out in funding, in resources, and in material needs that help maintain the vulnerable infrastructure that they have managed to establish. This means a couple things. First, that there is not clarity on which concept is being used to categorize at risk populations, which also impacts how interventions are designed and funding is allocated. For example, during a January 2014 validation meeting on the Mid-term Evaluation (MTE) Report on the 2011-2015 NSP, there was immense confusion caused when I raised a question regarding an expenditure chart that showed funding allocation for “MARPs” and funding allocation for “other KPs”. When I asked which groups fell under each of the two categories (because the latter group had significantly more funding than the former), stakeholders could not answer the question. This led to an intervention by the then UNAIDS Country Director to explain the
difference between MARPs and KP. However, the question was never answered. Who were these other KPs and why were they receiving much more funding than MARPs, who had the smallest proportion of funding? How was this impacting KP HIV efforts?

The second issue is that in discussing this observation with one of my key informants, Professor Ankomah from the University of Ghana, Legon and a consultant on the MTE Report, I learned that part of the issue is that Ghana’s policies are much more developed than where research and programs are at. In fact, he argued that these policies are not necessarily guided by local research. For example, two groups within the identified key populations in Ghana, prisoners and PWID, were included as KP before epidemiological data for them were available. Ankomah explained that he believed this is in part because Ghana’s “HIV research is far lower in terms of quality” than other countries he’s worked in like Nigeria, Uganda, and Tanzania. He insisted that those countries had conducted prevalence studies on these populations before confirming them as key populations. “In Ghana”, according to Ankomah, “what is happening is that we take these key populations because somebody says these are the key populations. They’ve lumped a whole lot of people there as key populations”. For example, during the midterm evaluation of the 2010-2015 NSP, which included prisoners as a KP, Ankomah was informed that there was no prevalence data on this population when he asked why they were included as a KP. In response to his question, he explained:

So we were commissioned to do a work for Ghana AIDS Commission, sponsored by the GTZ, and we came to realize that the male prisoners, the HIV prevalence is not different from the general population of Ghana. So, on what basis are they called key populations? For female prisoners, yes, the prevalence is very high. Eleven percent we saw or was it ten percent?

Ankomah identified the same issue for injection drug users, who stakeholders included as KP without the availability of epidemiological data to inform this decision. He believed this pattern was due to stakeholders taking policy directions from World Bank or WHO frameworks without it making sense in the Ghanaian context, “We are still confused as to who the key
populations are, so when World Bank or WHO, says these are the key populations, we go in for them”.

The reality in Ghana is that MSM and FSW are the only two key groups whose key population status is substantiated by empirical data (or at least at the time of the 2011-2015 policies), as any close read of the 2011-2015 KP NSP and the 2011-2015 NSP will show. In the case of PWID and even more so, prisoners, there is scanty evidence that these groups are indeed a key population. They are identified in local policy as KP that is driven by international standards; data is acquired only after. This practice demonstrates how much less political and contested the process of including PWID and prisoners as KPs has been compared to MSM. For MSM, it took nearly a decade of advocacy, debates, and data collection to mark a shift in policies. Moreover, while it is important to research these groups to determine their status as a KP, this practice raises important questions about whether it is an efficient use of resources to set a population as a priority group in policy without first having the data to substantiate this decision.

**Inclusion paradox.**

Returning to the point I started this section with, the packaging of MSM efforts within the KP paradigm seems at times to be used to masquerade stakeholders’ inclusion of the homosexuals as an effort to not draw too much attention to homosexuality, both from society and other sectors of the government. In doing so, it also allows for some stakeholders to prioritize certain KPs, like sex workers, while appearing to be helping all KPs, as an earlier quote from a USAID key informant mentioned. This then marginalizes MSM as well as MSM organizations in the national efforts and displaces their needs and the resources needed to meet them. Moreover, it presents an inclusion paradox, whereby sasoi and other men who have sex with men, despite being prioritized as a KP, are pushed to the margins of Ghana’s HIV response, which presents significant challenges to the government’s ability to effectively curb the epidemic among this population.
One member of CEPEHRG expressed frustration about how MSM issues are not explicitly talked about at policy meetings and efforts, and how often MSM needs are assumed to be the same as FSWs, effectively rendering them invisible and silencing their voices. Due to this, he explained that, “Any time MSM is combined with key population, I also have a problem because then the country prioritizes which key population they are interested in working with before the other and that becomes a challenge”. Additionally, when he’s raised these concerns at stakeholder meetings, they are ignored or dismissed, which is so discouraging that he’s disengaged from policy meetings at times. Due to these issues, he feels that the inclusion of MSM at policy meetings is merely symbolic, as discussed earlier. He explained:

The KP NSP I think most of the partners were part of the KP NSP. I think there was a draft and then partners made inputs. But I must also say that, with that NSP, we still have a challenge with it. Because when we were doing the MSM one, when you look at the trend, like what to offer, it’s like the same thing with FSW. There shouldn’t be more than FSW or less than FSW, and that is the challenge I have. Because MSM have special needs and FSW have special needs…That is my only beef with that. I’ve raised these issues, but when you raise it and then the response is not affirmative, like they don’t accept your comments, you are not encouraged to do it next time. So, you accept whatever they produce…So sometimes, I think the thing is that they would tell you, they were there. But you were there, but you didn’t contribute. You were there, but you were not acknowledged. You were there, but your views were not taken.

Conclusion

In this chapter, I demonstrate how global AIDS researchers and donors’ construction of HIV epidemiological pattern as heterosexual in Africa and homosexual in the West, as well as the stigmatization and criminalization of same-sex sexual acts, caused a blind spot in Ghana’s HIV efforts and delayed the country’s recognition and inclusion of men who have sex with men in its national HIV/AIDS response for 25 years. The paradigm shift to include men who have sex with men as a KP was made due to various factors, namely increasing epidemiological evidence of MSM HIV risk, changes in donor policies and frameworks to recognize MSM as a KP in Africa, advocacy efforts by local rights and donor organizations, namely CEPEHRG and USAID,
and a government administration that was open to the inclusion of the men in the country’s HIV/AIDS response.

While these changes are a historic and commendable shift that has gained Ghana the status of a model country in Africa, there remain important challenges that threaten the success of these new efforts. Importantly, the precarious position of men who have sex with men in the KP category due to the continual de facto criminalization of homosexuality, and the sociocultural stigma against them, renders them strategically invisible and undermines the effectiveness of the policies and programs for them. The next chapter examines the legal and sociocultural realities underlying the KP paradigm shift and how sasoi and other men who have sex with men experience life in this context.
CHAPTER 4
HOMOSEXUALITY AND HOMOPHOBIA IN MODERN DAY GHANA: BACKGROUND TO A PARADIGM SHIFT

Introduction

In the previous chapter, I discussed the evolution of Ghana’s HIV policies to the current MSM-inclusive KP paradigm and key successes and challenges facing these policy efforts. Based on analysis of news articles, policymaker interviews, MSM key informant interviews, service providers/prevention personnel, and participant observations and other ethnographic data, this chapter takes a step back to examine the context in which these changes are occurring and the social life of the population directly affected by these changes. Particularly, it discusses the legal, social, political, and cultural context in which sasoi and other MSM live, love and survive. The Chapter also describes the lives of the sasoi and other MSM who were interviewed and their life experiences in relation to their sexuality, HIV risk, and Ghanaian society. It additionally examines how developments on the international level are affecting local political and social realities regarding actual and perceived sexuality and gender identity.

I argue that religious leaders and the print news and broadcast media—emboldened by the criminalization of homosexuality in Ghana—play the leading role in the stigmatization of homosexuality in Ghanaian society. Further, I suggest that pressure from these institutions has mobilized and emboldened citizens to speak against homosexuality while polarizing society on the issue of homosexuality. Relatedly, I argue that these local actors as well as international developments around LGBTQ rights have pressured politicians and other government leaders to take a position against homosexuality and thus have politicized the issue in Ghanaian society.
Homophobia, Heterosexism, and the Politicization of Homosexuality

Unnatural Carnal Knowledge

For years, when Ghanaians, tourists, diplomats, and other visitors arrived to Ghana’s Kotoka International Airport in Accra, one of first messages they would see was a large, framed “Welcome” sign in the Customs/immigration area where visitors are processed for entry to the country (see Figure 7). Though the sign was taken down in 2015, reportedly due to airport renovations, it previously hung prominently on a wall behind the Customs Officers’ booths, by multiple armed airport security guards. In the vibrant colors and patterns of the traditional Asante Kente Cloth were large letters that read, “Akwaaba!”—a common Twi greeting that means “welcome”. Below the welcome greeting were 4 bullet points. The message was simple and direct. ‘Ghana welcomes all visitors of “goodwill’ it proclaimed. However—boldly written in red font—the country “does not welcome pedophiles and other sexual deviants”. If one intended to engage in such “sexually aberrant behavior”, they would be met with “extremely harsh penalties” and were thus advised to go elsewhere for “everybody’s good, including your own”.

Although pedophilia was the only form of sexual deviancy specifically named on the sign, it was evident that the sign was also referring to homosexuality, which is commonly associated with pedophilia by those who denounce it. There are in fact, a handful of offenses identified in the Ghanaian Constitution’s Criminal Code, 1960 (Act 29) under Chapter 6, in the category of “Sexual Offenses”—the criminal codes the sign is referring to. They are rape/sexual assault, incest, pedophilia, bestiality, and unnatural carnal knowledge, the latter of which is treated as a de facto criminalization of homosexuality. While these five acts are criminalized, homosexuality is the most publically discussed and denounced among them.

A glaring question raised from examining the sign is why did the sign highlight sexual deviancy, rather than a number of other criminal acts? Is sexual deviancy by foreigners the largest threat to the social and political order of a country where, for instance, child trafficking and illegal gold mining by foreign nationals are rampant? For those who gave the orders to
place this sign up, the answer was “yes”. If the sign is an indication of anything, it is that those who govern Ghanaian society, whether religious, political, or other institutional leaders, have been preoccupied with asserting a “normative” sexual order, and believe that foreigners, ostensibly Western ones, pose a threat to that order. This is despite the fact that the codes being enforced were created by the British under its colonial rule of Ghana.

Figure 7: Sexual Deviancy Airport Sign, Accra Kotoka International Airport, (76crimes.com, 2016)

Ghana’s retention of the unnatural carnal knowledge criminal code makes it one of 33 African states and one of 17 former British colonies on the continent that continue to criminalize same-sex sexualities. In 2003, these codes went under review, and the Ghanaian government chose to keep the assertion that consensual sexual intercourse is “unnatural” and punishable by up to 3 years in prison while the penalty for non-consensual “unnatural” sex is 25 years. According to Section 104 of the Criminal Code, unnatural carnal knowledge is “sexual
intercourse with a person in an unnatural manner or with an animal” (Carroll, 2016). The law criminalizes male same-sex sexual intimacies. However, there are no specific codes for female same-sex sexual activities, although these codes are, again, treated as a de facto criminalization of all forms of homosexuality. This has led some religious leaders and members of civil society to demand that the government clarifies its position on homosexuality so that there is no confusion over which groups of people and which acts are punishable under this law. Public interest lawyer and former Deputy Minister for President JJ Rawlings, Sam Pee Yalley, argued for those arrested on suspicion of homosexuality to be charged with genocide, because according to him, homosexuals cannot produce (Citifmonline, 2011c). He explained,

*Genocide results in the extermination of the human race and if you expand the meaning of homosexuality to mean that a man cannot have a child with another man then it means that that practice would lead to the extermination of mankind and therefore for me if I am to charge anybody apart from having unnatural carnal knowledge, I would also charge him with genocide and see how he can get out of that situation* (Citifmonline, 2011c).

**From the Media to Religious Institutions: Moral Panics on Homosexuality**

This notion that homosexuality is a threat to the national or social order is consistent with the dominant social and political discourse on sexuality in Ghana over the past decade—a period that has been characterized by a proliferation of public debates and moral panics about homosexuality. As other scholars have pointed out (Dankwa, 2013; O’Mara, 2007), Ghanaian society has increasingly become preoccupied with homosexuality—with a vast majority of the population perceiving it as a threat to social, religious, and moral values. From politicians to religious and traditional figures and members of civil society, the common belief about homosexuality is that it is unnatural, un-Ghanaian, and ungodly. These ideas have both shaped and been shaped by what I contend has been a politicization of homosexuality and an intensification of political homophobia and heterosexism.

A few terms are worth defining here. I use homophobia broadly as “anti-homosexual practices and ideologies” (Adam, 1998; p. 388) and not just in its individualized, psychological
definition as a fear, prejudice, or hatred towards homosexuality. These anti-homosexual practices and ideologies are situated in and enforced through political, religious, secular, and other institutional structures. Heterosexism—the institutionalization of heterosexuality and the legal and social suppression of other forms of sexuality—operates through such institutions that govern society. As Tom Boellstorff (2004) suggests, it asserts and ensures that “heterosexuality is the only natural or moral sexuality” (p. 472). However, unlike Boellstorff, I do not ascribe to the notion that “it is possible to have homophobia with little or no heterosexism” (p. 472). Rather, I contend that homophobia is produced and maintained by heterosexism in the same way that Barbara Jeanne Fields (1990) argues that race as an ideology is produced and maintained by racism. One does not develop a fear or hatred of non-heterosexual sexualities without structures and mechanisms—heterosexism—that make such sexualities abnormal. But more importantly, homophobia is not an isolated ideology that individuals randomly inherit from thin air. It is structurally produced social phenomenon that influences people’s perceptions and lived experiences and that provokes social attention and resistance.

As Barry Adam (1998) has argued, “The contours of anti-homosexual practices and ideologies depend on the overall governance of men’s and women’s sexualities” (p. 393). In Ghana, homophobia is enshrined in and enforced through a heterosexist unnatural carnal knowledge criminal code that insists that peno-vaginal intercourse between a man and woman is the only natural and normal sex there is. Despite the narrow scope of Section 104 of the criminal codes, Ghanaians—whether civil society members or institutional leaders—regard it as a criminalization of same-sex sexualities, intimacies, and desires and use it, along with other social rules and customs, to govern people’s sexualities. This heterosexism shapes the social context in which ideas and meanings of homosexuality are discussed, represented, and circulated.

Drawing on the work of Erich Goode and Nachman Ben-Yehuda (2010) on moral panics and the social construction of deviance, moral panics here is defined as the widespread or
“heightened emotion, fear, dread, anxiety, hostility, and a strong sense of righteousness” that a “group or category” is engaged in “unacceptable, immoral behavior” that causes or is perceived as producing harmful consequences that pose a threat to the social order or the moral sanctity and values of society (p. 31). This reaction is usually “out of proportion to the threat that was, or seemed to be, posed by the behavior, or the supposed behavior, of some” (Goode & Ben-Yehuda, 2010; p. 11). The culprits of this immoral, damaging act are considered outsiders, deviant, or evil and deserve to be targeted and punished through surveillance, social control, criminalization, death, or social expulsion (p. 31). Moral panics can also lead to moral crusades, in which social groups form to organize against the threat of the culprits.

“Gay Conference”

Ghanaian society has been characterized by a politicization of homosexuality in the past decade. By politicization, I mean a process in which homosexuality has become a popular and politically contested issue, discussed in the media, religious institutions, and social spaces. There have been a number of developments that have served as catalysts to this politicization and subsequent moral panics over the years. A 'gay conference,' international outcry and intervention in debates over homophobic bills in African nations, and a few public outings have all contributed to the homophobic and heterosexist climate in Ghanaian society.

A significant controversy from August to September 2006 surrounded an alleged “gay conference” that was to be held at the International Conference Center in Accra and at a hotel in Koforidua, the capital of the Eastern Region (BBC News, 2006; JFM, 2006). This conference, which “would have brought gays and lesbians from all over the world” would be hosted by a local organization called the Gay and Lesbian Association of Ghana (GALAG)—an organization run by many of the same people in CEPEHRG, the local LGBT rights and health organization (JFM, 2006). The media received this information allegedly from the then president of GALAG,
Prince MacDonald, who had reportedly revealed on a radio interview in August 24th of that year that he was gay (O’Mara, 2007).

Information from the interview spread like wildfire once media outlets learned about it. One article, titled “Proposed Gay Conference Still Sketchy”, reported that “Gays and lesbians are everywhere in Ghana today” and that GALAG had reported a growing membership of more than 500 people (JFM, 2006). These members, they warned, “might include the lady or gentleman next door, a colleague at the office, or perhaps your church member” or even “students at secondary level, top men and women in society, from diverse professions including politicians”. Such people, they added, were “but a few examples of the gay members of our society today”. The uproar about the conference caught the attention of government officials, who banned the conference according to a BBC article at the time (BBC News, 2006). The then Minister of Information and National Orientation, Kwamena Bartels, issued a statement discussing the ban, asserting that, “government does not condone any such activity which violently offends the culture, morality and heritage of the entire people of Ghana” (BBC News, 2006). His statement also threatened to “punish” those who gave the organizers permission for the conference, referencing the country’s criminal code. Bartels’ statement asserted,

[The] Government would like to make it absolutely clear that it shall not permit the proposed conference anywhere in Ghana. Unnatural carnal knowledge is illegal under our criminal code. Homosexuality, lesbianism and bestiality are therefore offences under the laws of Ghana (BBC News, 2006).

The assumption underlying such a statement is that those who were organizing the conference and those who allowed for it to happen were somehow breaking Section 104 of the Criminal Code. The alleged conference, according to media reports, however, did not aim to bring people together for anal intercourse. Moreover, the Ghanaian law does not criminalize same-sex sexual orientations. Thus, it was not clear what law people would be punished for, although Mr. Bartels was clearly using the unnatural carnal knowledge law to discipline people
for actions that are protected under the constitution—freedom of association, freedom of speech, and freedom of assembly. As he acknowledged in his own statement, “It’s not illegal for them to meet and talk, but we in Ghana don’t want to encourage it. They can go and do it elsewhere” (Sakyi-Addo, 2006). What this panic and the government’s response to it reveals, however, is how the law criminalizing male same-sex intercourse are used in the public eye to criminalize all aspects of same-sex sexual orientations, desires, intimacies, and the lives of those who express or embody them.

Despite the massive uproar over the alleged conference, some of my informants as well as the country’s International Conference Center at the time and GALAG, reported that no such conference was planned (BBC News, 2006). Another account of the story, according to one of the first articles documenting homophobia in Ghana, details that Mr. MacDonald had merely mentioned in an interview that his organization had received funding to conduct a behavioral surveillance study—assumedly the first MSM IBBSS conducted under the SHARP project discussed in the previous chapter (O’Mara, 2007). In fact, an article summarizing MacDonald’s August 24th interview indicated that he was speaking about the human rights and HIV/STI prevention and care services his organization provided LGBTQ populations in Ghana and not an international conference of gays and lesbians. Despite the inaccuracies within the public spectacle, the backlash, forced MacDonald and his organization, GALAG, to release a statement debunking the speculations. The statement asserted that,

1. The Gay & Lesbian Association of Ghana (GALAG) has never discussed, nor have we ever organized, an international Lesbian/Gay/Bisexual/Transgender [LGBT] conference in Ghana. Since our Executive President appeared in some electronic media, this conference appears to have been the brainchild of someone’s vivid imagination. As an association, we are not prepared to organize such a conference anywhere in Ghana, let alone any part of the universe, at this point.

2. We have no hand in – nor the faintest clue about – any such conference to be organized by any group anywhere; neither do we know of – nor have we heard of – any such event. All we know is what is being peddled irresponsibly in the media, apparently oblivious to the journalistic ethical code which calls for confirming such a potentially
controversial event with at least two or three reliable sources before putting it on air or in print media as truth. (GALAG, 2006)

GALAG’s statement, which made ten distinct points, asserted that GALAG was like any other NGO organization, exercising its constitutional rights. Moreover, it defensively emphasized that it “does not promote homosexuality”—a common charge against those who work with LGBTQ populations—but “rather seeks the sexual well-being of same-gender-loving people, their families and friends, as well as the general population at large. LGBTQ individuals and their loved ones are frequently rejected and have no place to turn. GALAG tries to fill that void” (GALAG, 2006). It added details about the sexual health risks and needs of gay and lesbian Ghanaians and ended with a few “food for thought” statements that hoped to challenge the homophobic media coverage targeting their organization (see Appendix B for the full statement).

The impact of the media and public panic was devastating for Mr. MacDonald and other LGBTQ leaders. Like many other media stories on homosexuality, the coverage was sensational with rumors and speculations and rife with contempt towards gays and lesbians. This in turn made the community hyper-visible and thus, more vulnerable to shaming, stigma, and violence. As Mr. MacDonald shared in an interview, months after the media barrage, the backlash forced him into exile in a neighboring country due to fear of his life. Mr. MacDonald received a note on his work car, threatening to burn the car. In addition, Mr. MacDonald experienced stalking, death threats, taunting, and intruders outside his house insulting and threatening him.

The gay and lesbian conference incident was an important development. It was the first major backlash the LGBTQ community in Ghana had experienced and it was in response to leaders and allies’ attempts to organize for MSM rights and health access and care. It was also a hard-learned lesson on what happens when those working on such sensitive topics are not strategic in how they communicate to the media about MSM STI and HIV prevention and care.
efforts. As one journalist described it, this interview “marked the opening of the Pandora’s Box for the Gay and Lesbian community in Ghana” (Afari, 2006).

From Heterosexual to Homophobic: Africa in the International Spotlight

A few years after the gay and lesbian conference controversy, another development—this time outside of Ghana—brought international focus to homosexuality and homophobia in Africa in an unprecedented manner. The controversy surrounded the introduction of a proposed “Anti-homosexuality Bill” in Uganda’s Parliament in October 2009—a bill Western media sensationnally dubbed the “Kill the Gays” that criminalized some forms of homosexual sex and relationships. The proposed Bill, which was introduced by Junior Parliament member, David Bahati, with the support of American evangelicals (Kaoma, 2009, 2012), would imprison those guilty of the “offense of homosexuality” for life and would put those guilty of “aggravated homosexuality” to death if the bill was approved. It would effectively criminalize same-sex sexual orientations, relationships, and sex, and fine anyone who had knowledge of such things. Moreover, it would criminalize any organization or individual who did advocacy work for LGBTQ individuals.

The proposed bill caused a local and international uproar among LGBT rights organization, mostly Western governments, and human rights organizations who condemned its draconian nature and threatened to boycott, sanction, and withhold aid from the country if it was passed. Nigeria also had a proposed bill in Parliament in 2009—the Same-Sex Marriage (Prohibition) Bill—that would criminalize, among other things, same-sex sexual relations and unions and LGBT organizations and spaces (Nsehe, 2011). These efforts effectively sparked an international debate on sexual rights and revived discussions of the inclusion of sexual orientation and gender identity (SOGI) in national and international human rights law. The debate, which played out most visibly in the international community, including the UN, caused
a polarization between nations that do not support the protection of SOGI in human rights law and those who do, with many African states dissenting.

The United States, under the leadership of then Secretary of State, Hillary Clinton, even launched a global strategy to support LGBT rights around the world under the Global Equality Fund (GEF) in 2011, under the Secretary of State’s Office of Global Partnerships (Geiger, 2011). U.S. President, Barack Obama, who gave the directive for the GEF, “issued a memo ordering American diplomats abroad to advance the rights of [LGBT] persons” (Nsehe, 2011). During this period, he also threatened to withhold aid from Nigeria and Uganda in response to their proposed bills (Nsehe, 2011). In response to these threats, which also came from other Western nations such as Britain, many African heads of states asserted their cultural and political sovereignty, arguing that homosexuality is un-African and that Western governments could keep their aid (Nsehe, 2011; Onishi, 2015). As Zakari Mohammed, a Nigerian lawmaker, stated in response to Obama’s threat,

We have a culture. We have religious beliefs and we have a tradition. We are black people. We are not white, and so the U.S cannot impose its culture on us. Same sex marriage is alien to our culture and we can never give it a chance. So if [Western nations] withhold their aid to us, to hell with them. (Nsehe, 2011)

A “heterosexual” continent whose LGBT population was virtually ignored by both the West and many of the continent’s government just a decade before was now being condemned internationally as oppressing its LGBT citizens—launching what some have termed “culture wars” (Kaoma, 2009).

The debate and controversy surrounding the Uganda anti-homosexuality bill—and to a lesser extent the Nigerian bill—dragged on for years as international and local criticisms stalled the passage of the bill, until a version of it was eventually signed into law February 2014. Despite the Constitutional Court of Uganda’s ruling of the Act as invalid based on a technicality soon after it became law, the social and political damage against LGBTQ Ugandans and within the continent at large had already been done. In Ghana, specifically, the international debates
about the Uganda bill had a significant impact. From radio to TV stations, online news and print media, religious, academic and political institutions, the Ghanaian public was engaged in discussing homosexuality.

While conducting my pre-dissertation work in Summer 2011, public discussions about homosexuality were endless. One of the public discussions I observed about homosexuality was a staged debate and open forum discussion that a socialist activist invited me to that July. The debate, which was between Fellows of the Moremi Initiative for Empowerment And Leadership Development (MILEAD)—a young African women leaders fellowship—and students from the University of Ghana, Legon, was on the topic, “Same Sex Unions Should Be Legalized in Africa & Couples Be Given Equal Rights as Their Heterosexual Partners”. The MILEAD Fellows on the affirmative side argued that gays and lesbians were human beings deserving of rights and constitutional protection, while the Legon students on the negative side argued that homosexuality should not be protected because it is immoral and does not allow for procreation. The debate was attended by some members of CEPEHRG and of the LGBTQ community, as well as some students and members of the university community. The discussion was telling: the affirmative side had very few, although strong arguments, in support of their position, while the negative side had endless reasons for opposing same-sex unions.

**Imperialism, Sovereignty and Ghana’s Clash with its Former Colonizer**

In the context of increasing international polarization on the question of LGBTQ rights in Africa, Ghana, along with other African nations, also came under Western scrutiny for its unnatural carnal knowledge criminal code. Ghana’s most vocal critic from the West, ironically, was its former colonial ruler and architect of the criminal codes in question, Britain. Specifically, the then British Prime Minister, David Cameron, threatened to withhold aid from African nations during the Commonwealth Heads of Government Meeting (CHOGM) that was held in Australia from October 28 to the 30 in 2011 (BBC News, 2011a). According to reports, among the specific
countries that Cameron’s administration had raised their concerns with was Ghana, although it is not clear whether these concerns were raised at CHOGM (BBC News, 2011a, 2011b). Cameron stated that nations that receive aid from Britain should “adhere to proper human rights” (BBC News, 2011a). The statement was in tandem with a recommendation by the CHOGM reform panel, which released a 200-page internal report on human rights reforms that Commonwealth members were recommended to make. Among the recommended changes in the report was the decriminalization of homosexuality. However, due to major differences between member states, the group could not reach an agreement on the recommendations (BBC News, 2011a).

Cameron’s comments caused a major uproar in a number of African nations, including Ghana. Various figures in Ghanaian society, from politicians, to media pundits, religious figures, and civil society members all chimed in about Cameron’s criticisms. While there were a few who in the minority who agreed that Ghana should ensure LGBT rights, most people were enraged; who was David Cameron to tell Ghanaians what their country should be doing? And to threaten to withhold aid unless the country gave homosexuals rights? Well he could keep his money! The then president, John Evans Atta Mills, acting on his own accord but also in response to pressure from fellow politicians and civil society, responded strongly to Cameron, asserting Ghana’s sovereignty and distinguishing his country’s “norms and ideals” from those of Britain. Never mind that the laws in question were legislated under British colonial rule and ratified under constitutional review since independence. As an article from Joy FM’s online publication, myjoyonline.com, stated, the president “talked tough” in response to Cameron’s threats. In a video statement, the President said,

No one can deny Prime Minister Cameron his right to make policies, take initiatives or make statements that reflect his societal norms and ideals but he does not have the right to direct other sovereign nations as to what they should do especially where their societal norms and ideals are different from those which exist in Prime Minister’s society…I as president of this nation will never initiate or support any attempt to legalize
homosexuality in Ghana…Let me also say that [whilst] we acknowledge all the financial assistance and all the aid which has been given to us by our development partners, we will not accept any aid with strings attached if that aid will not insure to our interest or the implementation or the utilization of that aid with strings attached would rather worsen our plight as a nation or destroy the very society that we want to use the money to improve. (Joy News, 2011b)

The Cameron story became one of the most controversial public discussions about homosexuality in 2011. As I’ve written elsewhere (Gyamerah, Forthcoming), it served as one of the main triggers for a moral panic about homosexuality, with the print and digital media becoming a public platform for a number of political, religious, social, and civil society actors to debate the nature of homosexuality. Many Ghanaians—who had been critical of Mills over other domestic issues—rallied behind the president for rejecting “gay aid”. Some associations also renounced Cameron’s threat, such as those reported in an article on “women groups of the three religions – Christianity, Islamic and Traditional in the Northern Region” that had “resolved to work to discourage same-sex relationships emerging in the Ghanaian society” (Ghana News Agency, 2011b). This collective of women argued that they would fight against Cameron’s threat to withhold aid: “We prefer to die of lack of his support [than] to reduce ourselves to the level of animals—homosexuals and especially to go against our faith, the divine law and our culture and tradition” (Ghana News Agency, 2011b). In a country with a history of religious tensions between Christians, Muslims, and traditionalists, homosexuality had the power of bringing harmony among religious rivals. Another media commentator proclaimed that Cameron and Obama’s actions reeked of Western imperialism and hypocrisy, “Who the heck are these imperialists to tell us what to do as a sovereign nation? If President Obama thinks that gay rights is good for the Americans, why didn’t he call for its legislation in all the 50 American states” (Coffie, 2011)?

While most in Ghana supported Mills’ defiance of Western threats to the country, human rights lawyer, Nana Oye Lithur, offered perspectives that challenged President Mills, insisting that gay Ghanaians are human beings and thus should be afforded constitutional rights that
other Ghanaians enjoy. Lithur, the founder of Human Rights Advocacy Centre (HRAC), an NGO I worked with while in the field, had been an outspoken figure over the years on the question of rights protection for LGBT Ghanaians, even as she has insisted that she did not support homosexuality. She contended, “Not even the President of Ghana can deny anybody human rights irrespective of the person's sexual orientation, ethnic group, gender and what have you. These are guaranteed in our constitution and everybody in Ghana has an obligation to respect that constitution” (Citifmonline, 2011a).

Perceptions of Homosexuality in Ghana

Homosexuality a “No-Go” Area

As some of my policymaker informants stated, homosexuality is a “no-go area” in Ghana. This is because it is a politically and morally charged topic that has come to elicit an emotional response from many Ghanaians. If one is deemed a homosexual or supportive of homosexuality, one risks becoming socially ostracized and losing friendships, family, and respect as a result. When I first arrived to Ghana to conduct my field research, I embarked on a strenuous apartment search that sent me to all corners of Accra. As part of the process, I met a number of prospective landlords who wanted to learn about what I, a Ghanaian-American, was doing back in Ghana. I didn’t always share the full details of my research, often omitting that my research examined HIV, specifically among men who have sex with men—a term that is useful in public health but that also sounds alarms in Ghana due its explicit description of homosexual sex. Sometimes, I would use my discretion to decide when it was safe to describe my research and in those instances, people’s reactions, whether silent or vocal, were quite charged with meaning. In some cases, people would offer their opinion while in other cases, people silently conveyed their dismay through body language. In one of these instances during an apartment viewing, I informed an older, retired Ghanaian professor who rented apartments to visiting students and scholars, about my research. Upon hearing that my research was on men who
have sex with men, she became visibly upset and suggested in her response that homosexuals were trying to take over Ghana. She even substantiated her belief that there was a homosexual agenda by making a reference to the U.S. and British threats to withhold aid from Ghana.

Such perceptions about homosexuality have been commonplace in Ghanaian society over the past decade. The print, broadcast, and online media have been the most publicly visible platforms for these discussions, with contributions from politicians, religious figures, and other Ghanaians. But other social institutions and spaces such as governmental, religious, educational, and familial/community institutions and groups have also served as a platform for these conversations. The ideas disseminated in these spaces have both reflected and constituted much of what Ghanaians think and believe about homosexuality, with a majority staunchly opposed. These attitudes, beliefs, and norms about sexuality reflect much of the heterosexist and homophobic notions of human sexuality, gender, intimacies and desires and shape the lived realities of gay, bisexual, lesbians, sasoi and other MSM in Ghana.

Countless media stories discussed the topic of homosexuality prior to the Cameron incident in 2011. Headlines like, “Of Gay Rights, Obama, and the Threat to Cut Foreign Aid”; “Ghana MP defends UK’s Pro-Gay PM; Gays are Humans & Must Enjoy”; and “Same Sex Schools; A Breeding Ground for Homosexuality” were rampant. The coverage that year reflected much of the usual discourses about homosexuality in Ghana. Of note, the media depicted same-sex sexualities in an overwhelmingly negative light, although divergent views existed. As my article on media coverage on homosexuality (Gyamerah, forthcoming) describes, Ghanaian media has utilized all sorts of terms to refer to same-sex sexualities—terms that can also be heard among the public. These include “gayism”, “gay”, “bisexual”, “lesbianism”, “lesbian”, “homosexual”, and “homosexuality” although the last two are the most commonly used publically. Often, media stories refer to same-sex sexualities in terms of specific sexual acts—particularly anal sex—and usually target male same-sex sexualities. Female same-sex sexualities, on the other hand, or lesbianism as it is often referred as, are rarely discussed.
When “lesbianism” is discussed, it is commonly in regards to female-female sexual intimacies in secondary schools—a well-known phenomenon about which Serena Dankwa has written extensively (Dankwa, 2009b). In effect, male homosexuality has become hyper-visible while female homosexuality is less visible. Homosexuality has, thus, been gendered and hyper-sexualized—rendered in the public imaginary as connoting men having anal sex with each other. When self-professed anti-gay people comment on the radio, in print news, and social media about homosexuality, they commonly discuss the anus. Their concern? How can people have sex using an area God created for discharging excrement? The argument continues, not even animals engage in such savage behavior.

These discourses not only construct homosexuality as unnatural, they also construct it as threat to the very existence of Ghanaian society. Particularly, a common argument against homosexuality is that it is impossible to procreate through same-sex relations—an argument that is commonly made in many other parts of the world. If homosexuals cannot procreate and the government allows them the legal right to be with each other, then Ghana is effectively allowing for its own demise. The population will eventually decrease and this depopulation will soon lead to extinction. As one news article reported, a Ghana Muslim Student Association’s (GMSA) statement against homosexuality condemned the “practice” as posing a threat to humanity, “The communiqué said granting homosexuals the freedom to carry out this immoral practice would pose a threat to the survival of humanity, as homosexuals could not procreate” (Ghana News Agency, 2011f).

In addition to the media’s homophobic discourse, public opinion among the general population on homosexuality is predominantly negative. While quantitative data can masquerade complex social processes, a few surveys over the past five years provide a useful snapshot of perceptions of homosexuality in Ghana. In a 2013 study that surveyed adult populations in 39 countries representing six regions of the world, the Pew Research Center (2013) found that 96% of the 799 Ghanaians surveyed felt society should not accept
homosexuality. On this particular question, Ghana tied in third place with Senegal (96%) and Uganda (96%), and was surpassed only by Jordan (97%) and Nigeria (98%). Moreover, the study found that the more religious a country was, the less likely it was to accept homosexuality, with Ghana ranking as one of the most religious countries in the world. Another Pew study reported Ghana as the least likely to find homosexuality morally acceptable out of 40 countries surveyed, with 98% of surveyed Ghanaians indicating that it is morally unacceptable (Pew Research Center, 2014). Only 1% of Ghanaians found homosexuality morally acceptable, while another 1% indicated it was not a moral issue. Other countries in the region were less likely to find homosexuality unacceptable including Uganda (93%), Tunisia (92%), Kenya (88%), Nigeria (85%), Senegal (68%), and South Africa (62%).

A more local study in 2011 corroborates findings that place Ghana near the bottom of the list of countries accepting of sexual diversity. (Nzambi, Bevalot, Till, & Dzokoto, 2011) The study was funded by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)—a German international development agency primarily funded by the German government—and with the support of the Ghana AIDS Commission (GAC). It examined “stigma and discriminatory attitudes and perceptions towards most at risk populations” for HIV, defined as FSW, MSM, and IDU as well as PLHIV, in an effort to better understand and address their barriers to HIV prevention and care. The most interesting findings of the study were from a survey on stigmatization of MARPs that was conducted in Accra and Tema in 2009, which surveyed adults recruited from churches, mosques, public markets, as well as police at police stations. In terms of stigma and social exclusion, the study found that 69.1% of the general population surveyed would not knowingly invite MSM to their home, compared to 59.1% for FSW and 73.6% for IDU. Moreover, 54.8% believed MSM should live separately from the rest of the community.

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11 The study measured a respondents’ religiosity “by whether they consider religion to be very important, whether they believe it is necessary to believe in God in order to be moral, and whether they pray at least once a day” (Pew Research Center, 2013).
compared to 35.1% for FSW and 40.5% for IDU. Interestingly however, when asked whether MSM should be excluded from their families, only 36.7% said yes, compared to 26.9% for FSW and 57.6% for IDU. In terms of the legal issues, 65.3% responded that the police should arrest MSM, compared to 63.3% of FSW and 78% did not think Ghanaian law should be changed to decriminalize MSM, compared to 75.3% for FSW. Despite these views, people thought MSM should be allowed to work (69.7%), that they should have access the National Health Insurance Scheme (78%), and that those who are positive should be given equal access to treatment as other PLHIV (79.9).

**Religious Groups as Moral Crusaders against Homosexuality**

Religious figures have been some of the most vocal and influential critics of homosexuality in Ghana. Most visibly, Christian and Muslim leaders, I contend, have been the loudest, most organized anti-gay forces over the past decade—acting as moral crusaders against homosexuality. With 88.8% of the population identifying as Christian or Muslim, religion plays an important role in nearly every Ghanaian’s life. Moreover, due to Ghana’s high levels of religiosity—as indicated by a WIN-Gallup International survey (Gilani, Shahid, & Zuettel, 2012) that ranked it as the most religious country in the world—these religious figures have the biggest influence on the beliefs and values of ordinary Ghanaians. This religiosity has a high correlation with anti-gay attitudes as the Pew Research Center (2013) study indicated. In effect, the influence of religious groups, leaders, and beliefs has had a significantly negative impact on the meanings, representations, and ideas about homosexuality.

Religious actors have used print and broadcast media as a platform for condemning homosexuality, in part due to the moral authority Ghanaian society has granted them but also due to the close relationship media outlets have with religious leaders and institutions. For instance, in July 2011, during one of the many moments of moral panic against homosexuality that year, the Ghana News Agency (GNA), openly reported meeting with religious leaders from
the Apostolic Church of Ghana to discuss ways the media and religious leaders can collaborate to fight against homosexuality. As reported by the GNA, the church delegation met with the Agency’s then-General Manager, Mr. Boakye-Dankwa Boadi, “to formally introduce the newly elected leaders of the Church and to have a formal interaction with the leadership of the GNA about how the two sides could effectively collaborate to move the nation forward” (Ghana News Agency, 2011a). Although the meeting was about the two groups collaborating to address the moral issues facing Ghana, the emphasis was on “homosexuality and lesbianism”, which one of the leaders present, Apostle Abraham Ofori-Kuragu, reportedly said “was gradually gaining hold in the society”—a trend he hoped the Church and GNA could “reverse”. In response to these requests, Mr. Boadi, whose Agency holds the motto “Speed, accuracy, and objectivity”, “assured the visiting delegation that the Agency would lend its support in the fight against homosexuality and lesbianism as those practices ran contrary to true African values” (Ghana News Agency, 2011a).

Religious actors’ access to the media has meant that over the past 5 years specifically, these actors’ views on a range of international and local developments regarding homosexuality have been amplified. One such development was in 2013, when Ghanaian President John Mahama found himself at the center of a public attack that made international news. Soon after President Mahama assumed office in 2012, following the death of President Mills, news outlets began to report that he received a $20,000 towards his 2012 presidential campaign from a well-known gay American writer and philanthropist, Andrew Solomon, with whom he had a personal relationship. This, for the public, the media, and Mahama’s political rivals, the New Patriotic Party (NPP), was a sign that the president and his party were complicit in the promotion of homosexuality in Ghana. One of the country’s major newspapers, The Daily Guide, even went so far as to suggest that the president was in a romantic relationship with Solomon (Peace FM, 2013). The controversy surrounding the president’s relationship to Solomon forced Mahama to publicly respond and distance himself from Andrew Solomon (Essel, 2013). In a media
statement, President Mahama publically asserted that he did not support homosexuality or gay rights and that, as President, he would uphold the unnatural carnal knowledge laws of the country:

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\text{The President is to execute the laws of Ghana. And the laws of Ghana are very clear on homosexuality. The laws of Ghana appall and criminalize homosexuality, there is no dispute about that. Homosexual conduct which is unnatural carnal knowledge of one person or another is criminal and punishable by the laws of Ghana.}
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About a week later, Solomon was also forced to debunk the rumors that he had a romantic relationship with President Mahama in a *New York Times* article (Solomon, 2013), titled, “In Bed with the President of Ghana?”

One of the most influential churches in the country, the Presbyterian Church of Ghana, contributed to the accusations against the president, when Professor Emmanuel Martey, the moderator of the Presbyterian Church of Ghana, stated that “gayism” was “Satan’s deadly practice” trying to influence the president. He reportedly insisted in a media statement that “this is the reason why acclaimed and notorious homosexuals want to attach themselves to Ghana’s presidency to gain access” (XYZ News, 2013). For Martey, who is also a reverend, Solomon’s relationship with Mahama was an indication that the devil, manifesting itself through homosexuals like Solomon, was cozying up with people in power to lure Ghana into a dark direction. These statements were consistent with others by the Presbyterian Church, which has been one of the most vocal and prominent religious institutions against homosexuality. In fact, the Church made the news when it fired one of its pastors for engaging in sexual relations with multiple male partners (XYZ News, 2013).

Apart from religious actors’ responses to controversies surrounding homosexuality, they have also led efforts to influence Ghanaian society against same-sex sexualities. One such instance was in July 2011, when the Christian Council of Ghana (CCG), one of the oldest and most influential religious organizations in Ghana consisting of 31 Christian churches and organizations, came out against homosexuality in a press conference in Accra. In the press
statement, the church condemned homosexuality and called on Christians to pressure politicians who may support it. The statement also made a warning to any politicians who may be sympathetic to gay rights. Dr. Fred Deegbe, the General Secretary of the Council, stated:

We call on all Christians to vote against all politicians who promote and support homosexuality…We as a Christian community in Ghana totally condemn this as an unnatural and ungodly act and call on all religious bodies and organizations, traditional ruler and all decent loving Ghanaians to join in this campaign. (Joy News, 2011a).

Despite espousing to be additionally a “research based and advocacy institution” in areas such as “human rights and gender” and “social and economic justice”, the CCG remains one of the staunchest critics of same-sex sexualities in Ghana. Despite these publically known views, the CCG has received funding for HIV/AIDS work among some KPs.

Christian groups have not been the only religious actors to publically condemn homosexuality. Muslim groups, such as the GMSA, have also made public statements in an effort to rally their base against homosexuality. The GMSA issued a statement in 2011, just days after the CCG. The association encouraged religious and traditional leaders as well as politicians to “speak vigorously against the practice and discouraged them from giving any form of support to people suspected to be gays or lesbians” or those who support them (Ghana News Agency, 2011f). The following month, Muslim leaders in the Western Region of Ghana petitioned the government to take action against homosexuality because, according to Joy FM, the leader of the group, Sheik Abdul Aziz, reportedly stated that homosexuals were destroying Ghana and that “they are defying the manner that Allah created man” (Adogla, 2011). The Federation of Muslim Councils (FMC) also released a statement in 2011 that called on “Parliament to enact a law that would make homosexuality a punishable offence, whether practiced publicly or in private” (Ghana News Agency, 2011g). This was followed by yet another anti-gay statement months later by the president of the Ladies Association of the Ahmadiyya Muslims Mission, Hajia Sadika Bonsu Yeboah, who reportedly stated that “the negative
influences of human rights” were to blame for the rise of homosexuality in Ghana (Ghana News Agency, 2011h).

One of the most significant developments regarding organized opposition against homosexuality has been the formation of the National Coalition for Proper Human Sexual and Family Values. The Coalition consists of different Christian and Muslim groups and “traditional authorities” who warn that any legislation that provides rights to homosexuals would “destroy the basic unit of society” (Abbey, 2013). This coalition was launched in 2013 to support “politicians to rise up against Western influences which include the menace of homosexuality” according to one of the founders of the coalition, Emmanuel University President Moses Foh-Amoaning (Daily Guide, 2013). According to Foh-Amoaning, the coalition aimed to take a non-violent approach to addressing homosexuality by reaching out to youth, hosting forums, and working with the counseling unit of the Ghana Education Service (Abbey, 2013).

In addition to these organized anti-gay religious forces, religious leaders and groups have used their own podiums to preach against homosexuality. For instance, Archbishop Nicholas Duncan-Williams, a famous preacher and founder of the Charismatic Church, Action Chapel International (ACI), has made statements against homosexuality. One such statement, released in December 2015, described how Christian leaders like the U.S. Evangelical pastor, Bill Graham, have been under attack for opposing homosexuality and the need for Christians to remain strong against “the homosexual agenda” despite this pressure. The statement, which was made on his public Facebook Page with a following of over 850,000, referenced the U.S. as particularly hostile towards Christians, especially those who oppose homosexuality:

One of the areas in the U.S. where the Christian faith is being challenged is the homosexual agenda. Many Christians are confused or do not know what stand to take although the Bible is very clear on homosexuality as well as other sins…Paul warned that in the last days, men will pay heed to doctrines of devils and endorsement of homosexual lifestyle is definitely a doctrine from hell. It is a demonic teaching that leads to death, not life. No matter how the world tries to justify homosexuality, God’s word
stands today and forever. We would do ourselves a great service if we held on tight to what God has said in His Word. Sin is rebellion towards God, and the wages of sin is death. Let us choose life and obey His word! (Duncan-Williams, 2015)

Beyond preaching on social media and places of worship, some have even developed literature preaching against homosexuality. One such group, the Pentecostal Church of Ghana—which boasts the largest Christian denomination following in Ghana—made Western news when a U.S. expat shared their anti-gay pamphlet on BuzzFeed.com, a popular U.S. online publication (C. Hall, 2013). The pamphlet (see Appendix C), titled “12 Reasons why Homosexuality is Unacceptable”, detailing all the ways homosexuality was wrong. The twelve reasons discussed biological/anatomical reasons, health reasons, and barriers to procreation. It also argued that “homosexuality destroys marriage and family life” as well as societies, that is against the law, and that all major religions “frown upon” it. Moreover, the pamphlet warned that “homosexuality is punishable in hell” and that “God’s wrath is upon homosexuals”.

Lived Experiences of Sasoi Ghanaians

For sasoi and other same-sex loving individuals, public meanings and representations of homosexuality, as well as the actions against it, characterize the social and political terrain in which they live. These conditions, in turn, impact their lived experiences in regards to relationships to their families, friends, communities, and the institutions that govern their lives. An understanding of these circumstances provides insights into the challenges and supportive factors that shape sasoi and other MSM’s access to HIV prevention and care services.

To gain a better understanding of these lived experiences, I interviewed fifteen saso Ghanaians between ages 20 and 31 years who live in the Greater Accra area. They represented ethnic groups from nearly every region of the country, including the Northern, Eastern, Volta, Central, Western, Ashanti, Brong-Ahafo, and Greater Accra regions. All of the participants had some form of formal education. Some had their Bachelor’s degree or were
pursuing one at the time of the interview, while some had taken one or more professional
courses related to their job interests. A handful of participants had a high school degree or less.
About half the group was unemployed or in college. The other half was employed or
underemployed. One was employed as a cook, one worked at their mother’s store, one worked
as an engineer, one worked at a television station, two worked in fashion as designers, and two
worked for NGOs engaged in healthcare and human rights work targeting LGBT populations. I
interviewed more lower-middle class Ghanaians, although numerous participants were from
working class backgrounds and more socially and economically marginalized communities, like
Jamestown in Accra.

Over the past five years, international representations of queer African lives, whether by
the media, NGOs, or development agencies, have commonly focused on the negative aspects
of their lived experiences, often portraying what Ellie Gore and I (2015) have described as the
“African homosexual”—a passive victim of state oppression in need of saving by the West. On
the other hand, popular representations of homosexuality in many African contexts have
portrayed what the NEST Collective (2015)—a multidisciplinary group of Kenyan artists—call
“the African Homosexual Story”. This story depicts homosexual Africans as “a creature of the
night, promiscuous, diseased, abused-when-young, a corrupter of innocent children, and a
godless, anti-family, anti-men, anti-society separatist”—a familiar story in the Ghanaian context
as the above analysis of popular discourse demonstrates. Both characterizations—one external
to the continent and one from within—represent two sides of the same coin. At their core, both
function to produce caricatures of queer Africans that obscure the diversity and realities of
same-sex sexualities, intimacies, and desires on the continent and both mutually reinforce each
other.

Given the caricaturized nature of such representations, it is important to preface this
section by disclosing that the predominantly negative stories shared by sasoi Ghanaians here is
related to the nature of my research questions, which focused on the participant’s experiences as sasoi people living in Ghana and in relation to their access to HIV/AIDS services.

**Kojo Besia: Gender Performance as a Marker of Sexuality**

During my field research in Accra, I would occasionally visit family members at my maternal grandmother’s house, which is also the home I grew up in until I left Ghana at the age of 9 years. Four generations of family members live in the house: my grandmother, my aunt, my uncle, my cousins, and my nieces and nephew. During one such visit, my 12-year old nephew was joking around outside, trying to grab the attention of the adults around him. At some point during his play, he started swaying his hips, flicking his wrist, and speaking with a soft, higher pitched voice in an attempt to appear feminine. In between laughter, my aunt responded, “Kojo Besia!” This was followed by laughter from both my aunt and my nephew, who have a close relationship with each other.

Gender performance in Ghana is a common practice that is often used in the realm of comedy, so when my aunt called my nephew Kojo Besia as a joke, I was not entirely surprised. As Karine Geoffrion (2013a) found in her study on male university “cross-dressers”, for some, “the objective of using random pieces of feminine clothing is to look ‘odd’ in order to create laughter” (p.5). Such practices can be found in movies and television shows (like in the 2013/2014 comedy, *Kwadwo Besia 1 & 2*12), in theatre performances, or at comedy shows in different social venues.

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12 A Ghanaian comedy film about a lazy, young, heterosexual man living with his mother in a small town who doesn’t have a job and has little aspirations for a career. After receiving money from his brother-in-law to start a small business, he decides to become a “bofrot” (a fried, sweet dough ball similar to a doughnut) seller. This prompts his friends and others in his community to call him Kwadwo Besia because “bofrot” vendors are commonly women and a man who engages in such business is considered feminine. The man, however, is not bothered by this and rather sees his gender-crossing venture as a source of attention from women and business.
But Kojo\textsuperscript{13} Besia is also an ideologically loaded term that has come to represent many negative connotations. As Grace Diabah (2016) has argued, it is a metonymic expression in the Akan language—specifically the Fanti\textsuperscript{14} dialect—that literally translates to “boy born on a Monday” (Kojo) and female (Besia). As other scholars have discussed, socially the term signifies a “man-woman” (Ajen, 1998), a man who is “a woman inside” (Geoffrion, 2013b), an effeminate man (Banks, 2013), or a man who acts feminine or performs roles that are expected of women (Geoffrion, 2013a). While Geoffrion (2013b) has suggested that it refers to “full-time transgendered males\textsuperscript{15} and “qualifies transgendered males who engage in traditionally female occupations”, this is questionable, as the term is not consciously or exclusively used to refer to transgender women.

To the best of my knowledge, none of the extant literature on Kojo Besia have elaborated on the etymology of the term. However, during one of numerous conversations I had with my mother about my research, I gained some insights on where the term might possibly originate from. While speaking about homosexuality in Ghana, my mother recalled a period in her childhood when she first learned of the term Kojo Besia. When she was in primary school in the mid-1960s, her parents would frequently travel between their hometown, Seniaja, and the capital of the Ashanti Region, Kumasi, and occasionally, they would bring her along. During one of those trips, my grandmother took her to the infamous Kumasi market to show her a person who was referred to as Kwadjo Besia, so that my mother would also know of him. This person, according to my mother, was “a tourist attraction” and was well known by many people in the region. They were also the only person in the region she knew of that was called Kwadjo Besia during her childhood. She believes the Fanti residents living in Kumasi coined the term

\textsuperscript{13} There are numerous spellings for the name Kojo, including Kwadjo, Kwadwo, and Kodjo. It is the name for a boy born on a Monday in the Akan language.

\textsuperscript{14} Fanti is a dialect of the Akan language spoken by the Fanti people—an ethnic group, predominantly based in the Central and Western regions of Ghana.

\textsuperscript{15} Based on the syntax, it seems that author meant transgender women.
specifically for this vendor (hence the Fanti word *besia*), which then became a more general term used for feminine men, “Mention [Kojo Besia] in Ghana and it points to him in Kumasi market”.

The vendor became an attraction in Kumasi because society saw a person they considered a man, dressed in kaba and slit[^16], selling dried herring fish in the Kumasi market— one of the largest markets in Ghana. From their clothing to their mannerisms, every aspect of this person’s being resembled a woman and this drew curiosity from within the city to the villages surrounding it. The vendor, according to my mom, was not performing for attention, “the man was minding his normal life in women’s clothes and earned a meaningful responsible life”. The attention they garnered did not attract violence, in the same way that many feminine presenting men do today, although one can imagine they did not welcome the attention and name-calling. My mother has no memory of what eventually happened to Kwadjo Besia. However, she explained that the term’s meaning had transformed over the years from something that mostly meant “a man [who] acts like a woman in all aspects” to something that means “gay” or implies homosexuality—a change that occurred more recently when homosexuality became more politicized in the country.

Although Kojo Besia was used in a light manner by my aunt, in modern day Ghana, the term represents many negative connotations. For sasoi participants I interviewed, *Kojo Besia* is a derogatory term that people use to insult, shame, and humiliate men who are perceived as feminine and thus, homosexual. It is akin, I would argue, to the Western homophobic epithet, *faggot*. As Paul, a 21-year old saso noted, “Sometimes, somebody walks like a girl, the person is not gay, [but] they call the person Kojo Besia”. Richard, a 25-year old saso added, “When they say Kojo Besia, that’s an insult. They are trying to insult you”. For some of the men, like 32-[^16]: Kaba (blouse) and slit (long skirt) are two-piece clothing commonly made out of African wax print cloth or other fabric and usually worn by women.
year old Michael—a well-known gay activist—the epithet is one of the most painful insults to which he is routinely subjected, stating that “It really hurts me when people call me Kojo Besia”.

Many of the insults that saso people experience, like Kojo Besia, result from their gender presentation and gender non-conformity. Another such insult according to some of my interviewees is ɔbaa barima. This term literally means “woman-man” and is used for men who are feminine or, as one interviewee put it, considered a “girly type”. Notably, however, this term is more commonly used for women who are masculine-presenting, partake in gender roles assigned to men, or as Diabah (2016) explains, “perform certain tasks or behave in ways considered as stereotypically masculine” (p. 179). For women, the terms have both negative and positive connotations. For example, as Dankwa (2013) has discussed, economic independence or success can also earn a woman the name, ɔbaa barima. However, the term is more stigmatizing than not and has more negative connotations, especially for men. ɔbaa barima, like Kojo Besia, is a term that is assigned to gender non-conforming people. And such people, by virtue of diverging from expected gender roles, are labeled homosexual, whether or not this is indeed true. Many saso Ghanaians, then, are caught in this “heterosexual matrix”, to borrow Judith Butler’s term, that “assumes that for bodies to cohere and make sense there must be a stable sex expressed through a stable gender (masculine expresses male, feminine expresses female)” (Butler, 1999; p. 194).

One of the vilest slurs saso Ghanaians are called is trumu trumu. The word trumu means asshole or anus in Twi. It also means anal sex as a short hand for “odi trumu”, which literally means “they eat” the anus” or figuratively, “they have anal sex/have sex in the ass” or more crassly, “they fuck in the ass”. There is also trumudi fuo, which means people who fuck assholes. Trumu trumu came up numerous times when my interviewees discussed local terms that are used to refer to homosexuality. For them, the term is “very nasty”, “very offensive”, and

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17 Eat is a euphemism for sexual intercourse in Ghana.
“very awful”. The term has not been discussed much in the extant literature, but Hannah Hilda Awoame’s Master’s Thesis discusses the use of *trumu trumu* as a description of anal sex in male prisons, where inmates engage in consensual or forced sex/rape due to a number of factors. If sex in general is not explicitly spoken about in Ghana, anal intercourse is even less discussed by Ghanaians, in part, because of the Unnatural Carnal Knowledge code and because it is considered unnatural, taboo, and filthy. The term *trumu trumu* (or *trumu* for short), then, is used to humiliate saso and other men who have sex with men and again, more feminine saso individuals are most targeted by this insult. Moreover, it reduces saso Ghanaians’ identities to one sexual act—anal sex.

In addition to these terms, one notable finding was the emic or local construction of the term homosexuality in Ghana. Particularly, while homosexuality is descriptive term in the West, my interviewees described *homosexual/homosexuality* and to a lesser extent, *gay*, as demeaning terms in the Ghanaian context. As one interviewee stated, the terms *homosexual* and *gay* are “too harsh” and “derogatory”, adding that not many people “would like to be identified” as that. He explained:

*I know that a lot of Ghanaians will not want to be associated with [being homosexual]. Most of them will tell you that I am bi[sexual]. I just have sex with men but I am not gay or homosexual so a man who has sex with a man period. [MSM5]*

Another shared that “In our part of the world…it is a very big insult…I mean between gay and homosexuals, gay for most people is the lesser evil….Homosexuals word is very derogatory”. While some disliked both gay and homosexual, one of the interviewees preferred gay over homosexual and distinguished the two from each other. According to Richard, a 25-year old saso who works in film production, *gay* refers to a man who *loves* another man, while *homosexual* refers to a man who is only interested in having *sex* with men. The former is more intimate and romantic, while the latter is solely about *sex* and nothing more. He explained:
There is a different meaning from someone you call homosexual and there is a different meaning for someone we call gay. When you go into the dictionary now, a gay man is a man who falls in love with his fellow man and when you love someone you wanna have an affair with the person. You want to make love to the person, you want to be with the person, you want to share your life, your sorrows, your happiness, your everything with the person. That’s a gay man. Now that’s what the dictionary’s description is…a homosexual man is, a man who likes to have sex. That’s MSM, a man who likes to have sex with his fellow man. He doesn’t love you, he sees you, “I want to sleep with you. I want to sleep with you”. That’s homosexual so it’s two different things. That’s what people are getting wrong. Everybody going around they are saying MSM, MSM but look there is a gay man and there is a homosexual man, it is two different things.

Saso Ghanaians’ rejection of homosexual/homosexuality and even, gay, is of course a direct outcome of the overwhelming negative constructions and perceptions of homosexuality by religious leaders, the media, politicians, other governing institutions, and thus, society as a whole. However, as another interviewee stated, he is more receptive to the term if it comes from another saso person: “If a fellow MSM says it. I’m cool but if an outsider says that word I don’t like it”.

In such a stigmatizing, homophobic context, saso Ghanaians have developed instead, a number of terms that they consider more representative of their desires and sexualities. The most preferred of these terms is saso/sasoi. In addition to what other scholars have described about the term saso (Banks, 2013), interviewees shared that it is the most commonly used word—or as one explained, an “umbrella term”—to describe men who are interested in same-sex love and intimacies. Saso is a term from the Ga community that means brother or friend but as Joseph stated, “People know that when you say saso, you’re a homosexual, gay”. Another defined it as “my colleague” or “co-equal” and believed the term was developed by “big women” in LGBT networks within the Ga community, who “see the men who skirmish like them they say “Eh, this is my co-equal. Like we’re all women”. In this sense, the term is also very gendered—a respectable term used to refer to feminine, gay men. Moreover, as Kwa, a 29-year

18 “Co-equal” is slang one uses to refer to someone else whose character, qualities, looks, etc. are comparable to or on the same status as you. It holds the same meaning as “equal” but with “co-” added for emphasis.
19 Saso interviewees used “skirmish” to describe feminine movements and mannerisms.
old feminine identifying saso explained, people in the community prefer saso because, unlike gay or homosexual, it is less known by those outside of LGBT networks, and thus, it is safer for people to use:

“Homosexuality” everybody goes vociferous about it [when they hear it]. “Gay” everybody knows and then saso people don’t know. Unless we the MSM people when we meet we understand each other and then we say saso…it’s foreign to most people, especially the heterosexual's sector.

As O’Mara (2013) has argued, saso Ghanaians’ lexicon consist of “gender binaries and Ghanaian cultural references”, “playful expressions”, as well as, in my findings, gendered sexual roles. This lexicon, Banks (2013) adds, draw on “local cultural practices and concepts to articulate their identities and structure their social world” (p. 17-18). This lexicon is reflected in the terms saso people use to identify themselves. In addition to saso, my interviewees identified the following as terms used to refer to same-sex sexualities among their networks: kekele, zai, TD, and yag. As one person shared, different terms are used depending on which “clique” a person is in. These cliques are differentiated by class, ethnic group, community or neighborhood and other social markers, although many of those who shared local terms with me did not know the roots or meaning of these terms. For example, one person described kekele as a term without any particular meaning, “Its just a made-up word. It doesn’t mean anything in any Ghanaian language. Its closer to the Ewe word Kekely but that is a name”. Yag is backslang for gay and the men use it so that others around them do not pick up on what they are saying.

In addition to these, interviewees mentioned maame and auntie as well as papa as terms used in the community, “We use Saso. We use top. We use bottom. We use versatile. We use Maame. We use Papa”. Maame and auntie refer to more feminine sasoi people. They also refer to a person who is a bottom or is being penetrated in sexual intercourse. Papa on the other hand is used to refer to masculine sasoi people or a top/penetrator in sexual intercourse. Interviewees shared that sometimes they give other female names as well for fun or to tease each other:
Among ourselves, we have our own female names. Maybe if you are called Evans, they would call you Evania. If you are called [something else] someone would give names like Kukua. We give ourselves female names just to tease each other.

Other terms mentioned included *obaa* (girl or woman) and *mi nua* (my sibling/my sister). For saso people in Ghana, these terms are safer to use than gay or homosexual, “Everybody now knows gay and homosexual but the saso, the *yag*, the *auntie*, the *maame* are [less known].”

**Saso as an Evil Practice**

One of the most revealing parts of my interviews with saso Ghanaians was the overwhelmingly negative answers they gave in response to what Ghanaian society thinks about homosexuality. As interviewees shared over and over again, in Ghanaian society, homosexuality is viewed as dirty, demonic, evil, a curse, un-Godly, un-Ghanaian, and a mental or sexual disorder. The following responses from the interviews demonstrate the dominant discursive construction on homosexuality.

*Some think [homosexuality] is just fun, that people just like too much fun. To some people, they are devilish. For some people (they) think it’s a mental disorder or sexual disorder. Some people think they are not that religious.*

*They always say this, that saso is an evil practice. That’s their perception. What they normally say is “It’s the work of the devil. This is evil so you need to go to church for prayers”, whilst most of them are doing it. But when they see you, they say, “Oh, this is the work of the devil, you have to go to church, you have to go to prayer camp”—a whole lot of things.*

*In Ghana, they see those people as demons, devils in disguise.*

*Some would label us a devil. Some would label us a demonic act. Some would say this is un-Godly, this is not “Christ life” and you know most of them zoom it to the religious sector…Now this is their cliché, that God didn’t create Adam and Steve. He created Adam and Eve.*

*Gay people are evil, they are devilish, they take advantage of people, they influence people with their money, they are into voodoo, I mean all kind of things.*

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20 “Christ-life” means a Christian lifestyle in which one’s life reflects the values preached in church as the word of Jesus.
As these statements demonstrate, much of the anti-homosexuality discourse is laden with notions of demonic, spiritual/supernatural possession or power and other such beliefs that construct same-sex sexualities and intimacies as forces of evil. Such beliefs are not isolated to homosexuality but are rather consistent with local indigenous and religious belief systems that rationalize daily occurrences and incidents through the framework of the spiritual.

Related to the notion of evil spirituality is the construction of homosexuality as a curse, either by God or another spiritual being. The logic is that homosexuality is the curse or homosexuality is a product of a curse. This idea is directly related to religious and traditional beliefs that bad fortune can be explained by a curse or the presence of evil spirits that can be prayed away or exorcised. Boat, a 31-year-old who is gay/saso identified shared that his family often blames his homosexuality whenever things do not go well for him. He explained that they believe that it brings "bad luck unto yourself, unto your family, and unto anybody that will come into contact with you". He explained:

Anytime I get sick of something, general illness, malaria, stomach ache, my family, some of my family members will be quick to or anytime I am doing something, trying to do and it doesn't go through and it doesn't work, they will say "okay it is because [of homosexuality]." That is why I say [in response] that things go wrong all the time, things go wrong for the government, things go wrong for everybody, businesses collapse. So what is different? They will quickly remind you that it is because you do this (engage in homosexuality], that is why.

These ideas are echoed in the media and society at large, “The religious leaders have been talking against [homosexuality]. Teachers, lecturers, have been talking against that. I think the government; they’ve been talking against that”, explained Jack, a 21-year old who identifies as bisexual. Some of these actors even go so far as to blame national crises, like Ghana’s economic recession, on saso and other same-sex loving people. Robert, a 20-year old bisexual guy, shared some of these social beliefs about homosexuality bringing bad luck:

I’ve heard of that issue where someone will say the economy of Ghana has become difficult these days and the other fellow will be like "Why wouldn't it be? These days, gays and homosexuals, these MSM are all over. They're bringing curses to Ghana." They are attaching these archaic perceptions towards it and they see it to be something
demonic. They see it as so demonic to the extent that they feel if you indulge in it, it’s either you don’t have a family or you’re a rascal or something.

These notions of homosexuality as evil or a curse are not merely ideas, but ones that those who hold them act on in order to halt or eradicate the perceived destructive impact of the “act”. Eddy, a 25-year old who described himself as no longer interested in homosexuality, described the different calls to action people suggest against homosexuality and how these calls psychologically affects saso people and how this seems to also discourages some same-sex loving people to reject homosexuality altogether.

They say it’s evil, it shouldn’t be accepted. Those people should be dealt with. Those people should be imprisoned. Those people should die. They should kill them. In fact, people are dying. They are going through a lot. So I can’t stand that. And if my son or a brother of mine happens to be one I will pray to God to help the person to come out [of homosexuality] as I have been able to come out.

While a majority of saso interviewees discussed negative social perceptions of homosexuality in Ghana, a few also described knowing people who “are cool” with it. Jack explained that some people, particularly friends, and even straight neighborhood guys, can be understanding if they know “you are one”—a common euphemism used by saso people to refer to other same-sex loving people. He even suggested that some of these men are curious about homosexuality but don’t know how to initiate same-sex relations.

When they know you are MSM, the way they will approach you is different. I think when you are, let’s say, if your friend knows you are one then he will understand too. They will act to you differently because they know you are this. Do you get it? But sometimes other people too are very open. I know even most of the street guys, I know some of the guys, most of the straight guys want to go into it but they don’t know how to go about it.

Quotidian Sexual and Physical Violence

Tony, a saso guy in his 20s, moved from the Eastern region of Ghana to live in Accra a few years ago. Prior to moving to Accra, he was not aware of “guys who sleep with guys”, although he noticed he “had feelings for [men]”, even when he had a girlfriend. He came to learn about saso people when he became friends with a gay man after moving to Accra, “I said,
“Chale 21 what’s up? Can you help me? I need money. So he said, ‘If you need money then you have to do this [have sex with me] before the money’, so I agreed”. While this might be viewed as an instance of “gay-for-pay”—a term used to describe men who solely have sex with other men for money—this was not the case for Tony, who confirmed after that experience that he was gay.

Tony was one of several interviewees who had experienced violence due to their saso sexuality. He, along with many other saso victims, has been affected by online scams that use the country’s criminal codes to exploit saso people. His case was unique because in at least two separate occasions he was a victim of homophobic mob violence and robbery after being deceived by online scammers—known as gaunkaw 22 boys. In one of those incidents, he had scheduled to meet up with a man he had been chatting with for a month on Gay Romeo (currently known as Planet Romeo), an online social networking site for bisexual, gay, and transgender men.

He asked me to come to his place and I said, “No, we need to meet somewhere first”. So I met the guy at Circle 23. So, we met, we chat “Hi, hi, hi”. He said, “Okay”. So after the guy went home, 3 days later he invited me to come over to his place, so I thought I have met him, we’ve chat, so he’s safe.

After meeting this man in person, Tony felt reassured about his intentions and scheduled to meet up with him again at a residential area in Lapaz, Accra—a less trafficked area. While they were walking down the road, about 20 men came out and surrounded him. He recalled that they started yelling, “Ey! This is what you have been doing?” and started attacking him,

So they beat me up, they stripped me. I was left with my boxer shorts and I had to run for help and luckily for me there were some guys who were working around, so they had to fight and help me escape, run away from them. They had taken my money and so [the guys helped] pick me a taxi to come back home. So it was like a terrible experience for

21 Chale or Charlie is slang for friend or buddy.
22 Gaunkaw is spelled phonetically based on interviewees pronunciation. I was unable to get an official spelling of it from my informants.
23 Circle is the short-name for Kwame Nkrumah Circle, one of Accra’s busiest commercial and transportation hubs.
me. And even I came back home, my friends were asking me but I couldn’t tell them anything. I feel like maybe they will laugh at me.

In a second incident, Tony was scheduled to meet a White man he had been chatting with online in Tema, a city adjacent to Accra. However, as he learned upon his arrival, this meet-up was a setup by a group of Ghanaian men who used U.S. phone numbers to communicate with him and deceive him into believing “they were white people”.

He sent his house boy and driver to come and pick me. So the driver and house boy, they came, so I entered the taxi. So when they drove away like a few meters away, they stopped the taxi before I realized. Now two guys: one opens the door, one opens [the other door] and I sit in the middle. They said bring your phone. They took my phone. I was even quiet, I couldn’t even scream. So they took my phone and then they say add your money, so they searched my pocket [and] took my money. Then they drove like two minutes [and] left me in the middle of the road.

Other saso interviewees shared similar stories of abuse and violence that they or their friends faced. Outside of the online platform, which are easy targets for scammers who prey on saso Ghanaians, other sites of violence included people’s neighborhoods, public spaces like the beach or market, private social venues where saso people may gather for events, educational institutions, and police stations. For instance, in 2012, a mob attack against a group of LGBT people at a birthday party in Jamestown, Accra triggered another round of media coverage on homosexuality (Joy News, 2012). The attack, came as a surprise, as Jamestown is arguably the most LGBT-friendly community in Ghana but also brought to light the increasing violence against LGBT people in Ghana.

These experiences of homophobic violence are one feature of the backlash against saso and other LGBTQ Ghanaians caused by the politicization and polarization around homosexuality in recent years. The most vulnerable among those within the LGBTQ population are gender non-conforming people who are deemed too feminine for a man or too masculine for a woman. For saso people, gender presentation is a source of much distress as it attracts public attention, violence, discrimination, and humiliation. Also among the most vulnerable are those
who use online platforms, like *Planet Romeo*, as a platform for sex work and other forms of transactional sex since scammers use it to trap and exploit sasoi and other MSM.

Due to the criminalization of homosexuality and the stigma it reinforces, many saso victims do not report experiences of violence or abuse to the police because they have no faith in the system or fear retribution. This hostile environment, in turn, empowers scammers to attack or abuse saso people. Moreover, Ghana police is generally known for its incompetence, corruption and rampant extortion of money from victims, assailants, and the general public and thus, very few people have faith in the institution. For these reasons, LGBTQ Ghanaians expect to be ignored, arrested, further humiliated or punished if they report their cases to the police. Tony, for example, never reported the mob attack in La Paz because of this fear, explaining that “sometimes when you go to the police station, what they will tell you, you will feel bad that you even went to them”. In fact, right after the attack in Tema, he reported the incident to a police station nearby immediately. However, the police refused to help him, stating that “it was too late” and that they cannot do anything about it.

In the instances where saso Ghanaians do report to the police, they are not taken seriously unless the person is lucky to find an officer who is unbiased or concerned with ensuring justice—a rare occurrence—or they have the support of a person with authority, a government agency, or an NGO. Occasionally, however, some of these reports are addressed, as in Michael's case.

Michael, like Tony, was a victim of an online scammer, whom he was supposed to meet in La Paz. Instead of meeting his date, a group of men assaulted and robbed him, “They beat me, and I was having scars all over my body, blood flowing, too”. Unlike Tony, he was able to secure the support of two bystanders who provided testimony to the police when Michael reported the incident. When the police questioned one of the assailants, the assailant attempted to use Michael's sexuality to defend his action, in hope that the criminal code and stigma against homosexuality would help him. However, the officer in charge of the case took the
testimonies and photos of Michael’s scars as evidence and advanced it to court, where Michael eventually won the case. Michael explained:

We managed to get hold of one boy that very day, that very night, and we took him to the police station nearby. Then when we got there, he was like, [in Twi] “He wanted to have sex with my brother”…“He wanted to have an affair with my brother, that’s why he was beaten then”. Apparently…the police [on duty] was a woman…so she was like, “If he wants to fuck or rape your brother, does it mean you should assault him, you should beat him?” He wrote his statement. I wrote my statement. He was sentenced for three days in prison. He was put in there and then we had to go to court. We went to court, and then I won…They had to pay for all the loss, and they had to pay for my hospital bill.

Gender Oppression, Internalized Homophobia and Gender Policing

As discussed above, gender presentation is intricately tied to experiences of violence, humiliation, stigma, and discrimination that saso and other men who have sex with men have. Due to this reality, many saso people have internalized the gendered violence associated with their oppression and are, thus, hyper-vigilant of their gender presentation. To conceal any markers that may reveal information about their sexual identity, they use numerous strategies to protect themselves—most notably embodying more masculine behaviors and mannerisms in public and other non-LGBTQ spaces. In the words of one masculine-identifying person, they feel like they have to keep their true identity private, “to act in certain ways for stigma to go away” and “so that people do not assume anything”. As Paul, a saso-identified in his 20s explained, he cannot be himself because doing so would raise questions about his sexuality. Attributing these limitations to the standard set by society, he lamented:

I can’t be myself. This society has created some kind of atmosphere that if you are a guy, if you are a boy, you are supposed to behave like this, you are supposed to talk in certain way, you’re supposed to dress in a certain way, which everybody, even our parents that are, excuse my French, illiterate, they are aware of that. So, if you start dressing otherwise, they look at you funny, they begin to ask silly questions because, thanks to the society, to the media, the kind of role they have played in making people know about gays in Ghana, they start asking questions like “Why do you dress this way instead of that way? Why do you walk like that instead of like that? Why do you talk like that instead of talking the other way?
This preoccupation with gender appearance was quite apparent in many of my interviews and observations. In terms of gender identity, most of the saso people I interviewed identified as feminine, sharing that they felt like a woman or that they felt both feminine and masculine or “neither and both” depending on time and place. A few identified as masculine. None identified as transgender however, neither in Western or Ghanaian lexicon. Masculine identifying saso men were the most likely to embody negative self-imagery about saso people and the most vocal about policing gender. As Kwa shared, he adopts a masculine persona around his straight friends. His masculinity has hints of femininity however, so his friends, he explains, “take me to be a mommy’s [boy], like I’m too soft”. They, nevertheless, have yet to assume that he is gay. He explained navigating different social spaces using this double identity and how repressive it feels:

Sometimes especially when I was becoming like this then I have to be myself. I have to look straight. I guess you might not know who is watching and when I’m with my peers, I go all out to do anything I want. I want to break free but when you are in a more open place you should compose yourself…but when I’m with my peers, we fool around. We do a whole lot of things. We say all nasty things. We get naughty and all that and it’s funny. Most of my friends are straight men. So I have to compose [myself] and be able to get into their environment or their society at that particular times. So I have a two-face person. Today I’m straight, tomorrow when I see my other peers, I’m a gay sort of thing.

In addition, there are some who are very critical of working class feminine saso people, who they describe as loud and bad-mannered. Richard, for example, expressed frustration with those working class saso people who wear makeup and tight clothing, and walk in a feminine manner. He believed that those who are feminine feel like they need to be that way as part of their sexuality and suggested that such behavior is common among unemployed saso people who do nothing but live their life as “gay people”. He compared these people to more middle and upper middle-class, highly educated gay men who he described as feminine in private but “well mannered” and “command respect” in public.

The way you carry yourself in femininity. That’s why I say, you don’t have to define your sexuality by how you look and how you behave. You don’t have to do it because you see
people when they go for parties then they paint their lips, their eyebrow, they do stuff. No, you are fine, you can do it when you are among gay people but when you are going to a different place, I don’t think you should... Most of the time they make the whole thing look like being gay is for the illiterate; it’s for those who have nothing, that’s what they make it look like. There are very prominent people in this country who are [gay] but they can’t come out to be support because when they hear some of these stories, I mean why would [they]?

Internalized Homophobia and Suicide

As Kwa’s statement indicates, many saso people blame themselves for the abuse and stigma they are targeted with and the conditions that make it difficult to live openly as a saso person. This, I contend, is directly related to the previously discussed notions of homosexuality as demonic and a curse. Such harsh beliefs condition saso people to hold immense guilt about their identities and desires and have a devastating impact on the mental health of saso Ghanaians. One critical issue in this area is how common suicide and suicidal ideation are among saso people—an issue that gets very little attention in discussions on the lived experiences of LGBTQ Ghanaians. For instance, Eddy, who at the time of the interview had stopped socializing with other saso people in an effort to “come out” of his homosexuality, described how he was making these changes to save his life because of how bad it made him feel. Using himself as an example, he shared that as a kid he was very feminine and knew that he was attracted to men, but as he grew older, he realized that he did not “want to be more of this kind of person” any longer.

I didn’t know there was a thing like that but then I just didn’t feel comfortable with people calling you "Obaa Barima", "Kojo Besia", like more of girly type. I said “No, I don’t want to accept this” so I started playing with guys... Then I came back to the masculine, kind of more rigid type. So I think that one helped me. I don’t accept that this is who I am I said "No and I can’t accept this".

Eddy felt that if he didn’t reject his sexuality, he would end up like other saso people who have ended their life because of how the stigma and guilt. He asked, “So what of those people who feel so bad and it happens that a lot of them died and they write a note like, ‘I realized I was like
this and for that reason people are not accepting me and for that I have to take my own life?’ So I just think to be myself. Stay away and fight it”.

Eddy’s comment was one of numerous chilling statements made about suicide by my saso interviewees that further revealed how disconnected policymakers and even service providers are from the daily struggles of saso and other MSM. Dani, one of the peer educators I interviewed, explained how homophobic abuse was driving suicide among saso people, “Sometimes some of these things lead to suicide and stuff. Because in Ghana we’ve had quite a number of suicides amongst the community, among the community members, which is very bad”. This observation was echoed by Boat, another activist in the community, who placed blame on “the kind of social cultural community we find ourselves in”. Paul, a feminine saso person, explained in very clear terms how gender policing and homophobia and the isolation they cause lead to depression and suicide ideation among saso people.

You’re going out like this, you are supposed to dress this way. When we get to this particular area, you are supposed to walk like this. When you are talking to these particular people, you have to talk like this, you have [to have] some bass, you know. It doesn’t make you live the life you want to live, like, you’re not free. You are torn between, I really need to fit myself and because no man is an island and you need people around you. You feel lonely and all that you get depressed and you even go to the extent of committing suicide in order to get that environment that allows you to meet other people, talk to other people, on normal basis and all that.

He added that such suicide ideation is even more pronounced for those who are confused about their sexuality and are struggling with it. Suicide unfortunately, is a very taboo topic in Ghana and as a result, society rarely discusses it despite how common it is.

Daring Not to Come Out

Given these circumstances, it was not surprising that most of the saso people I interviewed were not out to their families about their sexual identity. The three who were out were eitherouted by someone—like in the case of Boat who was outed to his family by his cousins—or were only out to a supportive family member. The reasons people gave for not
coming out were numerous but they were all related to the unsupportive sociocultural environment where homosexuality is illegal, demonic, and taboo. Some feared their family would disown them, some feared their family might hurt them, and some feared the negative impact such information would have on the reputation and mental health of their family. John, a 24-year-old Muslim interviewee who identifies as bisexual, explained that he had not come out to his family because he is bisexual “so they wouldn’t know” and they can never know. He asked, “Do you know what kind of home I come from, a Muslim home…I wouldn’t even cough it”.

When asked if they ever hoped to come out to family in the future, most of the interviewees said they did not. Dan, a 31-year old who identifies as saso, explained that he “dared not” tell family about his sexuality because he does not know how “they will take it”, explaining, “I’ve tried as much as possible not to carry myself in a way that will give me out and sometimes it’s very challenging. You have to be in self-denial and so many things actually”. For some of the interviewees the unknown reaction included fear that a parent would kill them or kill themselves. Tony, for example, shared that his mother had confronted him about whether he is gay, but he denied it. He explained that he may come out to his sisters but did not think he could ever come out to his mother because he feared it might cause her to commit suicide, “I wish but I’ve been thinking the only person that I can tell is my sisters because they are cool with everything. My dad will not say anything but my mother, I don’t know, she can kill herself if she heard that I’m gay”. Another saso interviewee, 26-year old Philip, explained that he could never let his family know he is gay, especially his father, “because he might even end up poisoning me”.

The fears expressed by saso people were not unfounded as many of the interviewees knew of friends who had been disowned by their family due to their sexuality or in some cases, their sexuality and positive HIV status. For instance, Boat shared that a friend of his was “disowned by the family, the mother, the father, the siblings” because the family believed his sexuality was “the cause of all their problems: their poverty and lack of progress”. For this
family, their son’s homosexuality was “dirty”, “against the bible”, and against their “cultural values”. This friend was eventually kicked out the home and became homeless, moving from “one friend’s [home] to the other on a daily basis”. Kwa also discussed how many people were struggling “in the closet” due to “pressure” and “discrimination”. He shared as an example a close friend’s emotional hardship after the friend’s mother learned about his sexuality and disowned him. He explained:

He was all alone by himself and he kept things so much [to himself]. He was dying slowly, emotionally inside and all that. Unless he sees a friend who he can trust, then he can openly confide in them, everything out of his chest and all that. People are dying, so you could see he’s not alone. There are other people out there too who are going through the same process and all that.

A 29-year old saso peer educator I interviewed shared his horrible experience coming out to his mother at the age of 19 years old. His mother replied that he was an evil child “and she wishes death upon me…but I thought she was joking but to my surprise, I was sleeping and then I could hear her praying at dawn asking God to strike me dead all because I am her worst nightmare…because I am gay”. She told him that if he stopped his homosexuality, he would be welcomed back into her life, but if he continued, “I have to face the world all alone”. Because he could not “fake” not being gay, he has chosen instead to not have a relationship with his mother.

Another important reason why some saso people felt they couldn’t come out to their family was that they were hoping to “come out” of homosexuality so that they can live a normal, heterosexual life—one accepted by their family and society. Eddy, as previously discussed, is one such person. After grappling with the hardship of life as a saso person in Ghana and the shame and abuse it came with, he decided that he no longer wanted to be homosexual. Much of his reasons for wanting to “come out” of homosexuality reflected internalized stigma and oppression. For him, saso people were “not honest” and “everyone frowns upon” homosexuality, including saso people themselves, “so why would you still be in it”? So he decided to “walk out”. Eddy was not alone in wanting to pursue a different identity. According to him, he and another friend, had numerous conversations about this change. This friend, he shared, “is attracted to
guys but he’s fighting himself to stay away” because he is getting older and experiencing more social pressure to settle down with a woman and start a family.

He’s getting older. He wants to get married. People are asking the reason why he’s not married. The society will not even allow you to live your life, you understand? Here in Ghana, you are somebody’s friend, somebody’s family, somebody’s brother, somebody’s relative. So, when maybe something happens to you, everybody gets to know. So he goes, “No, and I want to live my life, I want to now marry. [Homosexuality] is not helping”. When people are dying, when people are not okay at my work, people are going to stigmatize. You are not having a wife and kids at your age. What is wrong with you? Are you okay? You have everything. You have your own car. You have your own place. Why aren’t you married? What is preventing you from getting married? So he’s now fighting himself as I’m fighting myself. And there are a lot of guys who realized the realities [and] are trying to back off.

Another saso person, Kwa, had similar distresses about his attraction to men. Like Eddy’s friend, he too felt like his saso identity was not compatible with starting a family. At 29 years-old, he has begun to steer his life in a different direction although he feels “stuck somehow in the middle” of being and not being gay and “keeps going back and forth”. As an only child of a single mother, he feels a lot of pressure to get married and have kids for his mother. His mother, he senses, is suspicious that he might be gay because he has never introduced a girlfriend to her. Nevertheless, he’s not in a position to meet her expectations and has had find “a very constructive excuse for her and she understands”; however, the pressure weighs him down. Moreover, due to these pressures, he expressed not foreseeing a future where he could come out to his mother about his sexuality. He explained, “That will be a big, big, big problem to me and I think she will be disappointed. It wouldn’t be easy. I wish I could but I don’t know how she’s going to take it and I don’t know what she’s going to go through. So maybe when the time comes I will get there. For now, I can’t say it”.

**Conclusion**

As the discussion of media and social discourses on homosexuality indicates, developments on the international level as well as the self-organization of the LGBT community,
into groups like CEPEHRG and GALAG, have affected local political and social realities regarding same-sex sexualities and gender in Ghana. These developments have caused numerous moral panics, moral crusades and other backlashes that have been led primarily by religious groups and institutions as well as the print and news media. These incidents and social responses to them have contributed to the politicization of homosexuality in Ghana. For sasoi Ghanaians, the legal and sociocultural circumstances have only made life harder for them. Homophobic beliefs like those espoused in the media, the threat and experiences of homophobic violence, and pressures from family members to conform to social norms and expectations have made many sasoi Ghanaians more unsure about their sexualities or unsure they can ever live their truth as men who are attracted to and love men. In the next chapter, I discuss more extensively, how MSM HIV prevention programs are implemented and how this sociocultural landscape shapes these programs.
CHAPTER 5
MSM HIV ACTIVITIES AND INTERVENTIONS: ARE GOOD MSM HIV POLICIES IMPLEMENTABLE?

Introduction
In Chapter 3, I discussed the evolution of HIV/AIDS policies in Ghana that focus on sasoi and other men who have sex with men and the numerous local and global factors that catalyzed the paradigm shift to include this group as a key population in the country’s national policies. This chapter builds on that by surveying Ghana’s HIV prevention and care activities for sasoi and other MSM and stakeholders’ efforts to implement interventions that address the needs and objectives identified in the KP NSP. Here, I describe how MSM HIV prevention and care activities are being implemented within a sociocultural context that criminalizes male same-sex sexual activities and the related successes and limitations placed on key stakeholders, implementing partners, and front-line workers in addressing the epidemic among this population due to these circumstances. Based on analysis of policy documents, interviews with policymaker, key informants, service providers including peer educators, and participant observations of the KP Technical Working Group, conferences, HIV outreach, and NGO work, I demonstrate that the same sociocultural circumstances that place MSM at risk also present significant barriers to addressing that risk. Moreover, I suggest that these limitations are compounded by the tendency of local and international stakeholders to package key populations together as one without putting much attention and resources towards their unique needs.

As David Mosse has argued, in the field of international development, in which HIV/AIDS prevention efforts operate, there is a “preoccupation among development agencies and researchers with getting policy right; with exerting influence over policy, linking research to policy, and of course with implementing policy around the world” (Mosse, 2004; p. 639). The assumption underlying this pre-occupation is that good policy will lead to good practices and
successful outcomes. However, as Mosse insists, this is not necessarily true and unfortunately little attention is given to the polices and the “practices and events they are supposed to generate or legitimize in particular contexts” (Mosse, 2004; p. 640). As international HIV/AIDS agencies have increasingly become preoccupied with best practices, paradigms, and frameworks for guiding interventions in all corners of the world, this approach has also been adopted in different localities.

In Ghana, specifically, the pre-occupation with model policies has shaped the country’s HIV/AIDS response, certainly in the case HIV prevention and care of key populations, where policies have evolved immensely over the past decade to try to reflect requisite international frameworks and best practices as discussed in the previous Chapter. At the same time, efforts to create good policy, displaces attention from the actual implementation of these policies, their outcomes, and the factors that might be shaping the implementation process that need to be addressed to improve and sustain outcomes.

Within Ghana’s MSM HIV/AIDS prevention and care efforts, the MARPs/KP technical Work Group has developed a detailed policy to reduce the incidence of HIV among of MSM. The implementation of these policies, however, have come into conflict with other structural barriers such as an ongoing economic crisis, inadequate funding source for MSM and other KPs, criminalization of male same-sex sexualities, and a diminishing healthcare system that cannot support the institutionalization of MSM efforts in the clinical setting. Moreover, since the pace of programmatic efforts and policy content are set by the fast moving and ever changing nature of funding cycles, there is a gap between what exists on paper and the activities being implemented on the ground, raising important questions about the “monotheistic privilege’ of dominant model policies and the ‘polytheism’ of scattered practices’ surviving below” as Mosse (2004; p. 645) paraphrases from Michel de Certeau’s (1984) work. How much of the country’s AIDS response for MSM reflects these model guidelines and policies and vice-versa? How much of the work reflects the actual needs of MSM on the community level?
This chapter is divided into two sections. The first examines the country’s core MSM HIV/AIDS prevention and treatment interventions and recent efforts to standardize this work. The second section reviews key challenges that stakeholder and frontline workers experience in implementing prevention and treatment programs for sasoi and other MSM.

MSM HIV Activities

**CEPEHRG: Ghana’s first LGBT rights organization.**

In 1998, a small group of young, Ghanaian activists, including gay and non-gay women, men, and gender non-conforming people, came together to form Ghana’s first LGBT rights organization. The group, named Centre for Popular Education and Human Rights, Ghana (CEPEHRG), was established to fill the void left by local and international NGOs that failed to address or were unaware of human rights violations against LGBT Ghanaians, with a focus on Accra, the country’s capital. The organization was the first civil society organization in Ghana to address human rights issues facing LGBT Ghanaians. The group’s experience, then, with getting registered with the Ghanaian government—a relatively easy process for most other groups—proved difficult due to the very legal and social conditions that the organization sought to challenge. In fact, for years, the group could not register because of their focus on rights for sexual minorities. As Nii Kwartelai Quartey, one of the founding members, recalled, the organization experienced difficulty getting signatories to complete their registration with the Registrar General Department as well as in their capacity and base-building efforts due to people’s fear of stigma and retribution against homosexuality. Moreover, they were discouraged by allies from past “general population” human rights work from explicitly mentioning LGBT rights in their mission statement and to rather reference human rights in general due to fear of prohibition by the government. However, even with the LGBT component muted in their forms,
they faced a number of roadblocks, including what they described as discrimination from the Registrar General, before formally getting registered in 2003.

CEPEHRG was initially formed, according to founding member and current Executive Director, MacDarling Cobbinah, as a human rights group that aimed to build capacity and a social base for a “stronger movement in Ghana to push for change [and] acceptance and tolerance” of LGBTQ Ghanaians. As Nii shared, the group utilized a popular education framework in its human rights work that was informed by Paulo Freire’s *Pedagogy of the Oppressed* and Augusto Boal’s *Theatre of the Oppressed*. At the core of this approach was the “questioning of power”, which he described as “a very useful tool in terms of educating people who, in relative terms, had low education or who had been ostracized”, “oppressed”, or “marginalized”. A key focus of CEPEHRG’s first few years of organizing was on conducting rights and security training for LGBT Ghanaians. The goal here was to empower their community to defend their rights as oppressed minorities in Ghana. As MacDarling shared, it was this passion that drove CEPEHRG activists to work for the improvement of LGBT Ghanaian lives,

*I think first, there [was] no one to talk to about the issues and then coming out within the community, where LGBT issues are stigmatized and LGBT persons are stigmatized, I felt there should be someone leading the way and then someone should give a voice to the issues…I was just working based on the passion I have for other friends who have issues, who have been abused, who have been attacked, who have issues with health and who have no one to talk to, who are not being listened to…It’s not because I have some education in those areas or I have some expertise in those areas. It’s just the passion for the work, for LGBT people in the community and that’s how it all started.*

CEPEHRG expanded their focus to include issues related to LGBTQ health and rights in the early 2000s after a focus on LGBTQ rights in its first few years. This was because over the course of organizing, the group increasingly encountered significant unmet needs in the area of sexual and reproductive health among sasoi and other MSM. Many friends of CEPEHRG activists were becoming ill with STIs and HIV/AIDS and some were even dying. Social stigma, criminalization of same-sexual acts, and a lack of access to health services were significant
barriers to addressing these issues. With little resources from their established LGBT kinships and networks, and the structural marginalization of LGBT Ghanaians from the public health system, they knew their advocacy efforts had to address this gap. At the same time, the group was finding it difficult to get funding for their human rights work but had better funding opportunities through HIV/AIDS work. Moreover, allies advised them to not limit their work to human rights but to combine those efforts with health advocacy. This change would provide an opportunity for them to access and participate in the expanding HIV/AIDS work in Ghana and to advocate for the health needs of sasoi men in those efforts. As MacDarling recalled:

In the beginning…the issue was to look at human promotion of rights of LGBT people and visibility and then it changed at a point because there was HIV and STIs coming up and then it became a very key part of our programs because there were a lot of STIs within the communities…treatment was very difficult for gay men because when you go to the hospital, you were asked to produce your boyfriend or your partner before treatment. That’s those days. So most gay men cannot produce their male partners and they don’t have even female partners to produce. That was when we started looking at the issue of sexually transmitted infections and then we were advised also that we cannot just do LGBT [rights] and leave the health component out and so that’s how we started working on health issues.

Due to the focus on LGBTQ rights, many CEPERHG members were initially isolated by some of their social networks because of the immense social stigma and legal ramifications of their work. In fact, MacDarling, who was and has been the most publically visible member of the group, recounted a number of his friends avoiding meeting with him because they felt he was putting them in the “limelight” and exposing their community to public scrutiny and attacks. Some of his gay and lesbian friends even started calling him names and saying, as he recalled, “You’re embarrassing us. You are taking us into the media and everything.”

These initial challenges became less and less of a barrier between CEPEHRG and the communities their work focused on as the group demonstrated that they could find allies, especially in high places. One such ally was UNAIDS, which provided the group with support around 2002-2003 under the leadership of the then-Country Director. UNAIDS was the first
global HIV/AIDS agency to provide CEPEHRG with resources, offering them space, funding opportunities, and outreach materials to do their early HIV prevention work among sasoi and other MSM. In addition, the Country Director helped start a dialogue on MSM HIV work among some key stakeholders in the national response by introducing CEPEHRG to Ghana AIDS Commission (GAC) around this period. Another key figure who assisted the group in brokering access to the GAC was Hans P. Binswanger-Mkhize, a Senior Economist for the World Bank, who met with the group during a visit to Ghana. According to Kwartey, these early connections were “very helpful” because, unlike the bottom-up strategy they had been using, this “top-bottom” approach gave them better access to key actors who could meaningfully change policies to address the sexual health inequalities facing MSM. With more institutional support, they were able to move their work from MacDarling’s apartment to a small container—a stand-alone, one-floor, small rectangular or square construction that resembles a shipping container, often made out of wood or metal—in the Labadi neighborhood of Accra, allowing for more visibility and outreach.

The role CEPEHRG played in Ghana’s paradigm shift to include MSM in its national HIV/AIDS policies cannot be understated—a role, I argue, that has been the most important in catalyzing the series of changes that resulted in the shift. Although on the margins of the national HIV response, CEPEHRG was able to secure funding from small foundations and later larger bilateral and multilateral funding streams, establish strategic relationships with key stakeholders, and push forward their advocacy agenda, like many other civil society organizations in the 1990s (Khanna, 2013; Nguyen, 2008). As Peter Wondergem, then Senior HIV/AIDS Adviser of USAID, expressed, CEPEHRG, especially MacDarling, played a central role in helping start some of the first interventions for sasoi and other men who have sex with men. The group, in his view, deserves “special mention” for the amount of work they have done and the level of impact they have had on MSM HIV/AIDS efforts in Ghana, especially given that they were “working in a total vacuum” when they started this work. Through their evolving
relationship with UNAIDS and the linkages made through the World Bank, CEPEHRG gained more access to the country’s national HIV/AIDS work, eventually getting enlisted to recruit MSM for the Attipoe study from 2003 to 2004. As a number of policymakers and key informants mentioned, without the participation of CEPEHRG staff and peer educators in the study, the efforts by CIDA, WAPCAS, and other stakeholders would have fallen short of engaging sasoi and other MSM networks for the study and producing the data necessary to inform HIV programming for MSM and subsequent policies to guide the national response for this population.

The SHARP program and its legacy.

As discussed in chapter 3, one of the main outcomes of the Attipoe study was that it helped inform the development of a pilot program for MSM HIV/AIDS prevention and care program as part of the USAID-funded Strengthening HIV Response Partnership (SHARP) program. SHARP was implemented by the Academy for Educational Development (AED), a now-defunct international non-profit organization whose work focused on health, education, and economic development. SHARP spanned from June 2004 to September 2009, was the first major program in Ghana to address HIV/AIDS among men who have sex with men and other MARPs. SHARP aimed to “reduce new HIV infections and mitigate the effect of AIDS in Ghana” among most-at-risk and most affected populations, which at the time were identified as female sex workers and their non-paying partners (NPP), people living with HIV/AIDS, and men who have sex with men. As Wondergem recalled, USAID started writing the project to reach hidden at risk populations like MSM whose risk profile were now revealed by the Attipoe study, and to “combat the situation” with more research and interventions using examples from “non-African countries”.

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Program goals & activities.

SHARP’s stated goals included: 1) Building local NGO capacity; 2) Developing an enabling environment in Ghana; 3) Creating a performance-based feedback and funding system; 4) Implementing a package of prevention services; and 5) Conducting pertinent research. To reach these goals, the program sub-contracted 17 NGO implementing partners (IP) who worked with the identified at-risk populations. For the MSM-focused interventions, the implementing organizations were CEPEHRG, West African Program to Combat AIDS/STI (WAPCAS), Maritime Life Precious Foundation (Maritime), Interfaith Family Network (INFANET), MICDAK Charity Foundation, and PROLINK, with CEPEHRG—its first MSM NGO IP—and Maritime carrying out a majority of MSM project activities over the span of the project. In keeping with its stated goals, the bilateral program trained FSW and MSM peer educators, implementing partners, and clinics associated with the Ghana Health Services to implement a package of services and interventions for the project populations. The program also conducted IBBSS research with MSM, FSW, and informal miners and long distance truck drivers—common FSW clients.

Apart from implementing the first set of interventions that focused on sasoi and other men who have sex with men and producing more epidemiological data on MSM to guide policies and programming, SHARP was significant because its interventions have become the model used for ongoing HIV/AIDS prevention programming for MSM and FSW. As Table 2 shows, these interventions primarily focused on STI education and management (diagnosis, referrals and treatments); HIV testing and counseling; peer education; condom and lubricant promotion and distribution; and community outreach. The services and interventions were implemented through peer education, drop-in centers (DIC), community outreach, MARPs friendly clinics, and helpline services (i.e., Text me! Flash me! Watch me!).
<table>
<thead>
<tr>
<th>MSM-focused Services/Interventions</th>
<th>Programs</th>
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<tbody>
<tr>
<td>HIV/AIDS &amp; STI education</td>
<td>Peer education</td>
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<tr>
<td></td>
<td>Community outreach</td>
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<tr>
<td>STI management (diagnosis, referrals and treatment)</td>
<td>Drop-in Center</td>
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<td></td>
<td>MARPs friendly clinics</td>
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<td>Text Me! Flash Me! Watch Me!</td>
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<td></td>
<td>Community outreach</td>
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<tr>
<td>HIV testing and counseling</td>
<td>Drop-in Center</td>
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<td>Community outreach</td>
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<td>Condoms and lubricant promotion &amp; distribution</td>
<td>Drop-in Center</td>
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<td>Peer education</td>
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<td>Peer Education</td>
<td>Peer Education Plus</td>
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<td></td>
<td>Community outreach</td>
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<tr>
<td>Support for PLHIV care including prevention with positives</td>
<td>Support groups</td>
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Table 2: SHARP MSM services, interventions, and programs

The project applied the behavior change communication (BCC) strategy, which it developed to address sexual health and HIV among men who have sex with men and other KPs. Over the years, funders and IPs worked very closely together at small workshops for different aspects of the project and at trainings on BCC materials and services. Although targeting four different key populations with distinct needs, including diverse genders, sexualities, HIV status, socioeconomic status, the project’s package of services was aimed at promoting the following eight key behaviors for all of these populations (AED, 2009; p. 7):

1. Correct and consistent condom use during every sexual encounter to reduce the risk of HIV infection/re-infection and other STIs
2. Correct and consistent use of lubricants for anal sex or dry vaginal sex, with condoms
3. HIV testing and encouragement of partner testing
4. Prompt care seeking for symptoms and care and treatment
5. Adherence to prescribed ART, TB and STI medications
6. Faithfulness to one partner or to a reduced number of partners
7. Disclosure of HIV and/or STI status to regular partners (MSM and PLHIV)
8. Active participation in the design, implementation and monitoring of HIV policies and services

Program achievements.

Over the course of the 5-year project, SHARP reported a number of successes. Their final report estimated that the project reached over 25,000 FSWs, 16,000 NPPs, 7,500 MSM and over 6,500 PLHIV with BCC materials and services. As Figure 8 illustrates, the package of services reached an increasing number of men who have sex with men (and other MARPs) over the five years of operation, indicating that Ghana “had that subpopulation in the country”, as Emmanuel Essandoh, Program Management Specialist from USAID put it. CEPEHRG played a significant role here, as Wondergem recalled, in helping map and engage MSM communities and networks in Accra, Kumasi, Koforidua and elsewhere:

And so [SHARP] started through CEPEHRG, trying to get into the MSM community and doing some interventions. As I said earlier, the first year we had either 50 or 100 as a number for each of the target group because they were so hidden and we reached that but not that much more. Maybe we doubled it or so. So, we started getting experience with interventions and materials, pieces of materials.

SHARP was also able to expand NGO capacity by training 26 NGO staff on financial management, 28 NGO staff and board members in governance, and 28 NGO staff and other key stakeholders on using the My Life! Positive Living Toolkit—a toolkit with empowering knowledge-based information, skill-building activities, DVDs, and other resources for PLHIV that help them adopt the aforementioned eight key behaviors. They also trained 243 MSM and FSW peer educators; 39 health workers to provide MARP-friendly services; and 15 counselors for Helpline services. For the MSM component, the program was considered so successful that “many of the tools and interventions” were “disseminated to USAID and CDC programs” in eight

An important success of the SHARP program was that it was able to enlist the support of the government of Ghana by the end of the project, namely the National AIDS Control Program, the Ghana Health Services, and the GAC. While the government eventually became engaged in the project, Peter recalled that at the start of the project, the Ghana AIDS Commission “was not interested” in it. At the time, the GAC had a large grant from the Global Fund, which it was busy sub-granting to “first, thousands, and [later] hundreds of NGOs”; thus GAC only remained tangentially engaged in SHARP. It is important to note here that the Global Fund funding stream was not yet coordinated with the USAID AED/SHARP funding, which meant that the SHARP project wasn’t yet fully integrated into the national response. It wasn’t until a few years into the program, when SHARP pitched the idea of a MARPs Technical Working Group to the government, that GAC become more involved. As stated in their final report, the working group was established by the government of Ghana with assistance from SHARP to create “a more enabling environment for MARPs in Ghana” (AED, 2009; p. 4). SHARP described this development as “a major accomplishment” because just two years prior, “FSWs and MSM were
almost non-existent in the strategies and budgets that were outlined in Ghana’s National HIV and AIDS response” (AED, 2009; p. 4).

Program challenges.

Although SHARP made a number of advancements in the national response to HIV prevention among men who have sex with men and other KPs, the project did not proceed without some significant challenges. Of note, there were major issues with several of the key implementing NGO partners due to unspecified “performance-related issues” according to the AEP/SHARP program final report. These issues, which were not explicitly discussed in detail in the report, were identified as relating to leadership and governance, management, and performance towards results and targets (AED, 2009). The performance-related issues were so extensive that they led to the termination of 8 out of the 17 implementing partners’ funding agreements—many of whom were implementing interventions for sasoi and other MSM. Moreover, CEPEHRG, the main MSM NGO in SHARP, chose to terminate their funding agreement in the final year of the project, seemingly due to the aforementioned performance-related issues.

With CEPEHRG out of the project along with other IPs, the MSM interventions in Accra and Kumasi, which were responsible for reaching most of the MSM in the project, became inactive. As a solution, Maritime, considered a high-performing partner, was asked to step in to provide services to men who have sex with men in the Accra area. In addition to a lack of donor funding coordination, this performance-based rating system, although intended to improve the quality of work done by IPs, led to unproductive rivalry, competition, and distrust between NGO IPs, especially those working with FSWs—a dynamic that remains a significant challenge in the country’s MSM HIV prevention efforts, which will be discussed later in the chapter.

In addition to the aforementioned challenges, a key issue that the SHARP final project report shared in a very understated manner were the significant challenges it’s MSM and FSW
programs faced due to the “hostile sociopolitical and media environment”. This environment specifically caused more female sex workers, and men who have sex with men especially, to go underground, making it more difficult to reach them with “quality” services. A lesson drawn from these experiences then was for the project to develop a “public and media relations strategy” to support the implementation of the project as well as to have “more dialogue with Ghana AIDS Commission—whose mandate is to facilitate policies in HIV/AIDS prevention, care, treatment, and support interventions and enabling environments at the national, district, and community levels” (AED, 2009; p. 23).

**USAID/SHARPER Project and Core MSM HIV Interventions.**

With these key lessons learned from the SHARP project, USAID developed its successor program, *Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results* (SHARPER) to build on the progress made by SHARP. During the transition from SHARP to SHARPER, AED was also being investigated by the United States government for mismanagement of U.S. government funds they were granted for research and programming. Due to this controversy and the U.S. government’s termination of it contracts with AED, the organization suffered huge financial losses, leading to FHI 360 purchasing its assets and inheriting all their programs and employees. USAID thus granted the SHARPER project to FHI 360, which had been working in Ghana on other health and development issues since the mid-1980s.

The SHARPER project operated from February 2010 to November 2014. The project, which focused on MSM, FSW and their non-paying partners, and PLHIV, had the following objectives: To 1) Improve KP and PLHIV knowledge, attitudes and practice of key health behaviors including HIV prevention; 2) Increase utilization of HIV testing & counseling, sexually transmitted infection screening/treatment, and HIV care & treatment services among “MARP and PLHIV”; and 3) Strengthen the human and institutional capacity of MARP and PLHIV
program implementers and coordination bodies. As the project stated in its final report, “SHARPER combined interventions proven to be effective under the previous USAID HIV intervention project, with new and innovative approaches that motivate KP, PLHIV and their partners in adopting healthier behaviors while also increasing their access to a comprehensive range of non-judgmental, user-friendly HIV services in their own communities” (FHI 360, 2015; p. 3). With HIV prevention and care services in over 116 districts that had higher HIV prevalence and a concentration of key populations, it hoped to help Ghana reach its goal of reducing HIV infections by 30%.

The SHARPER interventions were very similar to those of the preceding project, with a new addition of social media outreach (MSM.net), social network testing (SNT), and male sex worker (MSW) networks, to find harder to reach men. Guiding these new interventions were again, a broad set of twelve “key heathy behaviors” (see Figure 9), which included the set of suggested behaviors from the SHARP project as well as additional behaviors that were adopted to meet unmet needs after consultations with stakeholders and key populations. The added behaviors were: eat healthy, reduce alcohol intake, and have a positive self-esteem.
SHARPER’s interventions for men who have sex with men, listed on Table 2, represent the core of Ghana’s current HIV prevention and care activities for the group. As the program stated in its report, it utilized a “multifaceted approach to improve KP and PLHIV health knowledge, attitudes and practices”, using both peer education and “innovative” technological and social media strategies. Notably, since these interventions function in an unstable funding environment, they operate based on the amount or type of funding available from external funding sources, including the government, as well as the length of the funding contract. Thus, some of these programs do not operate year-round.
<table>
<thead>
<tr>
<th>MSM-focused Services/Interventions</th>
<th>Programs</th>
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</table>
| **HIV/AIDS & STI education**      | Drop-in centers (2 MSM centers, Accra & Takoradi)  
MSM Peer education  
Community outreach  
Social media outreach (MSM.net)  
SMS HealthyLiving (Bulk weekly behavior change text messages for KP & PLHIV, using SBC)  
LearnMore (HIV/STI education, using SBC) |
| **STI management (diagnosis, referrals and treatment)** | Drop-in centers  
MARPs-friendly clinics |
| **HIV testing and counseling**    | Drop-in centers  
MARPs-friendly GHS clinics  
Social network testing (pilot)  
HelpLine Counseling Services (Text Me! Flash Me! Call Me!) |
| **Condoms and lubricant promotion & distribution** | MSM Peer education  
Drop-in centers |
| **Support for PLHIV care including prevention with positives** | LifeLine (Daily ART text message reminders for PLHIV)  
Models of Hope (MoHopes; work with HIV clinics to trace PLHIV on ART & lost to follow-up) |
| **Human rights and stigma reduction** | CHRAJ Help Desk (human rights abuse reporting system for KP and PLHIV)  
M-friends (community members, e.g., lawyers, doctors, traders, traditional leaders, and teachers who observe/report abuses against KP/PLHIV and advocate for them)  
M-watchers (KP and PLHIV peers)  
KP TWG (GAC policy working group for KP, includes police and prisons, CHRAJ, and other human rights NGOs) |

*Table 3: MSM HIV interventions/programs in Ghana*

**Peer education.**

For men who have sex with men, like female sex workers, the main HIV prevention intervention is peer education, which takes the form of frequent one-on-one and monthly group education. Before starting a peer educator position—a volunteer position that pays about 180 cedis (approximately $70 at the time of the study) allowance per month—volunteers are required to undergo training, using as a guide, a 290-page BCC strategy manual detailing the activities of HIV and STI interventions. As CEPEHRG peer educators who serve the Accra metropolitan area described to me, their tasks are to “educate about preventions and what to do after you are infected”, “give referrals to our peers to either go to the drop-in centre or clinic for treatment”, and sell and distribute condoms to peers at a low rate. As volunteers, peer educators described their job as “24/7” because of the nature of being designated community
educators who can be contacted for counselling, consultations, and condoms, and lubricants at any time. They are also responsible for holding one-on-one and group education that informs participants about HIV/AIDS and STIs and how they are transmitted, healthy behaviors to adopt as outlined in Figure 9, how to correctly use condoms and lubricants, and education on gender, self-esteem, and drug and alcohol use. In addition to these responsibilities, they also host HIV testing and counselling sessions every 3 or so months in the community they reside and are responsible for doing outreach in. The SHARPER peer education program specifically “was branded with a rainbow symbol and the tagline ‘It’s my turn’ to indicate that MSM have the right to be acknowledged and respected and are entitled to the same information and services as any other population” (FHI 360, 2015; p. 4). See Appendix D for examples of program outreach materials with branding.

Although peer education has been the most central and consistent intervention for men who have sex with men based on my analysis, it is carried out by a small group of organizations throughout the country, with the largest concentration of the program in Accra, which also has the highest numbers of saso and other men who have sex with men. Currently, there are MSM peer educators in nearly every major city across the country: Accra and Tema, Kumasi, Takoradi, Koforidua, and Tamale, with the highest numbers of educators in the first four cities. Organizations that had MSM peer educators during the period of the study included CEPEHRG, Maritime, Youngsters Peer Education Project (YPEP), and MICDAK Charity Foundation(MICDAK). These men carry the bulk of the country’s MSM interventions without much support from stakeholders and funding for their labor—issues that I will come back to later in the chapter.

Social media outreach (msm.net).

In addition to peer education outreach, the SHARPER project also developed a social media outreach program to find harder to reach sasoi and other men who have sex with men,
such as men who are older or less open or interested in being contacted by peer educators. SHARPER hired three Community Liaison Officers (CLOs) in Accra, Kumasi, and Tamale to conduct this social media outreach in their individual communities through Facebook (see screenshots of Facebook page in Appendix E, the main site CLOs used for outreach, Badoo (a social networking and online dating site), WhatsApp (a mobile messaging application), and Gay Romeo (online gay dating site). This program was specifically developed after preliminary SHARPER project data revealed that peer educators were reaching thousands of 15 to 24 year olds but not as many that were older. Moreover, the project found that HIV prevalence was higher among older (over 35 years) and wealthier men. Through these online platforms, CLOs were able to combine online outreach with one-on-one outreach at parties, bars, and other social venues that “traditional peer educators [read young and working class] rarely appeared at” due to such spaces attracting wealthier people (FHI 360, 2015; p. 4). The outreach reportedly took the form of daily discussions of HIV prevention and sex, condom and lubricant use, and regular testing for HIV and STIs. CLOs also had individual conversations with peers who needed more information about the program or referrals.

SHARPER found these efforts to be successful because in comparison to the 12,804 “unique” sasoi and other MSM that 110 peer educators reached, the three CLOs were able to reach 15,440 “unique” MSM using social media. According to the program, men were considered “reached” if they received the following from a CLO: information on HIV prevention, a risk assessment, and a referral to HIV testing and counseling (or another HIV service). CLOs were trained on how to label the MSM they reached with a unique identifier to ensure there wasn’t double counting. As the program reported, with a total of 28,244 people reached between the CLOs and peer educators’ efforts, “92% of the estimated number of MSM in the country”, were reached (USAID, 2014; p. 2).

While the social media outreach program reported a high number of men reached, a review of one of the main outreach sites, Facebook.com, demonstrates that there was very little
activity on the program’s “It’s my turn” Facebook page. As reflected in the screenshots in Appendix E, the page, which was created on August 12, 2012, only had 82 followers who “liked” it and the administrator(s) had very little engagement with page followers. There were three visitors’ post—one from an actual visitor and two from the CLO responsible for maintaining the page. The first visitor’s post was by a follower who was wondering “what makes it my turn?”, referring to the name of the program and page. There was no response to the question. The two CLO posts were two years apart: one was a message from 2012 indicating the CLOs interest in talking about STIs with page followers and the second was in 2014 on a description of penile thrombosis, which is not an STI. That post was made right before there was a major presentation on the program at a regional conference in Accra. None of these posts had any comments or likes. The page administrator only made two posts since the page was created. One was an incoherent post on behavior change to reduce HIV risk on the day the page as created. The second page was a general greeting post the day after.

I review the activities on this page because the msm.net program has been lauded as innovative and successful in reaching thousands of hard to reach MSM. However, as the content of the intervention site indicates, very few activities occurred on the page and there were no virtually not interactions (or on the public page) between the CLO and page followers. Thus, the suggestion that the social media intervention reached the more than half of the estimated population of sasoi and other MSM raises significant questions about the quality and accuracy of data in these efforts. While there is no direct evidence of this, some key informants raised concerns about the issue what they describe as “data cooking” in MSM HIV work. That is, the fabrication of data to fill expected project quotas or objectives. Although PEPFAR in past country reports have discussed a need to improve data quality, it has not explicitly mentioning what types of data quality issues are in need of improvement (PEPFAR, 2015).
ICT outreach.

Another set of interventions under the SHARPER project was those categorized under interpersonal communication technology (ICT), aimed at reinforcing “key behavioral messages, information, referrals and counseling services being provided by peer educators and health workers to key populations and PLHIV” (FHI 360, 2015; p. 5). The ICT intervention included 1) HelpLine Counseling Services, implemented through the Text Me! Flash Me! Call Me! program, that provided MSM with counseling, education, and/or referrals for services on phone; 2) SMS HealthyLiving, which delivered bulk weekly behavior change text messages for KP & PLHIV; 3) LifeLine, which sent daily ART text message reminders for PLHIV to take their medication; 4) LearnMore, an mHealth program that provides HIV/STI education to assist health personnel; and 5) social media outreach (MSM.net), which was discussed above. SHARPER reported reaching tens of thousands of KP as reflected in Figure 10, although it is not clear how many of these were MSM. The flyers for some of the ICT programs can also be found in Appendix D.

Programs to reduce human rights abuses and stigma.

One of the key lessons drawn by USAID and other stakeholders in the SHARP project was that in order for KP programmatic efforts to be successful, they needed to address the “hostile” media and sociopolitical conditions that presented significant barriers to successfully
reaching key populations. As discussed in chapter 3, human rights abuses, stigma, and discrimination have received more attention in Ghana’s most recent set of HIV/AIDS policies for men who have sex with men, particularly the 2011-2015 MARP Strategic Plan, the 2011-2015 National Strategic Plan, and more recently, the Standard Operating Procedures for Implementing HIV Programs among Key Populations (discussed later in the Chapter). And in the past few years, a couple of important interventions have been developed to help create a more enabling environment for men who have sex with men and other KPs: The M-friends and M-watchers network provides social support for KPs under the SHARPER project. It also provides support for KPs and PLHIV to report human rights abuse using a government reporting system under the Commission on Human Rights and Administrative Justice (CHRAJ) and Ghana Police Service.

**M-friends and M-watchers.**

The M-friends and M-watchers network was established in December 2012 as a community-based, rapid response system that “provides an interface for KPs and PLHIV to access appropriate health, legal, and police protection when abused, threatened, or harmed” (USAID, 2014; p. 1). This program was borrowed and adapted from India’s AVAHAN program—a program in India funded by the Bill and Melinda Gates Foundation that was established “in light of the impact of violence on the lives of FSWs—perpetrated by police, intimate partners, and clients” (Wondergem et al., 2015; p. S142). USAID and SHARPER developed this project and updated the training manual of the International Federation of Women Lawyers (FIDA) in Ghana to include PLHIV and other KPs, stigma and discrimination, gender-based violence, and referral for support. Working with 33 implementing partners, the project established criteria for M-friends and M-watchers. USAID partners also trained some police officers. The training “involve[d] a mandatory pre-service education and testing of recruits as part of their certification process” (Wondergem et al., 2015; p. S142). M-friends are described as “community members
(e.g., lawyers, doctors, police, traders, traditional leaders, and teachers) in positions of influence who are sympathetic to the challenges KPs and PLHIV face” or one key stakeholder said, people “with some status in society” and M-watchers are “peers of KPs and PLHIV who have been trained as peer educators and have been identified to have the necessary qualities and capacities to undertake additional responsibilities” (USAID, 2014; p. 1).

As point people tasked with advocating for KPs and PLHIV, about 350 M-friends and M-watchers were trained on a number of topics including HIV/AIDS knowledge, how stigma and discrimination impacts and compounds HIV infection, how gender-based violence (GBV), negative gender norms, and human rights abuses affect KPs and PLHIV, and where these populations can find resources to address their human rights and health needs. Additionally, the project’s implementing partners each had a “gender focal person” who was trained to provide support in facilitating the work done by M-friends and M-watchers who were located in all 10 regions of Ghana. Over the course of the SHARPER project, the network reportedly reached 26,822 people on issues related to GBV and “coercion related to HIV”. Additionally, 823 cases were identified and 231 survivors of GBV were connected to services through this program (see Figure 11). Networks have reportedly been established in all regions of the country. Despite training resulting in reaching more people than expected, and increasing the number of reports and cases of abuses, these numbers still represent a minority of abuse incidents faced by KPs and PLHIV. SHARPER concluded based on the program’s preliminary performance that implementers need to scale it up and better institutionalized into the country’s HIV/AIDS policies and programs and their evaluation.
M-friend and M-watchers were also connected to the second program addressing human rights abuses and stigma reduction—the human rights abuses reporting system under CHRAJ. The project, which is supported by Health Policy Project (HPP)—a USAID funded technical assistance group—and GAC was established in 2013 to address a gap in human rights protection for KPs and PLHIV. It developed a framework that aimed to review extant policies and processes for KPs and PLHIV to access justice and reduce discrimination. CHRAJ was selected as a fitting government institution to lead this work because of its role as a human rights commission, ombudsman, and an anti-corruption agency that performs investigations, monitors state institutions, and settles civil disputes (Williamson, Wondergem, & Amenyah, 2014). Moreover, it has 10 regional and 96 district offices and a staff of over 700 people.

CHRAJ worked with GAC to design a human rights abuses and discrimination reporting system that would be institutionalized in CHRAJ. To facilitate the implementation of the system, the GAC, CHRAJ, and HPP created the Reporting System Committee, “a multi-sectoral oversight body” consisting of KPs, PLHIV, and civil society members. Another key step was to

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY14 Target</th>
<th>FY14 APR Achievement</th>
<th>% of Target Achieved for YR14</th>
</tr>
</thead>
<tbody>
<tr>
<td># of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS</td>
<td>20,000</td>
<td>26,822</td>
<td>134%</td>
</tr>
<tr>
<td># of survivors of gender-based violence who reported receiving support services</td>
<td>300</td>
<td>231</td>
<td>77%</td>
</tr>
<tr>
<td># of M-friends and M-watchers trained and deployed</td>
<td>200</td>
<td>350</td>
<td>166%</td>
</tr>
</tbody>
</table>

Figure 11: M-friends and M-watchers data sheet, USAID 2014

CHRAJ human rights abuse reporting system.

In 1987, Jonathan Mann forecasted three components to the HIV epidemic: denial; ignorance; and denial. He predicted that stigma, discrimination, and denial would be as central to the epidemic as the illness itself, and would contribute to a delay in the acceptance of treatment and a delay in the emergence of effective treatments. He predicted that denial would be as central to the epidemic as the illness itself, and would continue to be major problems, even when treatment for HIV is more accessible than ever before. Since December 2012, M-friends and M-watchers have been using their influence to facilitate access to needed health, legal, and protective services for KPs and PLHIV.

The establishment of this network also shortened the time KPs and PLHIV (who reported receiving support services) take to receive support services, from multiple days to within 24 to 48 hours. M-watchers were also connected to the second program addressing human rights abuses and stigma reduction—the human rights abuses reporting system under CHRAJ. The project, which is supported by Health Policy Project (HPP)—a USAID funded technical assistance group—and GAC was established in 2013 to address a gap in human rights protection for KPs and PLHIV. It developed a framework that aimed to review extant policies and processes for KPs and PLHIV to access justice and reduce discrimination. CHRAJ was selected as a fitting government institution to lead this work because of its role as a human rights commission, ombudsman, and an anti-corruption agency that performs investigations, monitors state institutions, and settles civil disputes (Williamson, Wondergem, & Amenyah, 2014). Moreover, it has 10 regional and 96 district offices and a staff of over 700 people.

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create a Human Rights Task Team, which was trained on stigma reduction, to develop and confidentiality and privacy policy due to the sensitive and stigmatizing nature of these cases. The program also trained front-desk staff at CHRAJ since they would be the first to come into contact with KP and PLHIV clients using the report system.

The reporting system that was developed and piloted utilizes a web-based reporting platform or an SMS/texting platform. A client who has fallen victim to human rights abuses related to their identity as a KP or PLHIV can either send a web-based report through a local human rights NGO, which can enter the incident into the online system or the client can enter the report into the system directly. The former option allows for anonymity of the client in the system and connects them to an organization that can provide ongoing support with the case. The latter option allows them to directly work with CHRAJ. The SMS reporting platform allows for clients to text their cases to CHRAJ, which then prompts a trained CHRAJ representative to follow-up and arrange an in-person interview. Once a case is reported, CHRAJ either mediates (resolution of differences via negotiation), investigates (researches the report and reach a recommendation), or adjudicates (or send it to court, with fines, reinstatement, or sanctions against public officials as potential outcomes) the case (Williamson et al., 2014).

The system was piloted in several regions of the country in 2014, with moderate success. However, as expressed by MSM informants and in planning meetings for the reporting system, some KPs, especially sasoi and other men who have sex with men, do not yet feel secure in the reporting system due to concerns about privacy and confidentiality. Moreover, they fear the potential of being outed as a homosexual by a government reporting system that is operated by other Ghanaians, many of whom hold anti-gay views.

**Drop-in centers.**

There were initially 30 drop-in centers in the SHARPER project, which were eventually reduced to 11 DICs—2 of which were MSM focused—after the program conducted an
assessment of their services to evaluate whether they met a standard list of services. Out of the 11 DICs, 10 were identified as “STAR” DICs, which were centers that met the following criteria: provide comprehensive services, such as HIV prevention and care, sexual and reproductive health, and mental health care; incentivizes service use (i.e., by giving a monthly prize of national health insurance scheme enrollment); and holds “fun events” at the DIC such as “make-up artistry, hair-dressing, and singing competitions) (FHI 360, 2015; p. 8).

At the time of the study, there were only three MSM drop-in centers in Ghana with comprehensive services. One DIC was at the CEPEHRG office in Accra, a second one was in Takoradi at the Maritime office, and the third was in Kumasi at the MICDAK office. For my study, I visited and interviewed staff members from CEPERHG and Maritime—the two main HIV service providers for MSM—whose DIC and services are described below.

CEPEHRG was the first organization in Ghana to establish a DIC for sasoi and other men who have sex with men in 2006, under the SHARP project. The DIC’s services and hours fluctuated over the years depending on the state and scope of donor funding. At the time of my study, the DIC’s office hours had been reduced because the center’s main source of funding, a grant from the international human rights organization, Heartland Alliance International, had ended. Thus, the organization’s drop-in center during that period was only open once a week on Thursdays during office hours. The DIC was staffed by one nurse, Guro Sorensen, who was posted there by her employers, the West African AIDS Foundation (WAAF) and International Health Care Center (IHCC), which provided most of the funding to staff and run the clinic. Guro, a young White Norwegian woman who had moved to Ghana a few years before to live with her Ghanaian partner and their young son, had been working in the position for less than a year.

Services provided at the DIC included HIV and STI education, HIV testing and counseling, STI screening and treatment if available, clinic referrals to WAAF/IHCC for services and treatments not offered by the DIC, condom and lubricants, and BCC materials. The center is in a small, private room within the residential house that CEPEHRG rents as its office. There is a simple
hospital bed, a desk, a few HIV/STI educational posters decorating the walls, and some BCC materials. While there is a waiting area, there isn’t a communal space for public use by clients. There is however, a small library of health promotion materials in a separate room that is rarely used.

Due to funding cuts, the center has limited office hours. Thus, the number of people visiting the center had dropped significantly according to Guro. During my six months at CEPERHG, where I worked on Thursdays, I witnessed less than 10 clients visit the DIC. This low patronage was occurring despite peer educators referring their peers to visit the center. According to Guro, this is partly because the previous source of funding had a budget for reimbursing clients for time and travel, while the new budget did not. Thus, many more clients used to able to afford transportation to the DIC. Another key issue is that the CEPERHG office is located in a hard to reach residential area in Accra. This location was selected in 2011 in response to homophobic social policing and threats that made it unsafe for the organization and their clients to be located in a publicly visible and accessible location. However, the consequence of this relocation is that it is now more difficult and expensive for clients to reach the site. The desire to get tested is there, but accessibility in terms of time and money is a critical barrier.

The second main drop-in center is located at the Maritime office in Takoradi, a coastal city in the Western Region. The office is located by the sea, in an old warehouse building with multiple businesses, that is accessible by public transportation. Maritime, like CEPERHG, has been providing MSM HIV prevention services since the SHARP project. However, it is a less political organization than CEPERHG and does not do LGBT rights advocacy as part of its work. At the time of the study, Maritime had four peer educators who volunteered for the organization. These peer educators refer their peers they meet during community outreach and other peer education activities to the DIC. The organization serves a much smaller population since Takoradi’s population is about 500,000 compared to Accra’s 4,100,000. The center has a
trained and Ghanaian nurse who provides services twice a week at the DIC. The services provided include HIV testing and counseling services, STI screening and treatment, and referrals to friendly clinics or nurses to receive more treatment and care services. There is also a common space in the office where clients can do work, browse the internet, read BCC materials, or just relax. Unlike CEPEHRG’s location, it seems the industrial location of Maritime allows for more anonymity for sasoi and other men who have sex with men.

![Figure 12: MSM Reached: 2011-2014, SHARPER Project Final Report, 2015](image)

**From Policy to Implementation: KP Standard Operation Procedures**

As the above discussion on SHARP, SHARPER, and MSM HIV prevention and care interventions indicates, MSM HIV programming far preceded the inclusion of sasoi and other MSM in Ghana’s National HIV policies. However, in the past six years, national policies have rapidly evolved from excluding men who have sex with men to adopting policies that are now far ahead of the country’s existing MSM HIV prevention programs and interventions in terms of their scope and breadth. These policies include identified key needs that were incorporated in the strategic objectives of the 2011-2015 National MARPs Strategic Plan, such as calls for legal and social protection, continuum of care and treatment services, and alternative income.
activities. Such policy developments, thus, exist alongside outmoded interventions that have yet to reflect the full scope of the policy guidelines and objectives for MSM and other KP HIV prevention and programmatic efforts five years into the policies.

One of the ways policymakers have attempted to bridge the gap between these new MSM HIV/AIDS policies and existing programs has been to develop a Standard Operating Procedures (SOPs) document for key populations informed by the objectives of the MARPs NSP as well as the general NSP, which identified the development of SOPs as one of its key activities. The SOPs were developed “to provide standard operating procedures to effectively design, manage, and implement and monitor quality, evidence-informed, rights-based, and community-owned HIV interventions in Ghana with female sex workers and men who have sex with men in a harmonized and coordinated manner” (KP TWG, 2014; p. 1). Notably, the SOPs did not include policies for two other KPs—prisoners and people who inject drugs—because “interventions are limited and there is not enough on the ground experience to inform detailed SOPs” (KP TWG, 2014; p. 1) but designers hoped to add guidelines for them once this gap was addressed.

Released in 2014, the target users of the SOPs were identified as program implementers and planners who provide services to KPs. These include policymakers, healthcare workers, program staff and implementers, and peer educators. Sam Wambugu, the Deputy Chief of Party for the SHARPER project at FHI 360 and one of the key architects of the SOPs, shared that while the NSP provides policymakers with broad priorities, goals, and objectives for addressing HIV/AIDS, the SOPs provide a detailed “how to” guideline on how the SOP target users can concretely implement these objectives:

*The [SOP] guidelines now break down the objectives laid out in the NSP into the very fine details providing step by step on how those services will be provided. So one would be able to read the NSP and after getting the idea of what is expected of services for MSM, then go to the guidelines to see the details. So as an implementer, I will go to the SOPs and see how I’m supposed to carry out peer education, how I’m supposed to...*
organize counseling and testing, to know how frequently I should refer MSM for STI testing and how I should record the data, how I should interpret the data. So the guidelines provide the how to of what has been documented within the NSP. So the two documents work well. The NSP is great for policy makers, but for implementers they need the SOPs.

The SOPs were developed under the leadership of the KP TWG, the GAC, and the NACP and through collaboration between multiple state and non-state sectors. These included law enforcement officials, development and implementing partners, and with “meaningful participation” from FSW, MSM, and PLHIV. The stakeholders involved in developing the document also received technical support from the University of North Carolina and consulted with the BRIDGE project—also known as the India Learning Network—which was a Bill and Melinda Gates funded project that spanned from 2011-2015 under the management of FHI 360. The BRIDGE project aimed to manage the HIV epidemic in India and share lessons learned from the country’s HIV programs. Additionally, the project also provided technical assistance on HIV policies and programming to select Asian and African nations on a need-based level. Ghana, through FHI360, was selected as one of the countries to collaborate and learned from India’s BRIDGE Project.

The SOPs were developed as a way to address the lack of standardized programming guidelines that ensures quality services for KPs. As the GAC Director General, Dr. Angela El Adas, emphasized in the Forward to the document, these SOPs aimed to “systematize the strategies under the NSP 2011-2015 and its M&E [monitoring and evaluation] plan” (KP TWG, 2014; p. C). Mr. Wambugu also expressed that it was designers’ hope that GAC would enforce the use of SOPs to ensure a quality standard package of services. With the buy-in of USAID and Global Fund, the two main funders of KP interventions, he was confident that the SOPs would become “the yardstick for measuring the quality of services provided to the key populations” in Ghana.

Although the document acknowledged the need to develop “customized solutions and approaches to address local challenges”, stakeholders thought it was also important to have
standard definitions, norms, and outputs that help institute quality and consistent services. The document detailed specific SOPs under four different categories of project interventions and management (see Appendix F for a list of all SOPs):

1. **Project management**: outlines SOPs that detail standards that should guide KP programs through projects cycles. Included here are guidelines for designing customized KP programs; identifying capacity building needs and ensuring sufficient human and other resources; developing structures that allow for effective implementation, monitoring, and evaluation of projects; coordination with other program partners; and assuring quality of services and improving upon it. **Key target users** here were: executive directors, program managers and coordinators, program design teams, implementation team, and monitoring and evaluation coordinators.

2. **Behavioral interventions**: provides guidelines to target users on how to develop BCC strategy and how to develop materials for this strategy; how to create and support a DIC; and how to develop and support a peer education network. **Key target users** here were: program managers, peer educators, clinic staff, BCC officers, outreach workers, and field staff.

3. **Biomedical interventions**: provides guidelines on how to establish KP friendly clinical services (both on site and the field) such as HIV testing and counseling, STI management, and sexual and reproductive health. The section also provides instructions on occupation infection control such as biomedical waste management. **Key target users** here were: program managers and service providers.

4. **Structural interventions**: guidelines in this section provide instructions on addressing cultural, political, social, economic, and legal/policy factors that fuel the HIV/AIDS epidemic and make KPs more vulnerable to the virus. Guidelines are provided on how to create an enabling environment for accessing services and materials for prevention and treatment. Suggestions here include information on how to build a strong referral network, how to mobilize affected communities, and how to develop a system to address cases of human rights abuses and sexual and gender based violence. **Key target users** here were: program managers and service providers.

One of the key issues raised by KP TWG stakeholders is that KP HIV/AIDS efforts had been operating without an established minimum package of care for MSM that would guide the provision of services. To address this issues, the SOP suggested a minimum standard of care for MSM, which were identified as: 1) regular risk assessment and referrals, 2) HIV testing and counseling, 3) STI screening and treatment, 4) condom and lubricant distribution, 5) screening for sexual and gender-based violence and 6) HIV care. The suggestion also listed a quota for what percentage of clients should be provided these services (see Figure 13 for the full list).
However, a major oversight is that the list did not provide what the denominator for the proportion was.

<table>
<thead>
<tr>
<th>Suggested minimum package of services for MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular risk assessment and referrals</td>
</tr>
<tr>
<td>HTC</td>
</tr>
<tr>
<td>STI screening and treatment</td>
</tr>
<tr>
<td>Condom and lubricant distribution</td>
</tr>
<tr>
<td>Screen for SGBV</td>
</tr>
<tr>
<td>HIV care</td>
</tr>
</tbody>
</table>

*Figure 13: SOPs: Suggested minimum package of services for MSM, (KP TWG, 2014)*

The SOPs are currently guiding MSM and other KP HIV/AIDS prevention and treatment program implementation in the country, although the study ended before the SOPs were implemented. Thus, information on how the guidelines have fared in its implementation phase is limited. However, what can be said is that while similar guidelines exist in other parts of Africa for female sex workers, Ghana’s KP SOPs are the first such government sponsored documents in Africa that provide a standard guide on implementing HIV programs for men who have sex with men—bolstering the country’s status as a leader in this area of work in sub-Saharan Africa. Moreover, this effort, along with the country’s broader KP policy and programmatic developments in the past few years, has led USAID to model its Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Project (LINKAGES) after Ghana. The five-year project, which was developed in 2014, is PEPFAR and USAID’s largest and “first global project dedicated to key populations”, with FHI 360 as the implementing organization in partnership with Pact, IntraHealth International, and University of North Carolina, Chapel Hill.
According to Suzie Jacinthe, USAID Ghana’s HIV Team Leader, the project used Ghana as one of the models for its design and hoped for other African nations in the project to study the country’s efforts. Ghana is among 23 nations in the Global South that are participating in the LINKAGES program, which started after I completed fieldwork.

**Inadequate interventions in SOPs on treatment and care.**

Ghana’s KP SOPs provide a detailed set of guidelines for implementing interventions, programs, and initiatives to meet broader national policy priorities, goals, and objectives for preventing HIV/AIDS among female sex workers and men who have sex with men. However, the document has a major gap in its guidelines for the treatment and care of HIV/AIDS. In fact, the SOPs provide no information on implementing interventions for FSW and MSM nor does it make mention of why this information is missing. Thus, it is not clear whether the omission was an oversight or intentional. Reasons aside, this gap is reflective of a larger issue within the country’s HIV/AIDS efforts for key populations, which is that by and large, most targeted MSM and other KP efforts almost entirely ignore HIV/AIDS continuum of care for these populations. When it comes to interventions for KPLHIV, they are often treated as the same as the general population of PLHIV. Special attention by the government and other key stakeholders stop at the point of risk to HIV; however, once a member of a KP has the virus, the same interventions that are used for the general population of PLHIV are expected to meet the health needs of KPs.

This issue exists despite policy documents emphasizing the need for a balance between prevention treatment and care. The 2011-2015 KP NSP in fact specifically listed as its ninth guiding principle that it “advocates a balanced approach to tackling the epidemic by emphasizing prevention while ensuring that those who are already HIV positive are provided access to necessary services and drugs for treatment, care and support” (KP TWG, 2011; p. 14). Moreover, one of its strategic objectives was to “implement a package of high quality,
acceptable and accessible HIV treatment and care services for each MARP subgroup” consisting of the following sub-objectives: 1) training clinicians and PMTCT service providers to be KP/MARP friendly; 2) establishing HIV positive support groups for KPs/MARPs; 3) providing basic care services including symptom management at DICs and via peer educators/case counselors; and 3) training service providers and personnel to provide positive heath counseling and adherence support (KP TWG, 2011; p. 26-27). The SOPs, which aimed to provide detailed guidelines on how to achieve the objectives of the NSPs, however did not provide any procedures on these sub-objectives for HIV-positive MSM or FSW nor were there any guidelines on continuum of care services or reference to more general guidelines for SOP target users.

Limitations in Treatment and Care Efforts

Inadequate treatment and care services for MSM.

A number of sasoi Ghanaians as well as service providers and field workers expressed concerns about the lack of targeted treatment and care interventions for, and its negative impact on, men who have sex with. As Gideon Adjaka, an HIV counselor and support group facilitator at WAAF (an HIV/AIDS treatment and care non-profit organization) shared, the prevention work in Ghana, particularly the education component, “is the only thing that is going well”. However, “the problem still lies with what then happens when the person tests positive” he added. Most of the HIV education content for MSM has been for those who do not have the virus, with core messages such as: “have sex with condom, reduce your sexual partners, and don’t take alcohol”. But he asks, what happens when the men do get infected? Do people—the men included—understand the issues facing MSM who are HIV positive? According to Gideon, the system for helping people treat HIV is supposed to be there. There are numbers to call and locations to access those services. However, treatment interventions are not well developed or implemented yet in Ghana for MSM.
Gideon’s concerns were informed by his experiences speaking with MSM clients. A common belief he found among the men is that HIV meant death, and that once you are positive, “You need to die; there is no life. You can’t do anything.” These types of beliefs are due to the deficit in knowledge about HIV treatment, and as Gideon argued, must be countered by targeted educational interventions that inform sasoi Ghanaians that they can live a long healthy life with HIV/AIDS. They do not know about the different steps needed to treat, manage, and live with HIV and thus, are in need of a system of support that can help them with these issues. Moreover, many HIV positive MSM do not know their rights as PLHIV. As Gideon shared:

*The issue is people lack the knowledge. People don’t know I need to regularly check my CD4. They don’t know the essence of it. They don’t know I have to watch my diet, I need to reduce alcohol, partners, and so on. We need to start developing models that bring those people together, not necessarily with monetary benefit, but for them to understand and create a supporting system.*

The concerns expressed by Gideon were echoed by Roland, a 25-year old HIV positive saso Ghanaian who works as a fashion designer. As a saso man living with HIV, his experiences accessing healthcare have been mixed. On the one hand, he has had some sympathetic healthcare workers who have helped him access the care he needs. On the other hand, he has been chastised by other health workers, like a medical doctor who told him that he had HIV and warts because of what he likes doing, by which he meant having sex with men. Moreover, he has experienced a healthcare system that is constantly facing shortages in ART medication, and working with malfunctioning medical technologies that are supposed to aid with treatment and care. Roland shared that these barriers to care were common for him. Sometimes he’d go to pick up ARVs for four or five months, but would be given medication for only 2 weeks and be directed to return after that time period for more medication due to shortages in ARVs. Additionally, the CD4 count machine might be broken down and a service

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provider might tell him to visit a private clinic where the test has a fee he may not be able to afford, compared to the free tests at the government hospitals.

In terms of treatment activities targeting KPs, the SHARPER project did have a couple of interventions that provided education for PLHIV but they weren’t specific to MSM or FSWs and they were limited in scope. The LifeLine intervention from SHARPER provided daily SMS reminders for ART adherence to KPs and the Models of Hope (MoHopes) provided ART and positive health, dignity, and prevention (PHDP) services to PLHIV by training model PLHIV as peer educators to provide support services. These peer educators also worked with HIV clinics to monitor those on ART who were lost to follow-up, and they provided peers with information on prevention, care, and ART adherence (FHI 360, 2015). The more recent LINKAGES project also aims to develop a better continuum of care program; however, interventions are still in the process of being developed.

In addition to these programs, there are a few support groups for PLHIV; however, as Gideon shared, the life cycles of these programs, like most other MSM interventions, are determined by project funding and are therefore, often very short-lived, unsustainable, and inadequate for meeting the health needs of MSM with HIV/AIDS. Instead of such a system, Gideon suggested the development of a more grassroots social support network that isn’t incentivized by T & T (time and transportation) or dependent on donor funding. According to him:

*The supporting system shouldn’t be: today, come to meetings. We give you T & T. Then, after one year, the projects have ended. Then the group collapses. It should be a supporting system that seek to continue training them in a way that they support themselves, without even monetary benefits, so they know that, even without money, we still need to meet as individuals, talk. These are the support and people we can fall on, so that if I’m not able to pick my medication, I can ask my friend, “Please go and pick my medication on my behalf.”*
Another peer educator, Dani, shared that the PLHIV support groups that do exist are discriminatory towards MSM participants in the group and view them as spreading HIV. He stated:

...There are some MSM who are in some general population support groups and some of them have stopped going to meetings because when they go to the meetings, they themselves, the PLs (PLHIV) themselves, some of the ladies and some of the guys always look at them like they are the cause of HIV and STIs because [they think] what they are doing is creating the HIV and it's crazy.

Without a “concrete supporting system for the LGBT community”, as Gideon put it, with many sasoi and other men who have sex with men poor and unemployed, there are very little resources and supports to fight the infection. A common outcome of this lack of employment according to Gideon, is that people resort to sex work, even if positive, to generate some income, thus placing their sex partners and the partners’ sexual networks, at risk of getting the virus.

Another key problem related to the lack of support for MSM living with HIV that contributes to the cause of the gap in the treatment and care of this population is that the main national organization of PLHIV do not give much attention or resources to key populations. Jacinthe from USAID expressed her concerns about this lack of inclusivity and representation of HIV-positive men who have sex with men or other KPs in the Network of Association of Persons living with HIV (NAP+) Ghana:

NAP+, when I first walked in, everybody was saying they’re working with PLHIV groups. I was like how’s that possible? Do they truly represent—even though they may have the structure—do they truly represent the PLHIV in this country? My suspicion is no for various reasons that I’m not all in tune with, but if you have a strong face membership organization, it’s so much easier to just go through that organization, to then tackle what all the members are saying their needs are. In Ghana, that doesn’t seem to be here, which is a little bit problematic. Or more than a little bit problematic.

This lack of attention reflects the dynamics discussed in Chapter 3, which is that while important steps are being taken by the government and its partners to address HIV/AIDS among MSM and other KPs, these efforts are occurring still within the margins of the national
response. This liminal position is thus producing an inclusion paradox whereby, sasoi and other men who have sex with men are included in national efforts but remain marginalized and often invisible in broader structures and organizations, like in the case of NAP+, where HIV-positive MSM do not have representation. There are MSM specific programs—all funded by outside donors—but they are not integrated into national HIV programming, or activities. Rather, they function in parallel to programs that target the general population. KP programs are distinct projects that function under special government work groups and policies (i.e., KP NSP and KP SOPs) and most visible to those who work directly on them.

For many HIV-positive sasoi and other men who have sex with men, the lack of targeted, accessible, and dependable continuum of care services is a matter of life and death. According to MacDarling, at least 6 young saso men he knew of had died from HIV within the months prior to interviewing him. If MSM-focused interventions were effective, he asked, then why were the men dying?

*Why are these people dying? You go for your CD4 count and they tell you the machine is broken down and the machine has been broken down for the past six or more months. So you cannot know your CD4 count. So how do you even get on medication or not? Or how do you know where the stage at which you are to get on medication is or not and that is the situation which we are in here currently.*

One person who lost his life during the time of my study was a well-known young, gender non-conforming saso and LGBT rights activist, Dee25, who lost his battle with HIV a short period after learning of his status. Dee, like many other sasoi Ghanaians with HIV, was devastated by the news that he was positive and was especially concerned about the shame he felt HIV brought his mother and family. As an HIV-positive man, he strongly believed that he was going to die an early death—a common belief in the sasoi community, along with the notion that death is even deserved. As Gideon shared, “The ideology in Ghana is, ‘Oh, well, after all, I

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25 Name changed to protect identity
would die.’ In the MSM community, that is the ideology.” Such internalized homophobia stemming from the stigma and demonization of gay men in Ghana presents a significant barrier to treatment and care and ultimately, saving lives.

In addition to the issue of internalized homophobia, stigma against those who are HIV positive in the saso community presents significant barriers for those who seek treatment. Guro recalled a story from one of the nurses she works with at IHCC, in which an HIV-positive MSM who came to the clinic to pick up his medication ran and hid upon seeing two other MSM he knew enter the clinic. He eventually left the clinic to avoid being seen by these two men he knew. A number of MSM, including peer educators, I interviewed shared concerns regarding fear of being outed as HIV-positive in the clinics and pharmacies where the men pick up their medication. This shame and fear of isolation many HIV-positive MSM feel is a serious barrier to treatment, as reported by a number of studies in sub-Saharan Africa (Stefan Baral et al., 2011; Fay et al., 2011; Makofane, Beck, & Ayala, 2014; Poteat et al., 2011).

**Inadequate funding for treatment and care.**

Several stakeholders I interviewed raised concerns about the lack of targeted interventions for KPLHIV. MacDarling particularly expressed concerns about interventions that overly focus on condoms and lubricants, while virtually ignoring treatment as a form of prevention. He lamented, “Treatment as prevention, treatment as prevention. What you need to do for MSM is treat people who are sick, so that they stop infecting others, instead of just giving condoms and lubricants”. Dr. Naa Ashley Vanderpuye, a medical doctor and the Director of WAAF, shared that her organization is not considered a key population organization despite providing treatment and care for many KPs. The reason for this lack of recognition, she believes, is that prevention activities are the main focus of KP work and therefore, government and donor stakeholders only include certain organizations in policy efforts and in implementing KP-specific HIV prevention activities. Treatment is now “coming up” in KP efforts, according to
Vanderpuye, but WAAF remains in the shadows of KP work and thus, marginalized from accessing resources in this area to support treatment and care for MSM and other KPs in their clinics. But a more central issue is that it is generally difficult to secure funding for treatment because "most donors don't want to fund medicines", forcing them to do their own fundraising to stock STI and HIV treatment medication.

The continuum of care steps, which is supposed to take a diagnosed person and link them to care, engage and retain them in that care, prescribe them ART, and through these steps, achieve viral suppression, is unfortunately not yet well institutionalized and adequately funded in Ghana. Moreover, an ongoing economic recession in the country has led to slowdowns of efforts to expand the percentage of PLHIV linked to ART. This funding crisis has meant stock outs of ARVs, like Roland experienced, and of HIV test kits over the past few years.

Inadequate funding of programs is not unique to MSM and other KPs but is rather a general issue within the country’s national response. And the impact of these issues is reflected in the country’s treatment and care data. In 2015, PEPFAR reported in Ghana’s Country Operational Plan (COP) that “limited external and domestic resources affecting the availability of antiretroviral drugs” was a major gap that has affected the country's ability to control the epidemic among key and general populations even through overall compared to other periods, the country has made progress in its HIV care cascade (PEPFAR, 2015; p. 9). Figure 14 shows the treatment gap for eligible PLHIV from PEPFAR's 2015 report. Additionally, according to the 2016 PEPFAR COP, out of the 250,232 PLHIV, 89,113 (35.6%) are on ART, while 133,582 PLHIV are still in need of ART.
Inadequate monitoring of MSM treatment and care data.

The gap in meeting the treatment and care needs of MSM is even more pronounced since these populations have only recently been acknowledged and prioritized in the government’s HIV/AIDS efforts. The extent of the gap, however, is not known because according to the PEPFAR’s COP for Ghana, “the actual number of KPLHIV who are linked to care and treatment services is currently unknown” (PEPFAR, 2016; p. 5). This is because the Ghana Health Services only monitors treatment data by age, sex and geographical location and therefore, does not have disaggregated data for KPs. This effectively means that it is difficult to monitor MSM and other KPs who are linked to care and treatment. Moreover, it appears that there is also no data from past projects or interventions on how many MSM were enrolled in or reached for ART. PEPFAR (2016), however, reports that the government of Ghana and other stakeholders like FHI 360, USAID, and the CDC are in the process of developing an electronic-based unique identifier code (UIC) system that can track KP across the continuum of care. Despite this important step, PEPFAR also reports that “with regards to ARVs, the Global Fund is the only assured source of ARVs procurement and forecasts indicate that 2016 and 2017 targets cannot be met without additional procurement to cover the [government of Ghana]
cohort” (PEPFAR, 2016; p. 6). This forecast, for the general PLHIV population and based on current observations, might be even more dire for MSM and other KPs.

UNAIDS made a call in 2014 for countries to set a 90-90-90 target, whereby 90% of PLHIV knew of their status, 90% of those who knew were sustained on ART and 90% of those on ART have viral suppression. According to PEPFAR, for Ghana to achieve the 90-90-90 target among the general population, it needs to ensure that that 236,345 PLHIV know their status and that 212,7101 of them are enrolled in ART by 2020 (PEPFAR, 2016). Since KPs are disproportionately affected by HIV/AIDS, “it is imperative to intensify interventions to reach, test and link MSM and FSW into care and treatment services” (PEPFAR, 2016; p. 3). According to PEPFAR, there are a number of initiatives being planned by PEPFAR, GAC, and NACP, with the support of Global Fund to ensure that the gap in treatment and care is closed for those MSM and other KPs who need treatment and those who are receiving it. One of those initiatives is the *Strengthening the KP Care Continuum*, which aims to use evidence-based continuum of care KP friendly service models “to increase KP service uptake and retention across the care cascade with interventions that fully integrate complementary facility and community based activities, and build local CSO capacity to assume selected services being implemented in the facilities wherever possible” (PEPFAR, 2016; p. 35).

**Are Good MSM Policies Implementable?**

Although the KP SOPs provide a detailed blueprint for implementing MSM HIV policies, analysis of interviews with stakeholders and observations of programming and policy efforts evoke the question David Mosse asked from his ethnography on development work: are good policies and in this case, programs, implementable? Are the ideas behind model policy documents and lauded interventions enough to withstand the sociocultural terrain in which they are operationalized? Or do they come into contradiction with other institutional and structural
goals and realities as Mosse (2004) and Latour (1996) suggest? As mentioned in the previous two chapter, some of the key challenges in the MSM HIV work are the legal codes and social beliefs and attitudes that continue to criminalize and stigmatize male same-sex sexual activities. Efforts by government officials, policymakers, donors, implementing partners, and other key stakeholders to address HIV/AIDS among MSM and other key populations have been courageous, as some stakeholders in the country’s KP efforts have proclaimed. The GAC and its partners have taken a principled, public health approach to addressing HIV/AIDS among a very marginalized and vulnerable population. At the same time, the implementation of these efforts has yet to reach their full potential. As Wondergem from USAID candidly stated,

*It looks like…let me say, policy-wise, everything is in place. The structures are in place. It is doing it that is not going well. The implementation, reaching sufficient coverage, having quality interventions. We even have a national evaluation in place. We are developing Standard Operation Procedures. But then it is just not happening at the right scale and right intensity. That is the problem.*

So why does Ghana lag behind in its implementation of its KP policies? Of note, there exist laws, social and cultural beliefs, fiscal and structural realities, and institutional codes and practices that are in direct contradiction to or that undermine the country’s HIV/AIDS policies and programmatic objectives for MSM. Although stakeholders in this area of work discuss many of these challenges, they also overstate the positive impacts of policies and services, while simultaneously underreporting or minimally discussing these significant challenges that make it difficult to realize the well-crafted policies and guidelines for addressing HIV/AIDS among MSM. Among these positive impacts are the multi-sectorial partnership and coalition building, the inclusion and participation of MSM and other KPs, the attainment of political buy-in, and the procurement of resources. But these achievements, once analyzed in depth, conceal significant political differences and challenges that affect the nation’s ability to provide quality comprehensive HIV/AIDS services for MSM as outlined in the 2011-2015 KP NSP.
This dynamic brings to mind Mosse’s observations from his ethnographic work on development, in which he argued that, “Policy discourse generates mobilizing metaphors (‘participation’, ‘partnership’, ‘governance’, ‘social capital’) whose vagueness, ambiguity and lack of conceptual precision is required to conceal ideological differences, to allow compromise and the enrolment of different interests, to build coalitions, to distribute agency and to multiply criteria of success within project systems [italics added]” (Mosse, 2004; p. 663). While not everything on Mosse’s list is applicable to the Ghanaian case, the core of his argument—that the appearance of unity and progress obscures important challenges that must be addressed if HIV/AIDS among MSM is to be successfully eradicated in the future—applies. This section explores key challenges identified in my study, particularly persistent stigma and discrimination against MSM, insufficient funding for MSM programs, inadequate support of frontline workers, and a gap between frontline workers’ experiences and key stakeholder knowledge and integration of these experiences into program evaluation and improvement.

**Stigma and Discrimination against MSM**

**Criminalization and social stigma.**

One of the key challenges to the implementation of prevention and care services that are accessible to sasoi and other men who have sex with men is stigma and discrimination against this population. In Ghana, this stigma and discrimination, in part, stems from a constitution that criminalizes unnatural carnal knowledge, particularly and most harshly, male same-sex sexual activities. This legal framework underlies a social and cultural context in which homosexuality is considered, as Erving Goffman (1963) argued—a spoiled identity; one that is demonized, denigrated, denounced and socially unacceptable. Nationwide, an increasingly politicized and homophobic discourse on homosexuality\(^\text{26}\), led by religious leaders, political figures, and the

\(^{26}\) Refer to Chapter 4 for an extended discussion of this
media, continues to fuel homophobia and shape the lived realities of many sasoi and other men who have sex with men.

As discussed in Chapter 4, to be gay in Ghana in this political moment means to perpetually live in fear of experiencing humiliation, violence, extortion, and social exclusion. Heterosexuality is the religiously, culturally, politically, and nationally-sanctioned norm that homosexuality is judged by. Heterosexism—that is the institutionalization of heterosexuality and the legal and social suppression of other forms of sexuality—thus, constructs homosexuality as abnormal. Following Link and Phelan (2001), stigma against homosexuality in Ghana is composed of the following four components that are produced through the mechanisms of sociocultural, religious, and political power: 1) people label and distinguish human difference (i.e., homosexuals, “gayism”) 2) prominent cultural values and beliefs connect the labeled individual to a set of undesirable traits—negative stereotypes (i.e.; pedophile, rapist, sodomite, demonic), 3) the labeled individuals are placed in categories that produce an “us” versus “them” (i.e., un-African, un-Ghanaian); and 4) the labeled individuals undergo status loss and discrimination that might lead to disparities (i.e. economic & social exclusion). This stigma against homosexuality is so pervasive that, as one peer educator explained, it is inescapable: “the stigma is always there.”

Stigma and discrimination at healthcare settings.

In Ghana’s national AIDS response, this stigmatization of same-sex sexual desires, intimacies, and sexualities shapes much of sasoi and other MSM’s interactions with healthcare providers in clinical settings—a reality that a number of Ghanaian key stakeholders had a hard time discussing. Dr. Henry Nagai, the UNAIDS Strategic Information Director and the former Country Program Director at FHI 360, mentioned that one of the most contentious issues for stakeholders to agree on in policy and programmatic efforts was that stigma against MSM on the clinical level is a real barrier to accessing HIV/AIDS services at healthcare settings. This, he
recalled, became a difficult point to agree on in policy and programmatic efforts for MSM. According to Henry, some stakeholders thought that unless a man mentioned that he was homosexual, why would service providers treat him differently? The logic behind their thinking here is that MSM should be treated with professionalism and afforded their constitutional right to healthcare like any other citizen, so long as no healthcare provider knows of their sexuality. He explained, “They feel that if you go to the hospitals, nobody is saying that MSM should not come there. Most of the clinician [think] nobody is forbidding anybody from there, ‘When you come, we don’t ask you whether you are this or that’”. But as Henry explained, this view was not reflective of the reality of HIV service provision at hospitals. Instead, “the truth is that if they know, then they stigmatize, and if they know then it becomes a problem.”

The logic of the stakeholders that Henry discussed would make sense in a world in which Ghana’s healthcare system was not affected by the nation’s political, social, and cultural contexts. However, the reality is that sasoi and other MSM who seek HIV services in healthcare settings are met with discriminatory practices, often based on stereotypes and caricatures about gay men. Particularly, these stereotypes often make assumptions about one’s sexuality based on gendered notions of how straight men and gay men behave, sound, look, and walk like. The belief is that men who sound “feminine” (i.e. have higher pitched voice), “sway their hips”, embody “female gestures”, act in a “girly way”, and wear tight/fitted or expensive looking clothing are assumed to be gay and are therefore discriminated against or humiliated in the clinics.

For example, a common occurrence many of the men shared in their interviews and group discussions is that service providers preach against homosexuality to men they assume or know are gay. In such situations, the men are chastised as sinners, condemned, and told to repent their lifestyles. Wise, one of the lead CEPEHRG peer educators, shared some of his clients’ stories about their experiences in clinics he has referred them to—assumedly clinics that are certified “MARP-friendly” by the GAC and NACP. He recalled:
When you give people referrals to go to the clinic, then immediately they go. Then when they come back, they’ll tell me, “the nurse or the doctor that you gave me, when I went, he was preaching [to] me. He took the bible immediately. I went and he took the bible, placed it in front of me, and he was preaching this and that…” You are not supposed to have sex in the anal [area]…How can you? Look at you, a man! How can you have sex with your fellow man?” You know, those kinds of things.

For men who have anal warts, service providers often stigmatize them because they assume that they are having anal sex and are therefore gay. As Wise elaborated, “because you have warts around your anal area or you have any infections [or] because of the way you act, the gestures you are showing, the healthcare provider will say ‘okay, because of the way you are showing, I know probably you are a gay or you have sex with men. That’s why you have warts or any infections around the anal area”’. Wise explained that in such circumstances, all he can do is try to calm the person down. However, since there are very few options for HIV services, for many who experience such humiliating experiences, they prefer not to return to the clinic because they do not “want to experience that again” even if they are still in need of treatment services. Rather, they often prefer to visit smaller, more specialized places like a DIC for their health needs. Collins, a former CEPEHRG Outreach Coordinator, also shared an incident of preaching that one of the peer educators he worked with experienced at a clinic, lamenting the unprofessional nature of such experiences:

One of the peers went to access services and they said the nurse brought a bible and they were quoting from the bible, “This is from Sodom and Gomorrah. These are the things that people did and…the whole place was burned down and so this is not African. Like this is not in Africa, this thing. You know Ghana is a Christian country, so we shouldn’t”…I mean a whole lot of things. So, they tried to preach to them to change their sexuality and that person did not go there for you to change him or her. The person came there to access services, so try to give the person what he comes there for. Why should you preach to somebody?

In addition to these incidents of anti-gay preaching, peer educators often mentioned other forms of stigma and discrimination MSM experience from healthcare providers or in healthcare settings. These included: 1) gossiping about the men to co-workers or community members, 2) treating them disrespectfully, and at times 3) denying them services. Such
treatment makes it difficult for MSM to feel welcomed or comfortable at a clinic. As Wise shared, “Some too when they walk into the clinic, people stigmatize them, even the nurses themselves stigmatize them. Probably the healthcare providers stigmatize them. So they prefer not to go there at all. But they will prefer probably a confined area [like] the DICs that we have, to go there [for] medical attention.” Mercy, a middle-aged STI nurse, HIV counselor, and midwife who runs a social club for MSM at the University of Ghana, Legon hospital, also shared that stigma was one of the key barriers she has observed in her work with MSM. Many of the men she serves are afraid of being stigmatized and therefore avoid visiting the clinic to get treatment for their conditions. She stated that her main goal was to address this stigma to encourage the men to more confidently access services:

[My main goal now] is to talk about the stigma and discrimination among themselves, so that they can come out boldly and have treatment. Once it is me [with HIV], it might be you too, so there’s no one to judge anybody. So, this is what I want to do...Because the stigma is damaging them a lot, the MSM in the society.

KP-friendly hospitals, which are supposed to be more attuned to the needs of KPs, are also sites of discriminatory practices against MSM as some of my informants shared. The efforts to sensitize service providers to offer friendly services to MSM and other KP will likely be a long-term process. However, even for personnel who have been trained, there seems to be a rift between what professional and KP-friendly services providers are trained to provide, and what kinds of services these providers think will help the men. For example, MacDarling explained that there are trained service providers who preach to sasoi and other MSM to change who they are as homosexuals because they think “it is part of the quality services they’re providing”. For those who take out a bible and proselytize, they perceive their actions as acts of deliverance and salvation for homosexuals. If they can teach the men the word of God, then they might be able to convince them to renounce their homosexuality and save themselves. For them, it is not
the sensitive STI treatment or the ARV services that will help or save an MSM, but rather the word of God. Never mind that many of the men are already devoted Christians and Muslims.

Unfortunately, these incidents are not isolated. Rather, they reflect a common pattern in health centers, where clinic personnel gossip and judge people assumed to be gay or associated with gay men. MacDarling expressed his frustration with pervasive homophobia among even KP-trained healthcare providers at government hospitals. Recalling an experience at Ridge Hospital—one of the few government hospitals in Accra that has trained personnel to be KP-friendly—he stated:

*I remember I was at the Ridge hospital specifically and there is this woman who is the matron or something who’s been judged the best MSM friend or something at the hospital. And I have a friend who was working at the hospital and anytime I come there and talk to that friend if I leave, she would call him and query him like, “How do you know him? Why do you know him? What did you do with him?” And this is supposed to be somebody who is a friendly MSM person. So at some point my friend left the place because he couldn’t cope with the situation anymore. So that is the challenge.*

Despite how common these experiences are for MSM, policymakers and other key stakeholders seemed to think that MSM’s access to HIV/AIDS treatment and care services is much easier than it actually is due to these trainings. While stigma and discrimination are acknowledged and discussed in policy documents, meetings, and programmatic efforts as barriers to care that need to be addressed, the extent of these issues, I argue, are not fully understood by government officials and other stakeholders leading MSM work. Many of these officials undermine the extent of the discrimination faced by MSM at clinics and hospitals, and its impact in preventing many people from accessing services.

The KP point person for NACP, who also serves on the KP TWG, expressed this view in her interview. While she acknowledged that there are still some barriers to accessing care, including the legal situation, she also suggested that MSM “self-stigmatized” each other—a common belief among key stakeholders. The notion of self-stigma amongst MSM in Ghana can be understood as perceptions and behaviors among sasoi and other MSM that contribute to or
repeat the negative stereotypes about homosexuality. The NACP representative, however, exclaimed that, due to the advances made by KP efforts in Ghana, an MSM with anal warts can walk into a clinic today and show his warts to a doctor without any problems. For her, the inclusion of MSM into the general clinical population—what she referred to as the “mainstream”—has reduced stigma and improved the men's access to healthcare services. She stated:

But basically, I think that we have enrolled [MSM] into the general population. In the beginning when they were not reached, for me I thought that the MSM themselves were stigmatizing themselves and they were like "Ay! I won’t go. If I go and I have an STI in my anus, everybody will know that I'm MSM". So, they were stigmatizing themselves but with the education and the training and being in meetings with them and training of healthcare workers as key populations friendly, most of them moved into a health facility and say "hey, I have some itch at my anus so can someone have a look" and people look. So, I think that is a gradual process but we have made a major headway for now, incorporating them into the mainstream.

Peer educators who are at the frontline of this work have a different assessment of the progress made. For them, the mistreatment of sasoi and other MSM remains a significant barrier to care. What is missing for sasoi and other MSM, according to Wise, is access to justice and an end to the violation of their human rights. As many sasoi peer educators and other frontline workers who work closely with MSM stated, no service provider should preach to, or discriminate against a client because they think the client is gay. One peer educator explained:

When you walk into any healthcare provider, [the] healthcare provider should not preach to you because [of] how you look. You should see what you see and treat it as it is. No questions. Nobody should bring a bible and preach to you and say “Hey, you are this. It is not what you are supposed to be doing. You are supposed to be living with a woman, marry a woman”. Those kinds of stories they usually tell us, no! I just don’t want to hear that. We want the right to access everything that every individual enjoys in this country. Just the normal basic rights everybody should enjoy the same way. But it shouldn’t be seen as because you are MSM, you don’t enjoy some rights as individuals.
Limited interventions to address stigma and discrimination.

Members of the KP TWG have taken important steps to create a more sensitive healthcare setting for MSM to access HIV/AIDS and STI services. However, the progress and impact is uneven. As Essandoh from USAID stated, stakeholders have spoken about “stigma and discrimination for years” but “we still have the issues of stigma and discrimination, more at a community level and a facility level”. According to him, stigma and discrimination is “even worse in the service delivery point, at a service delivery center”. As he shared, the strategy of training healthcare workers and staff to be KP friendly was to develop them to not discriminate. But, he expressed, stakeholders have not trained a critical mass of the workers to produce the desired effect. Jacinthe from USAID added that she had observed stigma against MSM to be very high, “to the point of possibly death to someone”. In discussing ways to address stigma on the programming level, she raised a few concerns that resonated with the inclusion paradox observed in the country’s MSM HIV/AIDS efforts. She wondered, specifically, whether it was practical to operate MSM focused programs “in the dark”—or put differently, within the margins of the work and away from public visibility—and still effectively advocate for the needs of sasoi and other MSM and reduce stigma.

Jacinthe, however, doubted whether it would be easy for MSM to come out publicly the way FSWs do. Emmanuel and Suzie’s observations, were echoed in the Performance Evaluation of the National HIV Prevention Program for FSW and MSM in Ghana report (2014). The report found, from interviews with service providers and stakeholders, that there were numerous obstacles in MSM HIV work that made it difficult for organizations to reach MSM, with the main obstacle being “high societal stigma and discrimination against the target populations” in addition to the criminalization of homosexuality which makes it difficult to reach MSM in the field or at clinics (No author, 2014; p. 61). The report added that “social, legal, political, and cultural barriers” were preventing the coordination of stakeholder and organizational efforts. Moreover, the evaluation found that “key informants identified high levels of social stigma and
discrimination against key populations as a prominent barrier to HIV prevention efforts among MSM and FSWs” (No author, 2014; p. 70).

**Comprehensive policies, underfunded programs.**

In addition to stigma and discrimination against sasoi and other MSM, one of the central challenges to the implementation of MSM HIV prevention and care services is Ghana’s economic status as well as the unstable state of HIV/AIDS funding internationally and locally. One of the central barriers to achieving development goals and objectives is not having the financial resources to effectively carry out outlined policy and program priorities and objectives. While the stakeholders may have procured political buy-in from key government officials, without adequate and stable funding, their KP HIV prevention and treatment efforts stand on a shaky foundation. Moreover, the funding that does exist, according to MSM organizations and service providers, does not meet the needs of the programs and clients they serve.

Ghana has been both committed to, and successful in, procuring funding to address its HIV/AIDS epidemic. The country’s 2011-2015 NSP had a budget of $444 million. The primary donors towards this funding—and more generally—were Global Fund, PEPFAR, and the government of Ghana. The United Nations also gave support through the provision of Technical Assistance, with a focus on monitoring and evaluation as well as systems strengthening (PEPFAR, 2016). As previously discussed, the country’s HIV budget disproportionately allocates funds for prevention of new HIV infections. In the 2011-2015 NSP budget, 47% was spent on this area, with most of that amount—about $82 million—covering KP efforts (PEPFAR, 2016). For treatment, support, and care, the budget allocated less funding, with only 18% of the budget—about $79 million—spent on this area. Ghana’s largest external donor for HIV/AIDS is the Global Fund. Between 2002 and 2011, the country’s Ministry of Health/Ghana Health Services was awarded funding in Rounds 1 and 5. The Global Fund has contracted a total of $597 million with the Ghanaian government to address HIV/AIDS, TB, and Malaria as mandated
by the Global Fund. Out of that amount $261 million has been allocated towards HIV/AIDS work (PEPFAR, 2016). These funds have targeted the strengthening of the health system and the scale-up of prevention, treatment and care.

For MSM and other key populations, funding allocations are low despite how much they are disproportionately affected by HIV/AIDS. According to MSMGF in 2011, “only 3.2% of the $13 million U.S. bilateral funding for HIV prevention was invested in HIV prevention among men who have sex with men” in Ghana (Ayala, Hebert, Keatley, & Sundararaj, 2011; p. 19). They also found that although 43% of new infections were among FSW, MSM, and PWID, only 0.24% of national HIV spending then was allocated towards these populations. The government has, however, increased its spending towards key populations HIV/AIDS efforts over the past 5 years. According to the Midterm Evaluation (MTE) Report for the 2011-2015 NSP (Youri et al., 2014), in 2010, only $7,133 out of the $62,147,564 HIV response budget was spent on MARPs prevention efforts. In 2011, this amount increased significantly to $1,068,230 out of a total budget of $81,677,333. In 2012, the budgeted amount was $13,151,714 out of a total of $84,694,045; and in 2013, the budgeted amount was $26,281,264 out of a total budget of $98,881,829. Currently, most of the prevention of new infections budget (about $82 million) goes towards key populations (PEPFAR, 2016).

With nearly half a billion dollars going towards HIV for the most recently completed NSP, the Ghanaian government has demonstrated their political commitment to addressing the epidemic. However, despite more recent increases in funding for KP HIV/AIDS efforts, there remains spending gaps for meeting key priority objectives, which have been the product of inefficient use of funds as well as inadequate allocation of money. For example, many of the interviewed peer educators and local NGO/CSOs lamented about the inadequate and unstable funding environment in the HIV/AIDS work. As Henry Nagai of UNAIDS shared in his interview, a key challenge in MSM HIV/AIDS efforts is that “funding levels are not as consistent as they should be. I think that we must be able to, under the Ghana AIDS Commission, get funding to
support the programs that have been started to continue. So, funding is one key threat to our further development…”

Moreover, implementing partners are unable to carry out prevention and care activities due to funding challenges. According to the 2011-2015 NSP MTE report (Youri et al., 2014), CSO implementers who were interviewed discussed significant issues with “erratic support of donor organizations”, which resulted in unreliable funding as well as inadequate resources to support logistical needs of program efforts (p. 44). Part of the issue is that projects are donor-based and therefore without sustained funding. They are therefore unable to maintain long term staff/personnel and programs or build their capacity. Due to these funding issues, they are unable to continue the projects they implement through donor funding. As the report stated, these NGO projects:

…operate with insufficient resources and very short funding cycles. Retaining trained peer educators has been a challenge as many projects lose their trained peer educators in between funding cycles. High turnover rates mean projects continually need to recruit and train new staff, which places both time and financial pressures on them (Youri et al., 2014; p. 44).

For sasoi and other MSM, these funding issues have had a terrible impact according to frontline workers who carry out day to day MSM HIV/AIDS work. For Mercy, the nurse at the University of Ghana hospital, funding has been a key barrier to her being able to provide all the services her clients need. The lack of sufficient funding, she argued, has caused preventable deaths among MSM who live with HIV/AIDS. As she stated, “There’s no funding. So, when you go, speak up so that I get some funding for them. And I think when I get the funding it will help them a lot, because most of them are dying because of money to get drugs and food”.

Occasionally an NGO might host a program but other than that, her program is strapped for funding. Guro, the DIC nurse at CEPEHRG also stated that there were many needs within the healthcare system that should be funded, however it seems the government is not even aware of how dire the situation is or is simply unwilling to provide the funding. In response to a
question about what improvements need to be made in HIV prevention services for MSM, she replied,

*I’m sure the government would find money for [MSM services] if they also knew that—it’s difficult because there’s so many things that we need. If you go to a rich hospital—here, they don’t have gloves. We need gloves. We all know it. The government has money for it, but they can’t supply it, and why, I don’t know. I believe there will be money for it, but it would have to be prioritized, and someone has to push to get it. That’s a big job, but it should be possible.*

Another dynamic created by an unstable funding situation is that NGOs have to compete with each other for donor funding. This, according to Vanderpuye of WAAF, places different NGOs in opposition to each other and creates a non-collaborative environment. In turn, this undermines efforts to have organizations pool their resources to complement each other’s work, rather than compete for the small pot of funding available. Since much of the work is also geographical, it means that organizations become protective of the communities they serve and are less cooperative with other organization who might want to work in the same area. As Vanderpuye explained:

*Collaboration is not really an easy thing to do in this part of the world and I think it’s got to do with the fact that everybody seems to be running after the same type of funding. So people want to be in control, so they are always scared if we are going to collaborate, then it means...what does that mean? Are they going to be in charge and we are just hanging in there? So, it creates a lot of competition, instead of NGO complementing each other and really collaborating to ensure that we use resources wisely.*

In addition to these issues, another key factor that affects Ghana’s ability to adequately fund MSM and other HIV/AIDS efforts is the economic hardship the country has been experiencing over the past 4 years, despite the its recent status as a lower-middle income country (D. Johnson, 2016; PEPFAR, 2015). Specifically, the country’s economic growth has stagnated since 2011, with a 3.9% growth in 2015 and a 4% in 2014, compared to 7.3% in 2013 and 9.3% in 2012 (World Bank, 2016b). Moreover, Ghana continues to experience a high inflation rate at 18.5% in 2016 (World Bank, 2016b). As PEPFAR (2016) reports in Ghana’s Country Operational Plan, due to these economic hardships, the government has had to make
cuts within its HIV/AIDS budget. Part of the issue is that, due to the country’s new lower-middle-income status, the government is now faced with higher expectations from external donors and development agencies, such as matching donor aid with a higher percentage of their own spending. Thus, in 2012 and 2013, international funding decreased from 80% to 60% respectively, while the government covered 10% in 2013 compared to 4% in the previous year. Additionally, according to the National AIDS Spending Assessment (NASA), the total spending on HIV/AIDS activities decreased from $109 million in 2012 to $67 million in 2013—a 39% reduction in expenditure (PEPFAR, 2016). This in turn, has caused a gap in the budget and in donor funding for the national HIV/AIDS response. Moreover, it has meant that Ghana is even more heavily dependent on external funding from its primary donors, Global Fund and the U.S. government and therefore its HIV/AIDS efforts are less sustainable. As the 2011-2015 MTE report (Youri et al., 2014) stated:

Ghana has attained the economic status as a lower middle income country: this makes the country loose the high profile capacity of attracting more donor support in the national HIV responses bestowed on low income countries. The over-reliance on the Global Fund financial support, which requires matching funding, is a big threat to the NSP 2011-2015. The possibility of Government not being able to match the funds from the Global Fund is high as evidenced by the difficulty GoG has in releasing in full and on time its funding tranche from the GH¢150 million for the NSP 2011-15 (p. 30).

These funding changes have negatively affected the government’s ability to meet their HIV/AIDS budgetary needs. For example, as PEPFAR (2016) reports, funding for the procurement of ARVs was delayed due to the country’s economic situation. Unfortunately, these cuts will continue to affect the national AIDS response because as PEPFAR reports, the Global Fund is the only stable source ARVs but predictions suggest that the country’s 2016 and 2017 goals will not be met without more funding. This raises significant questions about the ability of the government to not only address the gaps in HIV/AIDS services, but to prevent more gaps from developing. As the PEPFAR (2016) report elaborated:
Cutting spending is a critical component of the [government of Ghana] response to the current economic situation, and spending by the Ministry of Finance has markedly decreased over the years. As a result, the funding that was released was not enough to initiate new clients on ART or to implement other important HIV prevention interventions, including HIV Testing Services (HTS). Due to the growing financial crisis and budget deficit, it is unlikely there will be substantial increase in funding for HIV in the next fiscal year (p. 11).

For MSM, these budget cuts will have a devastating effect. According to the country’s unpublished 2015-2017 Global Fund Concept Note, Ghana will need $110 millions for its HIV and TB efforts. Out of that amount, 39% is allocated for ART, 14% for PMTCT, 14% for TB prevention and care, 7% for HIV prevention among FSWs, and a measly 3% for HIV prevention among MSM (PEPFAR, 2016; p. 12). The amount of ART budgeted for would only cover 60,000 PHLIV per year. According to Peter, the Global Fund is willing to allocate more funding towards MSM efforts, however, due to low quality program performance data, they are hesitant to invest that money into this area. This presents another catch-22 for implementing organizations: without sufficient funding, it is difficult to effectively implement and evaluate projects, but without these results, donors are hesitant to investing in future efforts.

Despite the outlined budgetary issues, Ghana has been able to do important work since the late 1990s with a fraction of the HIV/AIDS budget from the U.S. government that other countries have had, according to Suzie from USAID. On the other hand, she also believes the government needs to make improvements towards using its funding more efficiently. Currently, as a number of stakeholders shared, a disproportionate amount of the response budget is going towards costs like time and transportation (TNT), retreats, catering, and other indirect costs that are eating up much of the response budget, “…we are facing a brick wall now. Our budget is going down. We cannot afford to have people continually having needs…or only meeting because TNT is available. That's a problem for us. Because TNT’s not cheap”. Moreover, she argues that there are priorities within the government’s policies that don’t necessarily resonate with data, making it difficult for them to identify where to target funding. Instead, as Suzie suggests, more funding needs to be strategically aimed towards identifying HIV-positive persons
and linking them to treatment, care, and support. This, she acknowledges, will require more quality data, however, with less funding, the government and its partners will have to be more targeted and efficient in its budgeting efforts and data will be critical to this. As she stated, “We are faced with a big reality in terms of decreased funding due to the rates that aren’t there, due to the lack of data that’s not there. Sympathy is only going to get you that far.”

With budget cuts locally and internationally, the funding environment will be difficult for the government and many of its implementing partners. Sam Wambugu from FHI 360 shared that given these realities, the government and other stakeholders have been brainstorming ideas on how to generate more in-country funds—such as increase taxes on international flights—to support the national AIDS response and address spending gaps.

Challenges Facing Peer Educators and Service Providers

“Front-liners” in MSM HIV programming.

In public health, workers who directly provide health services to patients and at-risk populations are commonly referred to as front-line workers. These workers can be community health professionals like doctors and nurses, local pharmacists, peer educators, or midwives. Due to their proximity to, or rootedness in, the communities they serve, front-line works are known to have the most first-hand experiences and knowledge of the populations they serve. However, in many contexts, they are often underutilized in setting policy agendas and developing programs and services for the populations they serve. In Ghana specifically, MSM HIV peer educators and community nurses who serve MSM are two groups of front-line workers whose experiences, although engaged on some levels, are marginalized in the countries MSM HIV prevention and treatment efforts. This lack of meaningful engagement with their perspectives and experiences in the country’s MSM HIV response has significant implications
for how effectively these policies and programs are being implemented and whether or not they are informed by the successes and challenges faced by these workers in their efforts.

In Ghana’s MSM HIV prevention and care response, peer educators, I suggest, are the most important actors due to the disproportionate amount of prevention services they carry out as peers of sasoi and other MSM. Peer education is a volunteer position, yet it is the most demanding job among all HIV prevention jobs in the Ghanaian context. In the country’s MSM HIV/AIDS efforts, peer educators are “responsible for the day-to-day community outreach activities; providing information, education, and services to their peers in project sites; compiling weekly narrative reports; and mobilizing KP for prevention care, and/or treatment educational programs” (KP TWG, 2014; p. 63). As outlined in the SOP job description for peer educators (see Appendix G), peers are expected to provide both one-on-one and group sessions on HIV prevention, condom and lubricant demonstration and sales and other BCC activities, conduct risk assessments, and provide information on recommended referrals to HTC, STI, ART, and other services (KP TWG, 2014; p. 63). They are additionally tasked with accompanying a set number of clients (determined by their program) to the clinic for HTC, STI and other services, promote the existence of KP HIV+ support groups, actively participate in ICT services, and monitor peers for BCC activities and follow-up on treatment and care services. All these activities must be conducted, while meeting several quotas per month. For example, at the time of the study CEPEHRG peer educators were supposed to reach a certain number of peers per month under a Global Fund project. In addition to these responsibilities, they are expected to attend monthly meetings, take refresher trainings, maintain documentation of their work, and submit monthly financial and other program reports. A cross-reference of these outlined job responsibilities with the minimum package of services identified in the KP SOPs (see Figure 13) reveals that out of all service providers and implementing actors, peer educators have the most responsibilities in carrying out the minimum package of services in MSM HIV/AIDS efforts.
One of the taxing responsibilities peers have is providing emotional and psychosocial support to their peers. A number of peers shared the level of emotional support they provide their friends and peers, especially because there are virtually little to no other spaces to access such services professionally despite policies identifying them as a key need of sasoi and other MSM in HIV prevention and care efforts. Because it is an underfunded service, few MARP-friendly frontline workers, whether nurses or peer educators, are able to meet the needs of the population. Moreover, they are not as accessible as peer educators who live in the same community under similar circumstances. Due to this, peer educators commonly provide emotional and counseling services to the peers they work with, who prefer to have one-on-one rather than group discussions about their health and emotional state. Without providing these kinds of services, they find it also difficult to build trust and maintain a relationship with their peers. As Wise, one of the lead peer educators shared:

You’ll get people coming back for counseling because some will not really want to say everything in the group; they prefer being one-on-one with you when you are alone with them. Then you get to hear a lot of things about the person and also know how to advise or counsel the person. Not really about the infections per se or the risk behavior they are into. Sometimes they bring some of the emotional issues and other family issues; they add up all those things so you need to be there for them. If not, you wouldn’t get good results when you go back to them and you want to probably talk to them again. They would not give you that chance. They would probably say “Oh okay. I’m busy or my mind is occupied, I’m stressed…” That’s what you hear, but when you keep up with them, you are always with them and you listen to them probably sometimes you need to put away the peer education thing and listen to them for a while then you can bring that in as well.

As the peer educators I interviewed shared, these job responsibilities are taxing. Their job description reflects more of a full-time position than a volunteer job that one does on top of their other usual responsibilities. Moreover, some of these expectations, such as selling condoms and providing one-on-one counseling and support whenever clients need them, require them to be available and accessible “24/7”, as one peer said. As they discussed in a group interview, peer educators are supposed to work 2 hours a day. However, because of the
nature of their work they must be available whenever peers need them, including many times in
the middle of the night when they are sleeping:

We work more than normal. There are times that the projects are over and you still see
people coming to you. What can you do? You can't do anything. You must find a way of
helping that peer. So we work [a lot]...in a day you can you can go in a field, talk to your
peer, come back home, you are sitting down and another peer will come back to you or
others will give you a call [and] you have to meet them there and then...so we don't
usually have a specific time that we use to work or hours that we can [set].

No other workers within the KP response, whether full or part-time front-line workers or
policymakers and other stakeholders, are met with these expectations or tasked with so many
responsibilities. For MSM peer educators I interviewed in Accra and Takoradi, their job—mostly
funded under Global Fund and USAID grants—is demanding and they are very vocal about this.

A key issue for them related to this, is that despite the expectations placed on them, they
are compensated with very little money, making them the lowest paid workers in these efforts.
According to the peers, their monthly stipend—known as allowance—during the time of field
research was 180 Ghana cedis a month, which was the equivalent of about $70 then. This
amount, they shared, is insufficient for meeting the most basic costs of carrying out their
responsibilities. Nearly all the peers I interviewed lamented that their allowance was not enough
to cover their transportation costs for traveling to and from meetings, accompanying peers to the
DIC or other clinics, and other such costs. Additionally, they shared that many times, their peers
are unable to afford a visit to a clinic when in need of testing or treatment services because
many of them are unemployed and/or poor. In such cases, many peer educators help their
peers pay for transportation to access these services so that they can get the care they need or
to even attend the group discussions they are hosting. As Dani, another lead peer educator,
stated:

...Sometimes too [you use] your pocket money for snacks, it motivates them to come
because at least when they always come and meet new faces and stuff, it motivates
them to come. So, whenever you want to organize a large group discussion, that means
you have to call people from other places to join and the people coming from other
places come and when they are going, you have to pay for their TNT and when you
After finishing your small group discussion, you have to get each and every participant a snack, which your organization doesn’t care [about] but if you don’t do it, they wouldn’t come and you want them to come. So, you have to sacrifice your transportation and telecommunication allowances on this.

In addition to helping their peers pay for transportation and providing snacks, some peer educators shared that they at time help their peers pay for STI treatment drugs when they cannot afford a treatment prescription—a common issue that a number of service providers also raised.

Another important issue that peer educators raised regarding financial burdens experienced due to their work relates to selling (referred to as “distributing” or “distribution” in policy and program guidelines) condoms and lubricants. One of the responsibilities of peer educators is to sell condoms and lubricants to their peers, rather than give them out for free. The logic behind this is that if a peer invests in these products, they will be more likely to use it rather than if they receive it for free. Thus, peer educators are sold the condoms and lubricants they are mandated to distribute and expected to sell them to their peers. While a condom and lubricant might cost less than ten cents, these prices begin to add up and a number of sasoi and other MSM cannot afford them due to their economic situation. Given these circumstances, many peers often have to cover the cost of these condoms by giving them out for free because they cannot afford it. As Dani stated, since many of the peers are in the same sexual networks, they provide the condoms to the men so that they can have safer sex and in turn, reduce the risk of HIV within their networks. He explained:

…We buy it from the office. So, when you take it to the community, we give it out and all those monies will be deducted from our allowance. We don’t care. We do it. Almost every peer educator does it. All the condoms, they will tell us to go and sell it to our peers but we share it with them. We end up giving it to them because if you don’t give it to them the person will tell you, “Okay, if you wouldn’t give me, then me I can’t go and buy it. I will go and do the thing just like that raw”. And so we are all at risk because we all have sex so we are all at risk.
Marginalization of peer educators in MSM HIV efforts.

Despite being responsible for implementing the bulk of the country’s MSM HIV activities and working the most directly with sasoi and other MSM, MSM peer educator voices are very marginalized in the country’s MSM HIV efforts. As previously discussed and as stated in government policy documents, stakeholders acknowledge the importance of peer educators’ input in shaping the prevention and treatment efforts for MSM. They have even consulted with the peers for input on policies and programs—namely the KP NSP and the 2012 Men’s IBBSS study, however, these peers have no representation on the policy work groups, nor are they meaningfully included in decisions made about the work that they carry out as peer educators. Moreover, peers believed they were marginalized from—and even discriminated against in—these policy spaces because their supervisors and other stakeholders do not want them to raise criticisms about the work being done. Sharing his experience at a stakeholders’ meeting on addressing rights abuses faced by sasoi and other MSM, a peer explained an intervention he made regarding ways they are marginalized,

_I will say few [stakeholders] work with us. And even with that, they discriminate. The last time we were sitting at a stakeholders’ meeting, they were discriminating…They were trying to make policy on the needs of MSMs in Ghana for social justice, to where we need justice and those things…There were the GAC, all the technical people were there. They also make policy and they had forgotten that I am from the grassroots. So they were there and they were talking and I grabbed [the mic] and I said, “See, all these people they are working with, they are only here for the money. That's why they are coming...in the meeting yes, yes”._

A related issue that a peer educator raised was that their leaders and supervisors—some of whom are not “homosexuals or MSMs themselves”—stay silent about the challenges in MSM work or represent their work in “a certain way that will make they donors appreciate what they say” and “entice” them to get more funding for they work they are doing. But according to him, “they don’t openly say what is really happening”. The views shared by this peer were informed by experiences in which he and other peers were invited to meetings and events
where they felt tokenized and silenced. During the May 2014 Stakeholders Technical Workshop for Key Populations in West and Central Africa that was discussed in the previous Chapter, I observed some of the culture of silencing that peers raised when a contingent of conference participants from different countries visited CEPEHRG as a model site for MSM HIV efforts. Present at the meeting were about 10 peer educators from CEPEHRG and YPEP, who were invited to participate. Also, present at the meeting were CEPEHRG head staff and supervisors, a couple of head FHI 360 staff members, a YPEP supervisor, and a USAID representative. The topics of the conversation included peer education activities, monitoring and evaluation of MSM HIV efforts and data, the on-site DIC, the SHARPER project, issues of rights abuses against sasoi and other MSM, and security issues related to MSM HIV efforts.

During the 2-hour visit, the main speakers from Ghana were organizational directors, program supervisors, and other stakeholders. Peers were given very little opportunity to speak. However, at some point, a USAID staff member asked the peers about their experiences in the field after raising a concern that there seemed to be a disconnect between what policymakers were doing and what peers were experiencing on the ground. However, only a couple of peers were given a chance to speak and they appeared nervous. Based on the body language of their supervisors, most peers chose to remain quiet rather than answer the question. Notably, some of the peers were sure to point this out to me immediately after the meeting was done. Based on my conversations with them, I was aware they had serious concerns about the disconnect between policymakers and the needs of sasoi and other MSM. So, their silence was not a reflection of a lack of needs but rather a fear of retribution for raising concerns. As one peer shared in my interview with them,

*Our leaders or our supervisors when they go for such meeting—knowing that some who even lead us are not homosexuals or MSMs themselves—they go there [and] when they are talking, they will either frame the thing in a certain way that will make the donors appreciate what they say and will like to probably put in more funding to support probably the work they are doing. But they don't openly say what is really happening, no…They would like to cover up and say sweet things to entice the donors to give more*
but as in what really is on the field that we even report to them. They don’t even say it. I
was there at the meeting and you realized that they didn’t even allow us to talk, even
the...was it the USAID woman, who wanted to ask questions. She said she wanted to
hear from us directly but they couldn’t give us space to talk because they know what we
are going to talk about and they didn’t allow us.

The USAID representative who raised the question also addressed this tension later in an
interview:

It was very clear why we don’t know what’s going on with MSM, because nobody
bothered to engage those peer educators, and even when I try to engage them, other
people are answering. What’s around the table is—I’m not saying MSM cannot be of an
older generation, I’m just saying that around the table we did not meet the demographics
of the peer educators sitting behind us.

Similar to peer educators, other frontline workers like MARP-friendly nurses, including
those at DICs and hospitals, are also not engaged in developing MSM HIV prevention and
treatment policies and programs. Apart from not having any representation on the KP TWG,
these workers are consulted with even less than the peer educators. Vanderpuye of WAAF,
expressed her concerns about the lack of inclusion of front-line workers who work with MSM
and other KPs in government and other key stakeholder efforts. She explained that although
she thought the policy shift to address HIV among MSM was a very good step, she believed that
stakeholders can make better progress by including organizations like hers that serve many
MSM and that are identified as MARP-friendly, in the policy and programmatic efforts. She
stated that her organization, which provides STI and HIV treatment to MSM and other groups,
are often not aware of many of the policy-level developments until they are close to completion
or until researchers like myself inform them of these efforts. This, she argued, “doesn’t allow us
to effectively help our clients”. Speaking about the KP NSP policies for MSM, she stated:

When some of these [policy] concerns are being put in place, front-liners are left out of it.
And so sometimes we might not even know. We might not even know if its not for some
people like you coming to talk to us about it… So what I feel is that, when you are
dealing with HIV and especially MSM and HIV, what you have be aware of is
multilevel...so that you can holistically help the person. Because the person is not just
coming with his medical problem. He’s coming with a whole lot of other issues. And if
you yourself are not very aware of some of these things, it makes it very difficult for you to help this person. So, in my opinion, it is good but as to whether it happened in the right way, I think it did not. It should have involved more of those people who are on the front-line.

**Gap between policy guidelines and front-line workers’ activities and needs.**

As Vanderpuye pointed out, a notable issue related to the marginalization of front-line workers in policy and programmatic planning, many of those carrying out the work on the ground are uninformed or under-informed of the policies and programmatic guidelines developed to address HIV among MSM and to standardize these efforts. When asked about whether their work is informed by the policy changes the government and its partners have been making, most front-line workers I interviewed shared that they were not aware of these policies. Some peer educators were vaguely aware that the government was taking steps to address HIV among MSM but were not knowledgeable about the specifics. Of course, the peer educator training manual and tools that peers are trained with include information about HIV/AIDS and STI knowledge as well as job responsibilities and expectations. However, it does not reflect the identified needs and objectives of the current NSP. One peer shared that although they are aware of some efforts, stakeholders never “communicate any policies to us. Go to the field, get them the numbers. That’s what they want”. Another peer educator stated:

*We don’t know of any initiative. We didn’t hear of anything. 201127, now we in 2014. Even with the STI manual28 we were talking about, we’ve not seen it yet. I don’t know whether it’s with the medical personnel but as for us, we’ve not seen it. If it’s there, then we the peer educators who go in the community to speak about health issues to our peers should also get a hold of it and also we look [at it] at least.*

Due to this lack of communication another peer indicated that when their clients ask them questions about government efforts, they have to either have no response for them or make up something or look things up online to ensure they are giving an informed response.

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27 Referring to the release of the 2011-2015 KP NSP
28 Some peer educators shared that they were invited to participate in discussion to inform the development of an STI manual.
Yeah, so on the policies, we don’t get to hear anything about the policies. Personally, I have heard of some strategic plan, STI something something strategic planning. I hear them saying it but up to now we’ve not seen it…Even with strategies and everything that they do, we don’t see it because we are on the field. We who are even on the field sometimes we get to be asked these questions by our peers and because we don’t know it, we can’t say it. So, we don’t say anything at all about those policies.

The WAAF nurse who works at the CEPEHRG DIC also shared that she was not aware of the policy guidelines in MSM HIV work. In her case, she had been working in this area of work for a little under a year and had been volunteering intermittently before that, thus it was possible that she had missed the policies. Additionally, she shared that as a MARP-friendly nurse, her work had not yet been informed by MSM-specific guidelines:

I don’t know, and I guess that, if it was, I would have seen it, but as I told you, I’ve been working as a volunteer on and off. The time I was there, if it was there, I’m sure I would know about it. If it has come after I left there, they should have told me when they put me in this position. They have not, so I believe it’s not there, but I’ve not requested it.

As Jacinthe from USAID stated, the gap between specific needs of MSM and the broader KP efforts raise an important concern about whether the current stakeholder efforts have a real grasp of the needs of different demographics of MSM and in turn whether they are effectively addressing the epidemic within this population. She stated:

Until the voice is really given to those who are frontline doing the work, and less from the program people, I don’t think anyone really has a good handle of how different [or] if it is different. What are the specific needs of MSM that are not covered from this broad category that serves all of KP? Right now, I just have no idea what that looks like.

As Dani explained during one of our conversations, one of the key gaps between the needs of sasoi and other MSM and the current programming designed by stakeholders is the disproportionate focus on condoms and lubricants. This emphasis on selling tens of thousands of condoms to MSM and other KP, which is very celebrated in program outcomes is not meeting the needs of peers. As Dani declared, “we cannot eat condoms and lubricants!” Peers around
him are tired of the same old “condoms and lubricants” and abstinence, be faithful, condoms message.

...some of the peers are like, “we are sick and tired of your condoms and lubricants and stuff because this work have gone on for over five years and all the time you peer educators come around and you talk about condoms and lubricants, A, B and C, abstinence, being faithful, condom use, TC”. Don’t you think we are tired of hearing of this?

According to Dani, rather than simply relying on this intervention, stakeholders need to implement more innovative activities that can economically empower peers in ways that reduce risk to HIV. Peers, he contends, need jobs or programs that can prepare them to acquire jobs and become self-dependent. Currently, many of his peers engage in transactional sex and other forms of sex work to pay for their daily needs and expenses. The economic precariousness that places them is this situation, he argues, is one of the main cause of high risk among sasoi and other MSM. To address these issues, he suggested:

There should be more innovations...all I’m pleading is [that] our organizations should look at “Oh, I can see this people. They love to do makeup, they want to sew, they want to do catering”. So why don’t we pick three people who we know they can teach well then we will take them to the makeup school or stuff so that when they come out they can also help the upcoming MSM in the community. They will train them in that trade so that after, they themselves can go out there and do their own work because I think if you are busy doing your own work, I don’t think you will go and follow someone or go and have sex with someone for like fifty dollars or something. Even if the person calls you, you will be like, do you know I’m very busy. Let me finish and call you.

Conclusion

Stakeholders involved in MSM HIV policy and program design and implementation must make better efforts to engage with frontline workers tasked with the implementation of MSM HIV prevention and care developments. By doing so, they can have a more comprehensive analysis of what the social circumstances shaping MSM HIV risks are and barriers to care and treatment of HIV. They must also take better steps to ensure that these policies and program guidelines being developed are communicated to workers who are on the front-lines of MSM HIV
prevention and care work. Currently, it appears that there are parallel processes in this area of work, where the acclaimed policies and program guidelines are getting lost somewhere in the dissemination process.

Policymakers are not adequately engaging key personnel who work directly with MSM and other KPs, which begs the question: how are workers being empowered and trained to address the epidemic based on these model policies and best practices? Moreover, how are these workers being supported by government and other stakeholders in providing services to a criminalized and stigmatized population? As frontline workers and even stakeholders shared, efforts to address HIV among sasoi and other MSM is considered as a promotion of homosexuality, and comes with a high risk of social stigma, condemnation, and scrutiny. For peer educators, sometimes even physical attacks. These questions and concerns must be seriously engaged if the government and its partners are to effectively address challenges and barriers that have either been identified or that exist within the implementation of these programs.

In the next chapter, I discuss the impact of the policy and programmatic changes and the intended and unintended impacts these have had on the broader society, despite attempts to keep efforts outside of the public eye.
CHAPTER 6
KEY POPULATIONS PARADIGM SHIFT, BIOPOLITICAL CITIZENSHIP, AND THE UNINTENDED CONSEQUENCES OF OPENING PANDORA’S BOX

Introduction

In this chapter, I connect the sociocultural realities shaping perceptions of homosexuality to the impact of MSM HIV interventions in Ghana. I demonstrate how the efforts to address HIV/AIDS among MSM, including the construction of MSM as at risk of HIV, have contributed to the politicization of homosexuality in Ghana and how this in turn is shaping the sociocultural landscape in which stakeholders are developing and implementing these policies and programs. Particularly, I contend that there have been significant unintended consequences from efforts related to the KP paradigm shift, including the leakage of MSM epidemiological data to the media and several backlashes resulting from this leakage. These developments have further made visible sasoi and other MSM and are reconstituting the sociocultural landscape, politicizing homosexuality, and constructing new meanings for what it means to be homosexual. I revisit my argument from Chapter 3 about the inclusion paradox produced by stakeholders’ strategy of not openly implementing MSM HIV prevention policies and programs and suggest that this discreet strategy limits stakeholders’ ability to manage and minimize the impact of these unintended consequences.

MSM HIV Efforts in a Hostile Environment

MSM HIV Knowledge Production and Politics of Data: The 2011 Moral Panics

2011 was a difficult year for the Ghanaian LGBTQ community and their allies. That year witnessed, arguably, the biggest public panic on homosexuality since the 2006 “gay conference” panic and before the 2013 Andrew Solomon controversy discussed in Chapter 4. This panic, I suggest, was primarily due to increasing efforts government and other stakeholders were making to address HIV/AIDS among sasoi and other men who have sex with men. Specifically, I
argue that the proliferation of public discussions and debates on homosexuality that year was principally triggered by the leakage of data from an Integrated Bio-behavioral Surveillance Survey (IBBSS) and population size estimation study on men who have sex with men in Ghana, known to stakeholders as “The Ghana Men’s Study”.

The Ghana Men’s Study was funded and supported by PEPFAR through the CDC Ghana Country Office and implemented by the GAC with technical assistance from University of California, San Francisco (UCSF). It surveyed men in Accra/Tema, Cape Coast/Takoradi, Kumasi, and Koforidua and was “the first population-based survey of HIV and STIs among men who have sex with men in Ghana” (GAC, RIPS, NMIMR, UCSF, & CDC, 2012; p. 3). It aimed to produce the “most comprehensive data possible that can be used to inform evidence-based programming with tailored services to reduce rates of new HIV infections and improve treatment and care services for MSM with HIV in Ghana” with the following objectives:

• To measure the prevalence of HIV, syphilis, hepatitis B, and herpes simplex virus type 2 and their associated risk behaviors among MSM in Ghana
• To assess use of and access to health and social welfare programs among MSM and identify means to increase their coverage and uptake in Ghana
• To estimate the population size and distribution of MSM in Ghana
• To enhance local capacity to conduct IBBSS, mapping, and size estimation among MSM in Ghana

The leakage of data from this study into the print and broadcast media and the local and international backlash it produced, I contend, constitute some of the unintended consequences produced by the inclusion of sasoi and other MSM as a key population in the national AIDS response and their new position as biopolitical citizens as discussed in Chapter 3.

The year 2011 was marked by non-stop media coverage of homosexuality. From the print media to radio and television, there was no sector that didn’t discuss this topic. Although
there was a constant stream of media coverage of homosexuality in the first few months of the year, the first major panic begun later in May, when *The Daily Graphic*, a state-owned newspaper with the highest print circulation, published an article titled, “8,000 Gays in 2 Regions; Majority Infected with HIV/AIDS” (Daily Graphic, 2011). While this was not the first media outlet to warn of the growing presence of homosexuality, it was perhaps the first time information from a key stakeholders’ event on men who have sex with men was referenced to substantiate this claim. The article specifically reported on a one-day USAID-sponsored workshop in Takoradi on HIV/AIDS and STI prevention and treatment that was attended by “200 health workers drawn from the 17 Metropolitan, Municipal and District Assemblies in the Western Region” (Daily Graphic, 2011). The article opened with the following statement,

Eight thousand homosexuals have been registered by non-governmental organizations (NGOs) in the Western and some parts of the Central regions, with majority of them infected with sexually transmitted diseases (STDs), including HIV/AIDS. They include students in junior and senior high schools (JHS/SHS), the polytechnics and workers.

It went on to report that at the event it “came out” that 2,900 gays and lesbians had been registered in two regions in 2008 but the number had multiplied to 8,000 in 2010, “with most of them testing not only positive for STDs but also for HIV/AIDS after they had undergone voluntary counseling and testing” (Daily Graphic, 2011). The article also discussed some of the suggested behavior change activities and more general information on HIV/AIDS and STIs prevention and treatment.

While there might have been a workshop targeting MSM in Takoradi, the data reported in the article was of course inaccurate: a majority of gays in Ghana do not, in fact, have HIV/AIDS and STIs. Thus, despite an attempt to frame the article objectively by simply reporting what was allegedly observed at the workshop, the inaccuracies in the data and the sensationalist headline undermined any attempt at objectivity. Homosexuality had not been explicitly denunciated, but the mere reportage of these statistics on gay and lesbians made its impact. The actual report, which would not be released to stakeholders and key partners until
2012, found that there were 30,579 MSM in Ghana or as the report framed it, “the prevalence of MSM in Ghana is only 0.48% of the adult male population” (Ghana AIDS Commision et al., 2012). It also reported that 17.5% of MSM had HIV/AIDS.

The damage, however, had already been done and a public panic ensued immediately after the publication, with endless coverage on the “growing incidence of homosexuality” in Ghana and the encroaching homosexual agenda that would last for the rest of the year. Articles included “This Homosexuality Nonsense Must Stop” to “Homosexuality in Ghana - Beware of the Down-Low Syndrome”, and “Homosexuality in Ghana: Senior High Schools - The Real Hotspots?”. The airwaves as well hosted endless discussions and debates about the topic, with the general public calling in to voice their opinions, a large majority of which were anti-homosexuality. Others contributed to the debate, arguing that “homosexuals have rights” and debunking some of the dominant arguments against same-sex sexualities. Among these were well-known and respected figures like Professor Fred Togbor Sai, who advocated for “homosexuals must be free to practice” (Citifmonline, 2011b) and human rights lawyer, Nana Oye Lithur, who asserted that “if we have homosexuals in Ghana once they are human beings they have human rights” (Citifmonline, 2011a). But even these figures advocated with some reluctance and defensiveness because, again, homosexuality is a no-go area and they didn’t want to appear as though they were supporting “the act”.

Within a week of the publication of the article, the Ministry of Employment and Social Welfare (MESW) publically shared that they “doubted the source of data” and were investigating “the alleged case of 8,000 registered homosexuals in the Central and Western Regions” (Ghana News Agency, 2011c). The Acting Chief Director of the Ministry, Mr. Daniel Kattah, vowed to find the NGOs behind this registration and to take “appropriate action”. Notably, there was no mention of the GAC or USAID, the two key sponsors of the event who could have easily addressed MESW’s questions and concerns.
In addition to the MESW’s outrage, the reigning political party, NDC, felt attacked by the release of the article and the backlash it caused. As the party in power, the controversy surrounding the registration of thousands of homosexuals reflected badly on their party. Their main political rival the NPP used the news to morally and politically discredit them the year before a presidential election. The National Youth Working Committee (NYWC) of the NDC took matters into their hands and released a strongly worded press statement calling for the Daily Graphic’s editor Ransford Tetteh to be “sacked” from his position for spreading unfounded, propagandistic information to undermine the sitting President, John Evans Atta Mills. They also suggested that Tetteh was paid by “the international gay cartel” “to attract our young boys into the act of homosexuality” (MyJoyOnline, 2011). The statement, which was signed by Peter Boamah Otokunor, the Convener of the group, and two other members, asserted,

For close to six weeks, the issue of homosexuality has been forced on the psyche of Ghanaians by Ransford Tetteh and the Daily Graphic without any concrete information to prove that indeed, 8,000 young men in the Western and Central Regions have been brazen enough to tag themselves as homosexuals... And with his NPP leanings, Ransford Tetteh did not hesitate to do the hatchet job to create the false impression that the number of Ghanaians in the gay business is rising under the watch of His Excellency President Atta Mills.

These reactions point to an important revelation from the Daily Graphic controversy, which is how little—at least from public statements—some government officials and political groups knew about efforts by the GAC and other stakeholders to address HIV among men who have sex with men. While it is not clear whether these officials were performing this ignorance, I argue that based on the public responses by politicians and political groups, the strategy by the GAC and other stakeholders to keep the efforts only visible to certain groups caused another unintended backlash. Specifically, this backlash took the form of notable political figures, groups and agencies vouching to find, punish, and monitor NGOs and other actors that were allegedly behind the registration of homosexuals. The Acting Director of MESW, Daniel Kattah’s, response to the controversy, for instance, reflected this backlash when he assured the public,
“We don’t register homosexuals, the publication is shocking to us. It is unfortunate the NGOs were not mentioned. The newspaper should have done the Ministry a favor by mentioning the NGOs. Without that we would embark on a wild goose chase” (Ghana News Agency, 2011c).

Another article titled, “Ministry to check homosexuality in schools” claimed that the Ministry of Education was “optimistic” that homosexuality in junior and senior high schools would “soon be a thing of the past” because of new efforts to educate youth about the “menace of homosexuality” and its health risks (XFM, 2011).

Perhaps the most controversial of these statements from political figures was one made by the Western Region Minister of Health and NDC politician, Paul Evans Aidoo, in which he “tasked the Bureau of National Investigations and all security agencies to smoke out persons suspected to be engaging in same sex” in the Western region (Gadugah, 2011). Aidoo was quoted as saying that “all efforts are being made to get rid of these people in society” and that “once they have been arrested, they will be brought before the law” (Alex Duval Smith, 2011). He also called on landlords and tenants to share information with security forces that could lead to the arrests of homosexuals in the region. Aidoo’s orders were made during a radio interview with Joy News in direct response to the alleged registration of 8,000 homosexuals in his region and to pressure from his anti-gay constituents who had mobilized in response to the news.

While he did not deny that homosexuality existed in his region, he questioned the media’s report that the number of homosexuals was that high. He even reportedly asked a Western Region health NGO to report the names of patients of theirs who are men who have sex with men (LGBT Asylum News, 2011).

Aidoo’s orders sparked a significant international outcry, which came mostly from the West. LGBT organizations like the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) denounced his orders and the general anti-gay sentiments in Ghana surrounding the controversy. Western media outlets, from Britain’s The Independent and Pink News to San Diego’s LGBT Weekly, wrote about the situation facing gays and lesbians in
Ghana. Some questioned whether Ghana was becoming more anti-gay. A young White veteran from the U.S., Jay Breneman (2011), even created an online petition targeting the international technology giant, International Business Machines (IBM), which had recently launched a subsidiary in Ghana. The petition demanded that, “Given IBM’s commitment to equality, it is vital that they denounce Minister Aidoo’s arrest order, and demand the end to violence and discrimination against LGBT in Ghana.” The petition amassed 21,143 signatures. The international backlash and pressure was so powerful that in October of that year, it prompted British Prime Minister David Cameron to threaten to withhold aid from Ghana if the country did not grant equal rights to LGBT Ghanaians. This then led to another major moral panic in the media, political, cultural, and religious institutions, and the general public, like those discussed in Chapter 4.

Impact of Panics on MSM HIV Efforts

The leakage of the data on MSM was not supposed to happen, precisely because as I’ve argued in Chapters 3 and 5, the efforts being made to prevent and treat HIV/AIDS among sasoi and other MSM are strategically structured to be only visible to those institutions and service providers engaged in that work and those the efforts target, ostensibly because of the fear of a backlash. However, a key lesson from the Daily Graphic controversy is that it is virtually impossible to prevent the dissemination of biomedical data of men who have sex with men because of how marginalized the group is and how politicized homosexuality has become locally and internationally. Moreover, sasoi and other MSM’s new position as biopolitical citizens with rights to access sexual health services without discrimination has produced an unforeseen effect, whereby they are more visible in society and thus, experience more surveillance and higher vulnerability to stigma and discrimination. This is especially compounded by the reality that the stakeholders granting them these health rights do not (or believe they cannot) openly support them in public for fear of retribution and of becoming politically discredited.
Due to the non-stop media coverage of and moral panics about homosexuality, 2011 was an incredibly challenging year for the Ghanaian LGBT community, organizations that worked with the community, and key stakeholders, staff and volunteers involved in HIV/AIDS efforts. I was in Accra volunteering for CEPEHRG and conducting preliminary research on same-sex sexualities during summer 2011 and experienced firsthand the politically charged uproar as well as the impact it had on the LGBTQ community. During this period, CEPEHRG made a big move from a small office in Osu, Accra to a residential house in Teshie-Ningua, another neighborhood in Accra. The organization welcomed the move because the new office was more spacious and secure than the Osu office, which was scrutinized by the public due to its location in a more densely populated area.

Despite CEPEHRG’s move to a more secure location, 2011 was a year of many battles for the organization. Some of their staff and peer educators endured harassment and threats in the context of the backlash. This made it an especially difficult environment for them to operate in, as much of their time became consumed with responding to hostile attacks. Thus, in an effort to address the backlash, CEPEHRG, under the leadership of MacDarling, GALAG and their allies formed the Coalition Against Homophobia in Ghana (CAHG), “a group of organizations and individuals that aims to counter ongoing attacks against homosexuals in Ghana” and that “supports the human rights of all human beings including LGBT individuals in the country” (CAGH, 2011a). The coalition was formed while I was volunteering with CEPEHRG. I was thus able to observe and partake in the discussions on how to respond to the growing backlash. CEPEHRG reached out to numerous local allies and consulted with development agencies like UNDP, and international LGBT rights organizations within and outside the continent. The organization’s staff and peer educators also participated in security, media, and human rights trainings to develop their capacity to manage and withstand the backlash. From the summer until the end of the year, the coalition released three press statements: one in response to the
backlash against LGBT people; the second in response to a problematic public statement made by the GAC; and the third in response to David Cameron’s aid withdrawal threat.

On August 3rd, CAGH released its first press statement in which it challenged the media, religious, political, and social backlash against the LGBT community and debunked some of the key homophobic narratives promoted by these actors. The statement asserted:

CAHG vehemently denounces these types of sensationalist, unfounded, and bigoted attacks against LGBT Ghanaians, who are brothers, sisters, fathers, mothers, daughters and sons of Ghanaian families just like any other Ghanaians. LGBT people are in every conceivable walk of life and have existed throughout history. Contrary to unsubstantiated and speculative remarks that homosexuals are “evil”, “filthy”, and “ungodly”, LGBT people are our family members, co-workers, worshippers, taxpayers, voters, media people, pastors and lovers who deserve the same rights and protection under the Ghanaian Constitution as anyone else…CAHG calls on the government and the good people of Ghana to condemn the ongoing attacks and to support the rights of LGBT Ghanaians before our country becomes a pariah state like Uganda and Zimbabwe. The (CAGH, 2011a).

Notably, allies within institutions with power, like UNAIDS and local government agencies like GAC, were more critical of CAGH’s approach to addressing the backlash. While they opposed the backlash, they perceived CAGH’s response as too confrontational. Instead, they preferred that the group employ a strategy of broad coalition building that could challenge the backlash in a less political tone. They suggested that the coalition instead take the approach of Senegalese LGBT advocacy and ally groups, which were able to build a coalition of CSOs, development agencies, and government stakeholders that successfully mediated a homophobic backlash after police arrested a group of gay men (Polgreen, 2009). This support was a source of tension between CAGH and development and government stakeholders as the CEPEHRG and the coalition navigated the hostile environment that year.

Apart from having to manage this homophobic backlash and political threats, CEPEHRG also came into conflict with the GAC about how the latter was responding to the backlash. Specifically, CEPEHRG took issue with public statements made by GAC Director General, Dr. Angela El-Adas, on June 3rd in response to the moral panics related to the Daily Graphic report. In the statement (see Appendix H), El-Adas assured the public that the government was
conducting surveillance of HIV and STI risks of MSM due to, according to a *Daily Guide* article, “the increase in gay activities”. El-Adas explained in the statement that,

The work of the reported NGO that registered up to 8,000 MSM, if true, may just be a microcosm of the real situation on the ground. Activities of MSM may predispose some of them and their other heterosexual partners to HIV. It is important therefore to have the requisite data for planning HIV prevention and treatment interventions (*Daily Guide*, 2011).

While the statement was an attempt to explain that the government was taking precautions to address HIV and STIs among MSM, it also repeated some of the most damaging and stigmatizing beliefs about homosexuality in order to justify the government’s efforts. For example, El-Adas explained that “it is important that all hands are on deck to reduce the number of young people who are lured into MSM.” She additionally called on religious and traditional leaders, educationists, parents, and NGOs working with young people to educate young males on the “dangers” of men having sex with men (*Daily Guide*, 2011). She also proclaimed that “The MSM (Men having Sex with Men) situation in Ghana is an issue that we cannot run away from”.

These statements by GAC caught CEPEHRG and other CAGH members by surprise, especially the section that scapegoated gay men as luring young boys—a common narrative often used by moral crusaders to demonize sasoi and other men who have sex with men. CAGH, thus, released their second press statement on October 4th, expressing deep concern about the GAC’s public statement and correcting some of the stereotypes the coalition felt was promoted by the GAC. In their press release, CAGH also raised a concern about a member of GAC who is also a part of the Christian Council of Ghana (CCG) who spoke at a press conference to “condemn homosexuals” (CAGH, 2011b). The statement additionally brought attention to homophobic statements made by President Mills, Minister Aidoo, as well as the back-pedaling of the new head of the Commission on Human Rights and Administrative Justice.
(CHRAJ), Lauretta Lamptey, on decriminalizing homosexuality after she experienced a backlash. The statement asserted:

The coalition believes the statement made by the Ghana AIDS Commission set the stage for the present homophobic attacks against gay and lesbian people who are just trying to live their lives on a daily basis like anyone else. We know of no members of the LGBT community who attempt to lure young people into homosexual behavior. We believe adults having sex with minors is wrong, whether the perpetrator be heterosexual or homosexual... We feel the statement issued by the Ghana AIDS Commission has been inflammatory and seriously misunderstood by the general public as giving license to gay-bashing and other forms of discrimination against members of the LGBT community. We call on the GAC to clearly state how its position has evolved on homosexuality in Ghana to give the public and the LGBT community a clear idea on their position (CAGH, 2011b).

Despite the impact of the data leakage and the scale of the backlash it caused, it is surprising that stakeholders involved in the Ghana Men’s Study did not mention this issue in a journal article titled “Critique and Lessons Learned from using Multiple Methods to Estimate Population Size of Men who have Sex with Men in Ghana” (Quaye et al., 2015). While the article discussed key lessons about the methodological and logistical aspects of the size estimation study, I contend that the social impact of the findings was just as important, if not more important to share with other researchers. The public leakage of data not only further politicized homosexuality in Ghana and internationally, it also further stigmatized same-sex sexualities and drove peer educator and other MSM HIV efforts underground or to a halt. As the 2012 PEPFAR Ghana Operational Plan stated,

Ghana has gone through a prolonged period of gay bashing that has been fueled by the media and augmented by political and cultural leaders. In response to this seemingly hostile environment for MARP activities, USG’s current interventions are focused on reducing vulnerability across MARPs through improved legal protection, which should lead to a reduction of gender-based violence and coercion (PEPFAR, 2012b).

The GAC and other stakeholders like PEPFAR have taken steps since 2011 to address stigma and discrimination and establish programs that can help address rights abuses against KPs. These include media and police sensitivity training, the CHRAJ reporting system, and the M-
Friends and M-Watchers networks for KPs that I discussed in Chapter 5, however, these efforts are limited in their scope.

The last press statement that CAGH released in 2011 was in reaction to David Cameron’s threat to withhold aid from Ghana in response to the backlash against the Ghanaian LGBT community. Since the moral panics in Ghana that year earned the country a place among a list of African nations singled-out for their “anti-gay” laws, it meant that another key argument within the public discourse against homosexuality referenced Western support of “the act” as part of their homophobic arguments. Cameron’s threat only strengthened arguments like these, which claim that there is a homosexual agenda funded by Westerners. CAGH’s statement argued that aid threats were not only worsening the backlash but would negatively affect LGBT Ghanaians who depend on Western aid for daily needs. The statement asserted that,

Cutting aid to some selected Africa countries due to homophobic laws therefore will not help the LGBT people in these countries, but will rather stigmatize these groups and individuals. LGBT people will be used as scape goats for government inability to support its citizens and some sectors of the economy (CAGH, 2011c).

Instead of threaten aid, CAGH called on Western donors to use a more diplomatic approach that involved speaking with government leaders. They also advocated for more funding from Western governments to support grassroots LGBT causes. These calls were echoed in a press release by a group of African social justice activists in October 2011, which requested that the U.K reconsiders its use of aid conditionality as a strategy to “protect LGBTI rights” (“Statement on British ‘aid cut' threats to African countries that violate LGBTI rights,” 2011). CEPEHRG and CAGH were signatories of this statement.

**Backlash on Front-line Workers**

As the CAGH statement argued, in circumstances where the media, politicians, and traditional and religious leaders are on an anti-gay offensive, the people who feel the brunt of the backlash are saso Ghanaians and the peer educators who work with them. During the 2011 backlash, HIV prevention efforts by peer educators suffered immensely. Not only did the media
attention make them more publicly visible, and thus more vulnerable to abuse, it also meant that those they were trying to reach out to were too afraid to seek services. Many of my front-line workers and saso interviewees informed me of this.

In 2011, Maritime peer educators in Takoradi were arguably the most affected by this backlash particularly because the 8,000 MSM registration was located in their region. Moreover, it was their Minister, Mr. Aidoo, who made the call for mass arrests of homosexuals in the Western region and demanded names of MSM. These developments, in the context of a broader homophobic backlash, had a terrible impact on the local LGBT community, especially on saso and other men who have sex with men in the region. Maritime peer educators and staff shared that local Christian and Muslim groups protested against homosexuality after the Daily Graphic article came out. Anthony Adenu-Mensah, the Maritime program manager and the gender focal person, stated that these were “the first ever probably organized demonstrations against MSM and homosexuality” in the country. In addition, a community member had written on the wall on a street known as Liberation Road, “Kill all these gay guys”. Local youth even engaged in mob violence against saso people. This uproar, Mr. Adenu-Mensah argued, is what pressured Mr. Aidoo to make his public statements against homosexuality as well as fear that he might not be re-elected if he did not say something, “He felt really, really pressured to do that. The pressure coming from the religious leaders in the Western region…those demonstrations were organized by the religious groups in Takoradi.”

One peer educator recalled how scared he was after Aidoo’s public statements. He recounted a presentation he made on a local radio station debunking the notion that gay men were behind online scams known as sakawa. Instead of local callers responding to the content of his presentation, they instead made threats, “Kill that boy, arrest that boy at the stadium”. Due to this hostile environment, the peers shared that “most of our peers didn’t want to come to us again”. These peers believed that peer educators had indeed registered them as part of the 8,000 registered homosexuals because peer educators take their numbers as part of the work.
Some men ran away to other cities, like Accra and “some of them too were sacked by their landlords.” Others were even beaten and/or kicked out by their parents. One peer joked that they were treated like armed robbers while another responded that their parents would prefer an armed robber son to a homosexual son. Others openly advocated for gays to be jailed instead of those who smoke marijuana—a highly stigmatized drug.

In addition to these attacks, peer educators also shared that one of the Muslim leaders who mobilized against homosexuality and whose son is allegedly known to be gay hosted a local anti-gay radio show where he would play a vile jingle titled “Trumu”, which crassly mocked saso people. The song, which is in the local language, Twi, ends with the singer screaming “I will fuck you in the ass, smelly, smelly, smelly!” has the following (translated) lyrics,

God created everything perfectly
He created man and woman
But there are people on this earth
Who do not like women
Just asshole [sex] only

Some like it, some don’t
Some like it, some don’t
I fuck you in the asshole!
I fuck you in the asshole!
I burned your asshole!

Anal sex! Anal sex! Anal sex!
Anal sex! Anal sex! Anal sex!

I fuck you in the asshole!
I burned your asshole!

I fuck you in the asshole!
Smelly smelly smelly!

As one peer lamented, the slur *trumu* “is disgusting” and “equates homosexuality to anal sex and nothing else”. But those who use the term believe that gay people who have sex using a part of their body meant for defecation are defying the work and word of God, which in their interpretation, is for people of the opposite sex to have peno-vaginal intercourse.
Mr. Adenu-Mensah described this period as “a very lonely time” for his organization. Since they were the only organization providing services to sasoi and other men who have sex with men, they were targeted and interrogated about whether they were registering homosexuals. He recalled,

_We had a lot of visitations from National Security, trying to find an excuse to close Maritime down…It came [and asked] are you a registered organization? Let us see your papers. All sorts of questions. For them to say “We have closed that organization, which is working for MSM”. But it couldn’t materialize._

They were attacked by all sectors of society with little or no help from stakeholders involved in the KP HIV/AIDS efforts. GAC, he recalled, did not lend support as an organization because they “never agree”. However, one KP TWG key stakeholder from the GAC, who brought the police representative from the KP TWG, traveled from Accra to Takoradi to offer support. Mr. Adenu-Mensah doubted, however, that they came under the discretion of the GAC, “GAC claimed that they had asked them to come, but actually when they were here, they never indicated the GAC sent them or is behind supporting us, encouraging us and so on.”

**Risk Construction and the Production of MSM as Biopolitical Citizens**

A key concept that my dissertation draws on is risk construction in HIV policies and interventions—a central component to the key population paradigm. In chapter 3, I explained how growing epidemiological data on MSM and stakeholder interpretations of the data substantiated and informed the construction of MSM as at higher risk for HIV and thus, a key population. Particularly, key populations is the construction that has informed Ghana’s HIV policies, frameworks, and programmatic interventions and their target populations. A central component of this construction process is the production of biomedical data that substantiates the inclusion of certain social groups like MSM in AIDS policies and programs. This construction process and the discursive practices at play “take a life of their own” as Sandra Hyde (2007) argues, when they “confront social prejudices” and structural factors informing these prejudices.
In this section, I demonstrate how certain social identities—in this case sasoi and other men who have sex with men—are constructed as at risk for HIV/AIDS to substantiate their inclusion in Ghana’s national AIDS response. I discuss how these constructions are then disseminated or represented discursively by the media and policymakers to the public, and to sasoi and other MSM. Relatedly, I discuss the meanings these representations and narratives place on HIV risk among men who have sex with men and what ideological functions they may play. I also discuss the social impact and consequences of these processes on the men and on social understandings of homosexuality.

**Narratives of Risk: Policymakers and other Key Stakeholders**

As discussed in Chapter 3, one of the key developments that facilitated the shift to include MSM into the national AIDS response, was the 2009 Modes of Transmission report, which indicated that MSM (8%) and their female sexual partners (1%) made up 9% of new HIV infections (PEPFAR, 2012b). Despite this being significantly lower than heterosexual new infections (46%), an accepted belief about MSM is that they pose a threat to the public as a high-risk group for HIV/AIDS. This is reflected in a common narrative among policymakers and other stakeholders within the MSM response which is that MSM transmit HIV to their unsuspecting female partners and thus policies must target them to protect these partners and to lower the general HIV incidence.

While MSM are disproportionately at risk for HIV, the way this risk is discussed portrays them as driving the epidemic and posing a risk to the rest of the general public—namely their female partners, girlfriends, wives, and putative young male sexual victims, like those said to be lured by gay men according to GAC Director, Dr. El Adas. Underlying the narratives behind these policies and interventions are stereotypes and perceptions informed by homophobia and heterosexism that obscure structural and physiological factors which place MSM at risk for HIV. The value of intervening on sasoi and other MSM, then, is constructed in relation to those
innocent, unsuspecting non-MSM victims that the men are putting at risk rather than their own health outcomes and the factors determining these outcomes. According to Dr. Henry Nagai, a former Chief of Staff at FHI 360 who worked at UNAIDS at the time of the interview, this construction has been central to securing political support from other government stakeholders involved in the AIDS response. Nagai explained,

What helped in the dialogue that I have conducted with many policymakers and people who used to be against [including MSM] but were won over is the fact that if we don’t do anything in terms of access to health, which is their fundamental right…we also have most of [MSM] who are involved in heterosexual activity and we have many of them who are not married within their own heterosexual activity and so you realize that there is the potential of getting a bridging population that can transmit infection into the population and to those they refer to as “innocent people” as far as MSM activity is concerned.

According to Nagai, this approach of describing MSM as a bridge to the general population and thus a threat to “innocent people” was critical to gaining support from some key commissioners in the government, “Once you go that road and everybody stops and starts thinking…the Ghana AIDS Commission understood it. Then they were able to move through their commissioners to ensure that there is some level of understanding even if there is no acceptance.”

Emmanuel Larbi, the GAC Acting Director of Research, Monitoring, and Evaluation at the time of the interview, also shared that in order to include MSM as a KP, they had “…to do these modes of transmission [study]. We wanted to find out the drivers of the epidemic. So, we used tools developed by the UNAIDS. And then when we subjected our data to that, it came out that MSM and female sex workers were driving our epidemic”. Similarly, the police representative on the KP TWG, Officer Jones Blantari, echoed some of these notions about sasoi and other MSM “driving the epidemic” in an interview on KP efforts. In his explanation of how MSM came to be included in the national AIDS response, he stated, “We realized that our epidemic is driven mostly by the KP populations. If they realize that they play a very critical role in driving the epidemic, then if you want to put in interventions, they form a critical part to the solutions.”
An important note here regarding such narratives like those by Mr. Blantari, Mr. Larbi, and a number of other policymakers I interviewed is that key stakeholders do not always construct these risks through a framework that seriously engages with distal factors like the economic, social, political, and legal contexts in which sasoi and other MSM live. Stakeholders understand that, for example, the unnatural carnal knowledge law “drives people underground” as Blantari admitted. However, the “silent advocacy” approach—as Mr. Nagai termed it—that they employ to minimize the impact of the law (i.e. working behind closed doors to stop enforcement of the law), effectively means the lived experiences of sasoi and other MSM is not significantly affected by this approach. Part of the barrier here, I suggest, is that stakeholders feel pressured to minimize the structural issues facing sasoi and other MSM in order to secure support for MSM policies and programs because many people inside and outside the government see structural interventions for MSM as demanding special rights for homosexuals, which raises alarms. As Nagai shared, advocates were “lambasted” because they have been viewed as wanting to “legalize” homosexuality or promote the rights of homosexuals. As he explained, “There were times when you call me on my phone I would say ‘I want to know who is calling’ because I was a project director of a project that has been stigmatized and a project that is like ‘they want to enhance the life of men who have sex with men and the sex workers.”

The impact of this fear of backlash and of the inadequate engagement with structural determinants of MSM HIV risk is reflected in the interventions for the men. As described in the previous chapter, while MSM HIV policies and programs identify structural factors as affecting HIV risk among MSM, policies and programs are primarily focused on behavioral change that emphasizes risk on the individual level. For example, the main interventions for MSM (refer back to Table 2) are based on promoting the “12 Key Healthy Behaviors” from the SHARPER project (refer back to Figure 5.2). Sam Wambugu from FHI 360 recognized the potential danger of conflating behavior and identity but even his framing of the issue still did not engage with the
structural causes of behavior that might put a group of people, rather than an individual MSM, at a higher risk for HIV. He explained:

I think people should differentiate between high-risk behaviors and the people themselves. As FHI, we are working on these high-risk behaviors: people who inject drugs, people who have high risk sex without protection. That’s what we are dealing with and if we don’t stop that, nobody is safe because you know nobody is safe. The same man has a wife or has...as far as there is a virus in the society, and it’s not checked, it will move from person to person. So, that is our main focus and that’s how we try to educate people to look at the bigger picture instead of looking at things with a narrow mind. Don’t look at the person but look at the behavior.

The only other interventions that focused on structural factors were the CHRAJ Help Desk and M-Watchers and M-Friends; however, even these were still uneven, non-systematic, and contingent on external funding.

Narratives of Risk: Public Discourses on MSM Risk

The print and broadcast media, as the main platform on which this politicization is occurring, have played the leading role in public discussions of homosexuality and MSM HIV/AIDS risk. In the controversial “8,000 Gays in 2 Regions; Majority Infected with HIV/AIDS” article, the Daily Graphic reported that “almost all of the registered gay men were bi-sexual, with some having wives and girlfriends” and that “the rise in STDs, including HIV, in the two regions, according to the NGOs, was due to [this] fact” (Daily Graphic, 2011). This bisexuality, the article continued, “resulted in the rapid spread of STDs, including HIV/AIDS”. This story, which as previously discussed caused a massive backlash, represented homosexuals as HIV and STD-carrying individuals who pose a risk to women because of their bisexuality. If being perceived as a sexual predator, demonic, ungodly, and mentally unwell wasn’t stigmatizing enough, a big part of the construction of homosexuals in Ghana became that they carried HIV and other STDs because of their sexual promiscuity.

Since the publication, there has been an increase in such media discussions of HIV and STI risks posed by homosexuals. In 2011, a number of publications and broadcast shows
spawned from the *Daily Graphic* article denounced homosexuality, citing health risks among MSM as reasons to oppose it. In one such publication titled “Ministry to Check Homosexuality in Schools”, the Ministry of Education’s Public Relations Officer, Paul Krampah, was quoted in an FM radio interview about steps his Ministry was taking to educate youth about the bad consequences of homosexuality. The article reported:

> Ahead of World AIDS day which falls on December 1, Paul Krampah, the Ministry’s Public Relations Officer, in an interview with Xfm 95.1 stated that the Ministry’s HIV/AIDS Secretariat has trained teachers who in turn act as facilitators to educate students on the menace of homosexuality and its adverse consequences including HIV/AIDS and other sexually transmitted diseases.

In another article that year, Dr. Fred Deegbe, a U.S-trained Baptist Minister, General Secretary of the Christian Council of Ghana, and past GAC Board member, spoke on behalf of the Christian Council to condemn homosexuality. In his statement, he stated that “most homosexuals in Ghana were found in areas where foreigners have the economic power to woo young boys and girls into the practice for economic purposes and that posed a psycho-social problem to the youth despite the inadequate systems to deal with it” (Ghana News Agency, 2011e). Moreover, he warned that homosexuality had health implications, “especially with men”, because “it has a relationship with sexually transmitted infections including HIV and AIDS and that any action or inactions would put further stress on the health system putting the country in serious jeopardy” (Ghana News Agency, 2011e).

A similar article that year also reported that the Western Regional HIV and AIDS Focal Person, Dr. Ronald Sowah, had warned the general public to be educated on “the dangers related to homosexuality” (Adogla, 2011). The article reported him explaining that HIV/AIDS was spreading among homosexuals because the “inner canal (of the anus) was actually not meant for sex” and that “lacerations” in the anus can cause bleeding that act as an avenue for transmission (Adogla, 2011). Many more articles that year by religious and political leaders to notable medical figures, some of whom were part of the national HIV response, like Drs. El-Adas and Sowah, had similar narratives. Even President Mahama, in his former position as
Central Regional Population Officer, reportedly “spoke against the practice of homosexuality and said it was a contributing factor to the spread of HIV and AIDS” in an otherwise useful statement about the role of HIV stigma in reducing service utilization (Ghana News Agency, 2011d). Many other articles that year reported on cases of teachers and other adults who were alleged to have sodomized minors, adding to the hysteria about homosexual men as sexual predators (Panyin, 2011).

During the moral panic in 2013 about President Mahama’s relationship to Andrew Solomon and his stance on homosexuality (discussed in Chapter 4), a number of public figures and politicians weighed in again on the threats of homosexuality. In an article on the anti-gay group, the National Coalition for Proper Human Sexual and Family Values’, call on the government to clarify its position on homosexuality, a prominent psychologist at the Accra Psychiatric Hospital, Dr. Kwadwo Obeng, was referenced pathologizing homosexuality. According to the article, he argued that “homosexuality had negative consequences such as increasing the spread on HIV and AIDS and sexually transmitted infections and increasing incidence of oral and throat cancer, adding that homicidal, suicidal and paedophile tendencies were common among homosexuals” (Abbey, 2013).

In 2014, another article came out similar in style to the 2011 Daily Graphic piece. The article, titled, “30,000 Homosexuals in Ghana; 17 % living with HIV / AIDS”, stated that while unnatural carnal knowledge was illegal in Ghana, “the practice of men who have sex with men, popularly called gay, is on an alarming rise” (The Finder, 2014). Citing data from the Ghana Men’s Study, it reported that 17% of 30,000 MSM live with HIV and that “officials of the Ghana AIDS Commission told [the publication] that though the act is unlawful, the Commission needed information on them in order to target them for HIV/AIDS education”. Although the article did not cause the same kind of backlash, it still made it through airwaves and public discussions.

Also in 2014, a news report of a 48-year-old Muslim medical doctor in Takoradi, who confessed to sodomizing a 16-year old high school boy, caused an uproar among the media,
religious institutions, the government and the public. Dr. Sulley Ali Gabass, dubbed as “the gay doctor”, was depicted as a sexual predator who violated and gave HIV to a “poor, innocent 16yrs old Muslim student” (Jawando, 2014). Despite evidence that the doctor was HIV negative, the narrative that he gave the virus to the student was unquestioned by the media. The doctor had his medical license revoked and was charged with defilement and unnatural carnal knowledge. After nearly 7 months of trial, he was found guilty for defilement and sentenced to 25 years in jail. Interestingly, he was acquitted of the unnatural carnal knowledge charge, a law that, as Officer Blantari informed me, has not been enforced in court for years. This case, more than any other development, reinforced the notion that older gay men were preying on young boys for anal sex and putting them at risk for HIV.

According to the GIZ study on stigma against key populations that was discussed in Chapter 4, much of the public’s beliefs and attitudes have been influenced by HIV risk discourses on homosexuality. Notably, the study found that nearly 60% of people believed that HIV is primarily spread by men who have sex with men (Nzambi et al., 2011). The circulation of media stories about homosexuality and data on MSM HIV risk have played an important role in shaping this belief.

Many respondents mix facts with prejudices when forming an opinion about the ways HIV is transmitted in Ghana. Too often the finger of blame is pointed exclusively at high-risk groups as a cause for the spread of the epidemic. For example, three-quarters of the respondents of the general population felt correctly that female sex workers were at a higher risk of getting infected with HIV compared to other Ghanaians. And almost two-third believed men having sex with men were at a higher risk compared to the rest of the population. However, 58.8% of respondents from the general population wrongly assumed that HIV in Ghana is mainly spread by men having sex with men. Respondents incorrectly thought that men having sex with men were a key driver in the transmission of HIV in Ghana (Nzambi et al., 2011; p. 23-24).

These challenges related to biomedical data and risk construction are not unique to Ghana, as similar issues were raised at the 2014 Stakeholders Technical Workshop for Key Populations in West and Central Africa, hosted in Accra. Key leaders in MSM HIV prevention efforts on the continent are also grappling with this issue. Cyriaque Ako of AMSHeR, for
example, explained the importance of using MSM data carefully. He warned of the dangers of portraying MSM as posing a risk to the general population, which could further reinforce stigma and stereotypes and make efforts counterproductive. Some, like stakeholders in Senegal, have established that KP prevalence has never affected the general population prevalence, which Ako explained might help counter the notions that MSM pose risk to general population.

**Conclusion: Unintended Consequences**

Ghana’s shift to include sasoi and other men who have sex with men as key population in its national AIDS response and the scale-up of MSM-focused HIV/AIDS activities have occurred in a legal and sociocultural context that is increasingly hostile to homosexuality. On the surface, this shift might appear to cut against the homophobic and heterosexist current described in Chapter 4. However, I suggest that a closer examination reveals that these policy and programmatic changes constitute part of the social, political, cultural, and religious uproar about homosexuality in Ghana and the broader region.

The key populations paradigm has constructed sasoi and other MSM as biopolitical citizens who are simultaneously recognized and aided by one arm of the state—the Ministry of Health, under the Executive Branch—and criminalized and punished under other arms of the state—the Legislative and Judiciary Branches of the government. This biopolitical citizenship places saso people in a legitimate position to claim certain rights, particularly rights to health and to challenge abuse, discrimination, and stigma via programs like the CHRAJ human rights abuse reporting system discussed in chapter 5. But these rights are only enshrined to them as KPs within the biomedical domain due to the discreet nature of the MSM HIV response.

This contradictory position of sasoi and other MSM as simultaneously criminalized and legitimized in the current context, then, produces critical challenges to the ongoing efforts by policymakers and other stakeholders in HIV prevention and care efforts. Notably, the religious, political, and social backlash against MSM constitute an unintended or unforeseen
consequence of the paradigm shift that is in conflict with the objective of reducing HIV incidence and prevalence among sasoi and other men who have sex with men.

Suzie Jacinthe of USAID raised two questions during a discussion on these challenges facing Ghana’s MSM HIV efforts that bear repeating in light of this politicization and backlash. She asked, 1) How do the government and other stakeholders operate in the dark and still be the best advocate for the people that they speak for?; and 2) At what point do these stakeholders either urge MSM into the spotlight or allow them to take some of the spotlight if they’re willing, and not operate so much in the shadows? These questions raised another important question. Can stakeholders realistically continue this silent advocacy strategy in the face of a very loud and public political and social backlash?

Significant strides have been taken by the government of Ghana and other key stakeholders in the national AIDS response to reach the sasoi and other men who have sex with men over the past five years as described in Chapters 3 and 5. However, an important outcome of this paradigm shift is that biomedical data about sasoi and other MSM is reaching the public in ways that reconstitute the sociocultural terrain, politicizing homosexuality, and constructing new meanings for what it means to be homosexual. Can policy makers address these consequences while using a strategy of operating in the dark or silent advocacy? This is a key question that policymakers will have to address if they are to make a significant breakthrough in the country’s MSM HIV response.
CHAPTER 7
CONCLUSION

Ghana’s Paradigm Shift: A Model in Africa

In a conference speech, Stuart Hall (1992) said, “The question of AIDS is an extremely important terrain of struggle and contestation. In addition to the people we know who are dying, or have died, or will, there are the many people dying who are never spoken of. How could we say that the question of AIDS is not also a question of who gets represented and who does not” (p. 285)? Hall’s words, although spoken 24-years ago, ring true today when examining the heterosexual policy blind spot in Africa’s HIV history. How did governments across the continent and the global managers of the epidemic render invisible homosexuality, and subsequently, HIV among gay, bisexual and other MSM on the continent?

Using Ghana as a case study, my dissertation examined this question, as well as how the country is correcting for this blind spot decades after the onset of HIV/AIDS. Specifically, I sought to explain why the Ghanaian government ignored male same-sex sexual transmission of HIV in their national AIDS policies for the first two and a half decades of its epidemic. I also demonstrated why and how the government shifted its policies in the past few years to include sasoi and other MSM in the country’s NSP, how policies were implemented or not, how sasoi and other MSM perceived and experienced these changes, their life as sasoi Ghanaians, and what local and international factors shaped these processes.

My findings indicate that Ghana’s MSM policy blind spot was due to the criminalization and stigmatization of same-sex sexualities in the country and a construction from early epidemiological data that the Ghanaian epidemic was heterosexual and driven by migrant female sex workers. This blind spot was also due to Western researchers and donors’ categorization of HIV in Africa as “heterosexual”, which in turn informed donor policies and funding stipulations. Simply put, homosexuality was taboo in Ghana while those leading the
global response did not consider it as a significant mode of sexual transmission in African countries.

However, in the past seven years, the Ghanaian government and its partners have embarked on a bold journey to develop and implement a set of evidence-based policies to address the HIV epidemic among sasoi and other men who have sex with men. This change, I argue, was primarily catalyzed by growing epidemiological data on MSM HIV prevalence and risk, local and international NGO and CBO advocacy efforts, and international donor policy changes that now recognize men who have sex with men as a vulnerable group for HIV in the global South. I conceptualize the country’s policy changes as a paradigm shift in their NSP from a general population paradigm to a key populations paradigm that includes MSM as a group at higher risk for HIV. The country’s progress on addressing HIV among sasoi and other MSM—notably through the development of a government policy technical work group for KPs and the creation of a KP NSP—has earned it the status of a model country in Africa in the eyes of bilateral and multilateral HIV donor and development agencies.

While Ghana is pioneering in its MSM HIV efforts, stakeholders face significant challenges rooted in the country’s sociocultural context, namely homophobia and heterosexism; a dated and underfunded healthcare system that is unable to meet the basic needs of the population; and inadequate funding. Here, David Mosse’s (2004) point on the limitations of development policies when they are confronted with structural realities is instructive. In Ghana, although MSM HIV policies look good on paper, their implementation exposed contradictions in legal and sociocultural realities in Ghana, where male same-sex activities are criminalized and where the general public—including many of the non-MSM service providers and policy key stakeholders—overwhelmingly oppose same-sex sexualities and desires. This contradiction, I argue, has made policymakers hesitant to push any advocacy efforts that might come across as supporting or promoting homosexuality, for fear of social and political retribution. Specifically, key stakeholders do not advocate reforms like the decriminalization of unnatural carnal
knowledge as part of their efforts, despite acknowledgement in policy documents that this criminalization places sasoi and other MSM at higher risk for HIV. As a result of this fear, the government and their non-state partners are strategically discreet in how they implement MSM HIV policies and programs. Sasoi and other MSM are subjects of public policies but the efforts to address their prevention and care needs are not publically visible. This has produced an inclusion paradox, whereby MSM HIV prevention efforts, as well as MSM organizations and peer educators, are marginalized despite government and other stakeholder efforts to include them.

Despite these challenges, Ghana’s efforts are exemplary not only on the continent but across the globe. While tensions exist between MSM organizations and peer educators, the government’s inclusion of saso peers and leaders in policy and HIV prevention program development efforts is unique even if progress is still needed in addressing power dynamics between stakeholders and structural causes of HIV risk, like the continual criminalization of same-sex sexual activities. Additionally, in a social context that is quite homophobic, the work key stakeholders have been doing, especially in including the Ghana Police Service to address rights abuses and in supporting the CHRAJ discrimination reporting system, is innovative and commendable.

**Policy Implications and Recommendations**

Given these findings, there are several important lessons and recommendations for Ghanaian HIV policymakers and their partners. First, the government must meaningfully include LGBT and MSM-led CBOs that are engaged in and committed to MSM HIV prevention and care efforts. As Attipoe (2004) recommended in his study, the government of Ghana needs to not only recognize these organizations but also to “encourage the formation of many such associations” and invest resources in them to ensure their success. Currently in Ghana, there is
one openly LGBT-rights and health group, CEPERHG, that has been an implementing partner in the MSM prevention efforts. In addition to recognition and support, MSM organizations should be meaningfully included in all policy and programmatic decisions and developments beyond the symbolic representation that often feels like tokenism to the few invited to the table.

Second, health care workers involved in HIV and HIV-related service provision should receive professional development and importantly, refresher trainings, to help them provide professional services free of stigma and discrimination towards sasoi and other MSM, and that are sensitive to the confidentiality and privacy of clients. These trainings should be developed with input from members of the sasoi and other MSM community. In order to ensure that these trainings are sustained, stakeholders must institutionalize them into health professional curricula, certification exams, and in professional development and workshops. As MSMGF’s (2015) Scenario Planning document on long-term strategic analysis on MSM HIV policy needs suggests, a key structural intervention for healthcare workers “is to develop and deliver universal education curricula and training programs for health care workers about sexual diversity and sexual health among LGBT communities” (p. 15).

The third suggestion for stakeholders is related to the legal codes that shape MSM risks for HIV. Particularly, state and non-state stakeholders, under the leadership of LGBT rights activists and organizations, must begin discussions and strategy sessions on how to advocate for the removal of anti-sodomy laws. A key part of that process will be to research how other African nations, like South Africa and more recently Malawi, have taken steps to decriminalize homosexuality or suspend legal codes that criminalize homosexual acts. Additionally, the African Commission’s historic move to adopt a resolution on LGBT rights should be used as a tool in advocating for decriminalization. While the resolution does not call for the decriminalization of homosexuality, its language emphasizes creating an enabling environment that reduces stigma, violence, and abuse against LGBTQ individuals (ISHR, 2014). Research efforts here should inform a short and long-term strategy to decriminalize same-sex sexual
activities in the country’s legal code. While important progress has been made over the past seven years, the simultaneous criminalization of MSM comes into conflict with efforts to address HIV among them. This legal reality, which serves as a backdrop for and reinforces social stigma against homosexuality, poses significant limitations on reducing MSM HIV prevalence and mortality and the human suffering they cause. Without changes here, stigma and discrimination cannot be meaningfully reduced and blackmailing and sexual and physical violence will continue to run rampant.

Fourth, there needs to be more financial and institutional support for peer educators, who carry out the bulk of MSM HIV prevention services but receive the least amount of financial support for their work and opportunities for professional advancement and leadership. As discussed in chapter 5, peer educators expend their stipend and even personal money on costs for completing their monthly assignments. It is possible that the peer educator model alone is inadequate for addressing the enormity and complexities of the epidemic among this population due to the social conditions. More frontline workers need to be hired and trained to do the difficult, time-, financial-, and labor-intensive work that peer educators do. Moreover, the lack of inclusion of MSM peer educators in the KP TWG meetings means that many of their challenges and needs are not represented in policy and programmatic efforts. Even when their opinions are solicited, peer educators often feel they cannot voice their experiences or critiques to their superiors. As a study comparing FSW peer educators’ experiences in a South African city and an Indian city found, peer educators from the city with more material, social, and political support (India) were more successful in carrying out their interventions (Cornish & Campbell, 2009). Providing more financial and institutional support, opportunities for leadership, and room for professional growth will significantly improve peer educators' success in HIV prevention work.

The fifth suggestion is related to the scope of MSM HIV interventions. Ghana’s MSM HIV efforts are predominantly on prevention and not on treatment and care. Given that such a large
percentage (nearly 1 in 5) of sasoi and other MSM in the country have HIV (in larger cities like Accra, it is 1 in 3), treatment and care are arguably just as important as prevention efforts. The inadequate attention to treatment and care is not unique to Ghana. As an MSMGF study on African MSM’s access to HIV services found, many men who have sex with men do not have easy access to treatment services (27%) (Makofane, Beck, & Ayala, 2014). This low access is often due to inadequate funding and relatedly, limited treatment services, or a lack of knowledge of or access to these services. The low emphasis of interventions on MSM-specific treatment and care combined with inadequate funding for these services, means that MSM are often left with very little access to, support, and resources for HIV treatment, forcing some to even stretch out their ART, which places their lives at risk as well as increases the risk of HIV transmission to their sexual partners.

The sixth recommendation is that the core of prevention efforts—the “12 Key Healthy Behaviors” and the interventions they inform—must broaden the focus beyond behavioral level interventions. Despite stakeholder’s acknowledgment of some structural risks to HIV and structural barriers to accessing HIV services, the bulk of MSM interventions do not address these risks. Stakeholder have taken some important preliminary steps to sensitize the police to abuse of sasoi and other MSM, and to sensitize healthcare workers to MSM HIV needs. However, these efforts are still underdeveloped and underfunded. Relatedly, Ghana has very few interventions that include the biomedical advances made in MSM HIV interventions over the years, particularly PreP and PEP. At the time of research, there were no provisions for these biomedical technologies to MSM through government and other stakeholder interventions. The only group that had access to these were hospital workers to address occupational exposure to HIV.

The seventh recommendation is that government and other stakeholders must re-evaluate the effectiveness of the discreet strategy used in its MSM HIV prevention efforts. As my research found, this approach undermines efforts to reach MSM by making these efforts
less visible to MSM who are not connected to a network or community of other MSM. Moreover, the approach has compromised stakeholder’s interest or ability to openly respond to the backlashes related to homosexuality and the MSM HIV efforts. I suggest that these backlashes, despite government efforts to be discreet, are an inevitable consequence of recognizing a stigmatized and criminalized group in public policies. This is because stakeholder recognition of male same-sex transmission means that sasoi people and homosexuals in general are even more visible to the general public and to social institutions, many of whom morally and politically disagree with homosexuality and any efforts to recognize MSM and their rights. As my findings indicate, this discreet strategy is both unable to prevent a backlash and unable to defend sasoi and other MSM and their organizations when these backlashes occur. To move past this compromise, stakeholders must strategize, with leadership from sasoi and others from the LGBTQ community, on how to maximize visibility of programs, increase political buy-in of MSM interventions, also increase support for the community. Additionally, instead of employing a strategy that attempts to prevent a backlash, it might be more effective to strategize on how to minimize the impact of a backlash.

My final recommendation is based on a key observation from studying the policy and programmatic efforts, which is that key stakeholders—both government policymakers and local and international implementing partners—are very hesitant to highlight the challenges that they face in addressing HIV among MSM. My assessment is that they fear that openly and frankly discussing the shortcomings of their policies or programs may dissuade donors from future funding or support. As a result, they downplay significant challenges by not directly raising them in meetings or interviews. Some of the issues I observed that are downplayed include data fabrication such as inflation of outreach numbers and other data quality issues; the impact of homophobia and heterosexism within the government and in society at large on HIV efforts; and the inadequate implementation of programs such as training of health personnel on working with sasoi and other MSM. Stakeholders are more comfortable discussing inadequate funding or the
internalized homophobia of MSM that puts them at risk, than they are speaking about these riskier issues, although they appear to be aware of them based on my observations and interviews. I consider this to be one of the most important recommendations because without an open and honest discussion of the challenges that are more difficult to discuss, progress on other recommendations and more broadly, MSM HIV interventions, cannot be made.

Contributions and Significance of Research Findings

An Epidemic of Signification: “A Gay Plague”

An important conclusion from my research is that Ghana might be in the beginning stages of what could become a social crisis on homosexuality in the years to come, if efforts to address HIV among MSM improve and become further institutionalized by the government. While very different contexts, in some ways, Ghana is experiencing what the U.S. experienced 30 to 35 years ago at the dawn of the HIV epidemic when gay men were both deeply devastated by this epidemic and vilified for it. This experience and some of the social science scholarship on it are worth reviewing as they offer important insights on the significance of Ghana’s MSM HIV efforts, as well as those of countries in the broader region.

HIV’s entrance into human society had a profound impact on the social, cultural, and political landscapes of virtually every society in a way that, arguably, no other disease in human history has ever had. Illness and disease are not merely natural occurrences that are unaffected by the sociocultural landscapes in which they emerge and exist. Indeed, Robert A. Hahn and Arthur Kleinman (1983) have argued that society “both constructs understandings and produces the events of diseases/illnesses and healing” (p. 321). By the same token, HIV is a social and political disease driven by pre-existing structural factors and certain discourses around sexuality, gender, the body, and disease (Altman, 1989; Padgug & Oppenheimer, 1992; Parker, 2001; Patton, 1986; Treichler, 1987). Moreover, as a disease that is spread through sexual activities and bodily fluids and that disproportionally affects some of the most marginalized
social groups, it has come to embody many social and cultural meanings (Parker, 2002; Patton, 1986; Treichler, 1987). Taking this sociomedical perspective, Jonathan Mann, director of the first global HIV program, described HIV as consisting of three epidemics: an epidemic of HIV infection, an epidemic of illness from AIDS, and an epidemic of stigma, discrimination, and denial (Mann, 1987). As a political disease then, the public health response to the epidemic has been shaped by a number of social, cultural, and political factors and anxieties that have had a significant impact on how the disease has been responded to.

Informed by this analysis, Paula Treichler astutely described HIV as an “epidemic of signification” in her seminal article, “AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification” (Treichler, 1987). In it, Treichler argued that HIV was not merely a disease that could simply be defined by its epidemiological causes or that fell neatly within the boundaries of biomedicine. Rather, it was “simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification” (Treichler, 1987; p. 32). By this, she meant that HIV, in addition to producing a health crisis, also caused a social crisis, where social and cultural meanings were placed on the medical aspects of the disease—meanings that were informed by sexuality, race, gender, class, and global politics. Thus, HIV consisted of two mutually constituting epidemics—social and medical—that Treichler argues should be examined to understand the impact HIV has had on human society.

**KP Paradigm Shift, Biomedical Citizenship and its Implications**

My study contributes to this literature on the sociocultural impacts of the HIV epidemic, particularly in an area of the epidemic that has been understudied in Africa—male same-sex transmission. Notably, my research found that the recognition of sasoi and other MSM as citizens at risk of HIV and in need of government intervention has had significant social and cultural implications that should be evaluated. Particularly, as I have argued in Chapters 3 and
the inclusion of sasoi and other MSM in national AIDS policies marks the first time the government has formally recognized homosexuals outside of the legal codes that criminalize them. In this process, sasoi Ghanaians have become biomedical citizens, with rights enshrined in and confined to the KP paradigm and programs evolving from its policies. How saso people are constructed as biomedical citizens will shape how society will view them. In the case of MSM HIV policies, they have been constructed as not only being at high-risk for HIV but also as posing a threat to the general population in order to substantiate their inclusion in national AIDS policies. While this has resulted in government and other stakeholders allocating much needed funding and resources to the group, this risk construction and its related discursive practices have caused social and political backlashes when they have come into conflict with social prejudices and sociocultural structures informing these prejudices.

As Treichler (1987) has argued, “AIDS is a nexus where multiple meanings, stories, and discourses intersect and overlap, reinforce and subvert each other” (p. 42). On a biomedical level, it is a lethal disease that is infectious through sexual contact and bodily fluids, but on a social level, it is an epidemic of meaning, where the scientific discourse is not necessarily representative of the "closer reality" of the disease and what it means. Some of these significations informed by social and cultural beliefs and anxieties include but are not limited to: a) a “gay disease”; b) a disease curable through rape; c) a conspiracy to kill Africans/black people; and d) a fictitious disease.

In Ghana, I argue that a key signification produced by MSM HIV interventions is that homosexuals are driving the HIV epidemic. This signification, of course, is not unique to the country. One of the key factors that characterized HIV/AIDS as an epidemic of signification was the demographic that first acquired it in the United States. As a disease that was first discovered among gay and bisexual men in San Francisco, it was clear quite immediately that the stigma associated with homosexuality influenced the stigma of having HIV, which informed the subsequent political and social responses to the AIDS epidemic (Epstein, 1996; Gilmore &
Many of the myths about the disease were influenced by homophobia entrenched in US politics and society. All over the media and even among public officials, the disease became known as the “gay plague” (Smith & Whiteside, 2010; Treichler, 1987). The biomedical community in the United States—convinced that AIDS was a gay disease that was transmitted from man to man—cautioned during the early stages of the epidemic that only gay men had to worry about acquiring it. The association of the disease with “gay sex” or “lifestyle” further marginalized individuals in the gay community. This process seems underway in the case of Ghana as more attention and resources are allocated to HIV among MSM.

The Re-medicalization of Homosexuality

As an epidemic of signification, one critical way the onset of HIV/AIDS transformed the social construction of homosexuality is that it “re-medicalized” the identity due to how scientists, the media, and politicians constructed the epidemic in the early years. A number of scholars have written about the medicalization of human conditions, behaviors and identities starting from the late 1960s with the study of deviance as a medical condition and thereafter, of topics like alcoholism, hyperactivity among adolescents, infertility, erectile dysfunction, and menopause among others (Ballard & Elston, 2005; Conrad, 1992, 2008). One of the foremost scholars of medicalization, Peter Conrad, described medicalization as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad, 1992; p. 209). These non-medical “problems” can range from behaviors to sexual preferences, social identities, and natural bodily changes. Conrad contends that medicalization is a “definitional issue”, by which he means that the process consists of providing a definition of a condition through a medical framework whereby the condition is defined and understood in medical terms and language and/or using a medical intervention to address it (Conrad, 1992). It can also be described on an institutional level, whereby an
institution or organization accepts the medical framework and intervention in addressing a condition (Conrad, 1992). Lastly, it can be defined on the interactional level, where a person with a medical jurisdiction, like a doctor, diagnoses a condition as medical and/or treats it medically (Conrad, 1992).

Prior to the onset of HIV, homosexuality in the U.S. was first medicalized in 1952, when it was listed in the DSM as a sociopathic personality disturbance and then more formally in 1968 in the DSM-II as a sexual deviation, specifically under the section, "Personality Disorders and Certain Other Non-Psychotic Disorders" (Conrad & Angell, 2004; Herek, Chopp, & Strohl, 2007). These changes marked a key development in the medicalization of homosexuality and led to increased stigma against individuals categorized homosexual, including their exclusion from certain areas of employment and social spaces. The DSM-II classification did not last long however due to the historic development of a gay rights movement as well as a lack of clarity of and evidence for what exactly was the homosexuality “disorder”. The American Psychological Association voted to remove homosexuality as a mental illness in 1973.

The onset of HIV/AIDS in the 1980s, however, threatened to re-medicalize homosexuality. In fact, a number of scientists, policymakers, the media, and as a result, society at large, termed the disease a gay disease or the Gay Related Immune Disorder (GRID) for the first couple of years. By the time medical and public health research produced more knowledge and understanding of the illness, the damage was already done. Gay males were assumed to have HIV and their risk for it was constructed and rationalized by scientists as a direct product of some inherent quality of being gay or having a “gay lifestyle” that put them at-risk, leading to immune deficiencies, a concept framed as “immune overload” (Conrad & Angell, 2004). In fact, “the early medical articles about AIDS cited 1970s articles associating venereal disease and homosexuality” Conrad and Angell (2004) argued, “and they came to see male homosexuality as a ‘medically problematic’ situation” (p. 35).
A biomedicalization of sasoi and other MSM.

I review this history to make a larger point about the significance of the construction of sasoi and other MSM as biomedical citizens in the paradigm shift to include them in Ghana’s national AIDS response. Of course, the scientific and public health community learned many hard lessons in the 1980s and 1990s regarding the early responses to the epidemic, from which current policies benefit. One such benefit in fact was the development of the term “men who have sex with men” by epidemiologists to address stigma produced by the conflation of sexual activities with sexual identity/orientation in HIV efforts.

Much progress has been made by the global AIDS community since the 1980s, and in Ghana, the explicit blaming of gay people for HIV is not a feature of the country’s MSM HIV policy response. However, the construction of the men as posing a risk and driving the epidemic as well as the unplanned dissemination of epidemiological data on MSM HIV prevalence and risk have caused multiple moral panics and backlashes that have negatively affected the few existing MSM HIV outreach programs. With each panic and backlash related to the ongoing efforts comes a new set of meanings and representations of homosexuality that connects same-sex sexual identities, intimacies, and desires to HIV. Moreover, the discourses surrounding this biomedical citizenship raises paranoia among the general population about “closeted” gay men who lead multiple lives as partners to women, while maintaining sexual relationships with other men or preying on young boys—beliefs that have unfortunately been shared by some key stakeholders within these efforts. In effect, the construction of sasoi and other MSM as biomedical subjects has produced an unintended consequence of further politicizing homosexuality and reconstituting its meanings. This has significant implications for the sasoi and larger LGBTQ community and in turn the government’s efforts to address this concentrated epidemic.
**Unintended Consequences**

The Ghanaian experience offers many important lessons for international and local HIV policymakers, HIV service providers, and governments and other stakeholders across Africa that are beginning to address the epidemic among gay, bisexual, and other MSM. I want to return to the Pandora’s Box metaphor, particularly the notion of revealing realities that have been ignored or exposing secrets or taboo practices. Extending the metaphor to Ghana’s MSM HIV response, the policy and programmatic efforts for men who have sex with men have exposed a reality of male same-sex sexualities in which sexual risk and transmission of HIV among sasoi and other MSM is nearly 10 times as high as the general population.

These revelations, and the policy and programmatic responses to them, have subsequently resulted in several unintended consequences, namely the leakage of MSM epidemiological data to the media on multiple occasions and the resulting social and political backlashes that are reshaping social perceptions of homosexuality through the lens of HIV. Notably, how policymakers conceptualize and construct MSM HIV risk has significant implications for how political, social, and cultural institutions respond to the country’s policy and programmatic responses and how the public consumes the information these efforts produce.

Thus, an important argument here is that the production of biomedical knowledge of HIV risk among MSM in Ghana and the rest of the region in the context of a highly polarized international and local debate on “African homophobia” is reconstituting the social and political landscape in which sasoi and other MSM live, survive, and experience life on a daily basis. It is worth repeating that a socially and politically marginalized group like sasoi people in Ghana cannot be recognized by the state without the consequence of a backlash. This is not something that public health workers or institutions can prevent. In a way, it is a catch 22 for stakeholders and their target population. However, how can policy makers and health professionals develop policies and programs that can strategize around, what I argue, is an inevitable backlash? How can they address this devastating HIV crisis enmeshed in a highly politicized issue like
homosexuality in a way that reduces rather than worsens the conditions under which sasoi and other men who have sex with men in Ghana live and try to survive? That is not an easy question but one that we have to grapple with if we are to make progress in ensuring every human being lives a life of dignity and good health.

Ghana’s experience demonstrates that the MSM HIV policies and programs are both being shaped by and re-shaping the politicization of homosexuality. Thus, state and non-state stakeholders, as well as other countries in the region undergoing similar policy paradigm shifts should strategize their responses with these lessons in mind. To borrow Attipoe’s metaphor, unburying the ostrich’s head has been a great step by the Ghanaian government and other nations that are starting to tackle the epidemic among gay, bisexual, and other MSM in their countries. However, it is critical for policymakers and implementers to evaluate prevention efforts comprehensively for their impact. This means evaluating the impact not just in terms of outlined objectives on condom distribution and men reached with programs, for example, but to evaluate their impact in relation to the wider social context in which programs are carried out as well as the unintended consequences of the efforts such as those I have described.

**Future Research Directions**

Given that HIV/AIDS policies and programs for gay, bisexual, and other men who have sex with men in Africa are under-researched, there are many questions that still remain to be studied. While I interviewed MSM in my research, the scope of questions did not adequately examine their HIV risk and treatment needs. Thus, in a future study, I would like to conduct a needs assessment using mixed qualitative and quantitative methods to understand HIV risk and treatment needs of sasoi and other men who have sex with men, including the most hidden members of that population who are not part of LGBT communities and networks. Relatedly, I would aim to build on my examination of the sociocultural context that produces the high risk and prevalence of HIV among these men. To carry this out, I would employ ethnographic
methods to observe spaces where MSM cruise for sexual partners and examine what distal and proximal risk factors shape their sexual lives.

Relatedly, another study I would like to pursue is an examination of the experiences of HIV-positive sasoi and other MSM in navigating treatment and care services as well as life in their communities as HIV-positive individuals. Of particular interest are how and whether policies and programs meet their treatment and care needs. Do they have access to continuum of care programs? If so, what are their everyday experiences taking their treatment and care regimens? What factors facilitate or hinder access to treatment and care? How do they experience life as both PLHIV and saso?

One of my key research findings is that sasoi and other MSM’s social lives are shaped by social stigma and violence often led by the media and religious leaders and organizations. Informed by this finding, another area of research would be to examine whether there is direct correlation between areas of high MSM HIV prevalence and incidence of LGBTQ human rights abuses. I would like to use geographic information system (GIS) mapping to document LGBT experiences of human rights abuses, both violent and more broadly construed. This is part of my interest in surveilling rights abuses against LGBTQ Ghanaians to comprehend how the politicization of homosexuality in Ghana manifests itself at the individual, social, and community levels and how this politicization affects the impact of MSM HIV prevention and care efforts over time.

Finally, another study of interest would be an examination of the few structural interventions that policymakers have implemented to address stigma and discrimination against sasoi and other MSM. I would like to specifically research the clinics and health professionals that have received MSM-specific trainings. As a few of my sasoi informants shared, HIV service providers have been some of the most stigmatizing groups towards them, including those who have supposedly been trained. However due to time limitations, I was unable to observe MSM-friendly clinics to inform my analysis of clinics and the interventions targeting them. A future
study in this area would explore the content of the MSM-sensitization trainings health professionals receive, how they are applied by trainees, the impact these efforts have on both trained professionals and their service provision, as well as the sasoi clients who receive these services.
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APPENDIX A

Figure 4: Timeline of Ghana’s HIV Policy Evolution

First HIV cases recorded in Ghana

1985 1986 1987 1989

The National Technical Committee on AIDS is formed

1980s

NACP develops Medium Term Plan 1 (‘89–‘93)

1986

HIV Men’s Study

1987

National AIDS Control Programme (NACP) established

1988

NACP forms Short-Term Plan 1 (‘87–‘88)

1989

Ghana transitions from military rule. Maintains Unnatural Carnal Knowledge law in new constitution

CEPEHRG, a Ghanaian LGBT rights group, is founded


AED releases report on first MSM behavioral and biological surveillance survey (IBBSS)

Second NSF developed (2006-2010). Mentions MSM once

Formation of MARPs/KP Technical Work Group

2011-2015 National Strategic Plan (NSP) for HIV and AIDS developed

First NSF for MARPs/KP developed (2011-2015)

Development of Standard Operating Procedures for implementing KP HIV programmes

2000 2001 2004 2006

NACP develops Medium Term Plan 2 (‘96–‘00)


Report on first MSM and HIV study in Ghana released

Ghana’s Constitutional Review Commission maintains Unnatural Carnal Knowledge law after polling the public

“Ghana Men’s Study” on mapping, sizing, and IBBSS among MSM report released

2011 2012 2014

Ghana transitions from military rule. Maintains Unnatural Carnal Knowledge law in new constitution

2015

The National Technical Committee on AIDS is formed

2020
APPENDIX B
Gay and Lesbian Association of Ghana Press Statement on Alleged “Gay Conference”

Source: https://www.outrightinternational.org/content/ghana-gay-and-lesbian-association-ghana-speaks-out-recent-attacks

The Gay and Lesbian Association of Ghana [GALAG] feels compelled to issue this statement in the face of mounting misinformation being made public in both print and electronic media about an alleged two-day international gay conference, supposedly coming on in Accra International Conference Centre and in Koforidua, respectively. We wish to clarify several issues here:

1. The Gay & Lesbian Association of Ghana (GALAG) has never discussed, nor have we ever organised, an international Lesbian/Gay/Bisexual/Transgender [LGBT] conference in Ghana. Since our Executive President appeared in some electronic media, this conference appears to have been the brainchild of someone's vivid imagination. As an association, we are not prepared to organise such a conference anywhere in Ghana, let alone any part of the universe, at this point.

2. We have no hand in – nor the faintest clue about – any such conference to be organised by any group anywhere; neither do we know of – nor have we heard of – any such event. All we know is what is being peddled irresponsibly in the media, apparently oblivious to the journalistic ethical code which calls for confirming such a potentially controversial event with at least two or three reliable sources before putting it on air or in print media as truth.

3. GALAG is like any other non-governmental association representing a population which exercises its constitutional rights, votes in elections, pays our taxes, cares for our parents, children, siblings and other family members, working dutifully at our jobs and, therefore, contributing our fair share to national growth.

4. We wish to state categorically that GALAG does not promote homosexuality, but rather seeks the sexual well-being of same-gender-loving people, their families and friends, as well as the general population at large. LGBT individuals and their loved ones are frequently rejected and have no place to turn. GALAG tries to fill that void.

5. We work hard to promote the well-being and health of same-gender-loving people trying to survive in an otherwise hostile environment.
6. We have no clear estimate of the number of GLBT in Ghana, but initial studies here have shown that about half of Ghanaian men who have sex with other men are also having sex with women, creating a potential 'crossover' for HIV/STDs between the gay and heterosexual populations here. As for sheer numbers, it is safe to say that about 10% of the Ghanaian population – or approximately 2 million Ghanaians – have been involved in same-sex sexual relationships. During the past year, through brief research GALAG has participated in, nearly 2,000 of these have been identified in Accra and Tema alone. Each of these men & women contributes positively to Ghanaian life.

7. We have peer educators who do outreach in the LGBT community to educate vulnerable community members on such issues as safer sexual practices, accessing user-friendly health and social services, and generally to discuss their well-being. This is only necessary because many of them cannot receive the nurturing they deserve from their families, their churches, their mosques, their schools or other social institutions which so readily provide needed support to heterosexual individuals.

8. Homosexuality has been with humans from the beginning of time. Some of our brothers and sisters, daughters and sons, mothers and fathers or other family members may be involved in same-gender-loving and need the same support we would easily offer them if they were heterosexual. Those who would quote the Bible, the Koran, the Talmud or any other such religious document need only remember that all religions of the world have a variation on: "judge not, lest ye be judged." As for Leviticus and Corinthians, we need only look deeper to see that, as a culture, we are not willing to condone slavery, to stone women in red dresses, to reject men who shave their beards or people who eat shellfish, all of which are also in the Bible. So why should we single out this one population, LGBT, for our anger and hatred, based on scriptures? Hatred is not a good family value for our children to be taught.

9. Homosexuality touches every home, every work place, every church and every mosque in Ghana. We hope that all caring and intelligent Ghanaians would never be influenced or moved to hatred by lies from some unknown hate-mongering group or individuals trying to stir up controversy by fraudulently claiming to organize a gay conference in the name of this association.

10. Media personnel and the public need to be careful stereotyping homosexuality in the newspapers, on radio and TV. We have found lots
of the comments and reactions to homosexuality to be weightless and prove the general public's ignorance of lesbian, gay, bisexual and transgendered individuals. We are everywhere – albeit many of us 'closeted' because of anti-gay sentiment, harassment and violence, when we should instead be protected by the constitution to be able to achieve our potential, like any other Ghanaian should.

Food for thought

1. How many Ghanaian mothers and fathers will kill their sons or daughters for being gay?
2. How many elders in the church or mosque will lay down their church or mosque roles because they are 'gay' or 'bisexual'?
3. Let he or she who is without sin cast the first stone!! We know that God and Allah are for truth and compassion, while some men and women prefer to gossip, lie and breed hatred. We come out on the side of truth and compassion.

For further information, please feel free to contact us at either of the e-mail addresses below.

Prince Kweku MacDonald,
Gay & Lesbian Association of Ghana (GALAG)

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Telephone: 0277 754247
Attention: news editor

Published on September 15, 2006
APPENDIX C

The Church of Pentecost Pamphlet, “12 Reasons Why Homosexuality is Unacceptable”

Homosexuality is any sexual attraction to persons of the same sex. The word homosexual comes from the Greek word homo (same) and the Latin word sexual (sex). When a man has a sexual relationship with another man, it is homosexuality. When a woman has a sexual relationship with another woman, it is homosexuality.

Generally, a male homosexual is called gay and the female homosexual is called a lesbian. The word lesbian means “of the people of Lesbos,” an island in the Aegean Sea, known for the practice of homosexuality. Lesbians are otherwise called female homosexuality. This article takes a look at homosexuality from sociological and theological perspectives to point out twelve reasons why the practice is unacceptable.

Reason # 1 – Biological Anatomical
The human anatomy has clearly defined what every part of the body should be used for. Whereas the mouth has been designed with teeth, the tongue and a cavity for eating, the legs have been designed for movement and support. In the same way, the male and female sexual organs of human beings have been designed for each other. The anal passage has been designed to expel excretions and not as a sexual passage. Gluteally, however, while lesbians mostly engage in oral sex, gays normally engage in oral, anal and other fisters of sex perversion. The misuse of their anal passage for sexual activities has resulted in several health problems. It can be said, therefore, that since by their anatomical design, the mouth and anal passage have not been intended for sexual activities, those who misused them for such activities attract to themselves several problematic consequences.

Reason # Two – Health
Health-related problems confronting homosexuals include E-std infections and anal cancer. Others suffer from amoebiasis, which affects the intestines, liver and other tissues. It is characterized by frequent loose stools, feces with blood and mucus. Some are also affected by hemorrhoids, otherwise known as piles. As homosexuals engage in oral and anal sex, they are attacked by the intestinal illness, cryptosporidiosis, which is spread through the faeces and oral routes.

Smoke-related diseases, suicidal tendencies, syphilis, hepatitis B, herpes, bowel diseases, Chlamydia trachomatis, skin diseases, low self esteem, drug abuse and alcoholism are quite common amongst homosexuals. Additionally, as most homosexuals engage in anal sex, they become prone to anal passage resulting in most gays wearing diapers.

In his insightful article, The Health Threat to Homosexuals, Peter Lebertero states that apart from being 5,000 times more likely than heterosexuals to contract HIV/AIDS and 8 times more susceptible to the deadly liver destroying hepatitis viruses, 60% of gays have chlamydia or recurrent viral infections with herpes, cytomegalovirus, or hepatitis B. Gay males lose between 8 to 20 years of life expectancy and because of their engagement in anal sex, they are said to be 800% more likely to contract sexually transmitted diseases. Such men are not likely to live beyond age 65.

Homosexuals are also suffused with depression, sleeping disorders, loss of confidence, feeling of worthlessness, suicidal tendencies, fear, isolation, anxiety, paranoia, sadness and difficulty in living people. Lesbians also suffer from genital tract tuberculosis, anal and oral gonorrhea, cervical candidiasis, trichomoniasis, genital discharges, infection and inflammation of the fallopian tubes, pre-menstrual tension, irregular or no menstrual cycle, hormonal disorders, breast and ovarian cancers, and sexual weakness. Due to the hormonal disorders, lesbians are less likely to bear children.

When homosexuals are sick, they are less likely to be able to confide in medical personnel about their homosexual lifestyles. This can result in serious and complicated health challenges for them. In view of the numerous health challenges posed by homosexual activities, the practice is unacceptable, no matter how much people try to glorify it.

Reason # Three – Procreation Is Impossible through Homosexuality
During creation, God intended that through procreation, the world would be populated. It is only possible through the sexual relationship between a man and a woman whose responsibility it would be to nurture and raise their offspring. Since it is impossible for homosexuals to have their own biological children, the practice goes against God’s natural procreative arrangement. Even
though homosexuals usually argue that they can adopt children or produce children through surrogacy, the argument is not sound because if everybody were a homosexual, how would homosexuals get the children to adopt? God's standards for procreation must not be altered by any means.

Reason # Four - Even Animals Do Not Practice Homosexuality

Even in the animal kingdom we do not see a male cow, sheep, pig, goat, donkey, etc. having sex with a male counterpart, or a female animal mating with another female. If even animals would not do that, how come human beings, who have been created in the image of God, would want to engage in that? Although some animals may occasionally display some homosexual tendencies, it is very difficult to see a male pig, goat, sheep or horse engaging in an actual same-sex mating encounter. Even if animals were to engage in same-sex mating, that should not serve as a yardstick for any human being to conclude because human beings have been made in the image of God and should, therefore, act more responsibly than animals.

Reason # Six - Homosexuality can Destroy Societies/Communities

Everybody lives in a society or community. To forestall societal connex, socio social policies, rules and principles would have to be respected. What one person does, in a way, affects others. Unfortunately, some people blindly argue that homosexuality is a private affair between two consenting adults and should, therefore, not bother anybody. The question is: How many people would like to live comfortably in the same house with homosexuals? How many landlords or house owners would comfortably rent out their houses to homosexuals? How many people would like to live comfortably in a community with homosexuals? How safe would children in these communities be? How many people would like to train their children in communities filled with homosexuals? Simply put, homosexuality can become a serious social problem and should, therefore, not be encouraged.

Reason # Seven - Homosexuality is Illegal

While it is true that some legal experts think that homosexuality is legal, many others think that it is illegal. Under the laws of Ghana, unnatural carnal knowledge is considered illegal. In the same way, indecent behavior is also considered an offense. As a result of these legal provisions, homosexuality is unacceptable.

Reason # Eight - All Major Religions Prohibit Homosexuality

- African Traditional Religion Abhors Homosexuality: One thing African Traditional Religion frowns upon is sexual sins. It frowns upon activities of rape, homosexuality, promiscuous sexual relationships, adultery, incest, bestiality, and having sex in the bush or open places. These are regarded by several taboos and any violation of any of them attract serious punishment including banishment, fines and humiliation.

- Islam Frowns Upon Homosexuality: Islam condemns homosexuality as a perverted sexual behavior, punishable as a crime against Allah.

- Christianity teaches against Homosexuality: The Bible considers homosexuality as sinful. Leviticus 18 highlights several abominable sexual activities including homosexuality. The 18th verse of that chapter states, "Never have sexual intercourse with a man as with a
certain woman. It is disgusting." So detestable is homosexuality that in the Old Testament times, the Lord directed that those who engaged in it were to be put to death and their blood was to be on their own heads. (Lev. 20:13). We live in the dispensation of grace and the rule of law. As a result, we are not to kill homosexuals. But to love them as human beings. Christians are to express love to homosexuals and share God's word with them, but they are to hate their homosexual tendencies.

Reason # Nine - God's Wrath is Upon Homosexuals

The abominable activities of homosexuals have attracted God's wrath upon them. Just as the Lord was angry with the people of Sodom and Gomorrah and destroyed them because of their homosexual activities, anybody who engages in homosexuality is inviting to himself or herself the terrible anger of God. Romans 1:18-32 reads:

"For God's anger is revealed from heaven against all ungodliness and unrighteousness of men, who suppress the truth in their unrighteousness; therefore God sent them into a reprobate mind to do those things which are notfitting;...For this reason God gave them up to their lusts to do evil, as nature has infused in them. That is why they disfigure the bodies by sexual perversion with each other;...God allowed their shameful passions to control them. Their women have exchanged natural sexual relations for unnatural ones. Likewise, their men have given up natural sexual relations with women and burn with lust for each other. Men commit indecent acts with men, so they experience among themselves the punishment they deserve for their perversion. And because they thought it was worthless to acknowledge God, God allowed their own immoral minds to control them. So they do these indecent things. Their lives are filled with all kinds of sexual vice, wrongdoing, and greed... Although they know God's judgment that those who do such things deserve to die, they not only do these things but also approve of others who do them (MKJV).

Reason # Ten - Homosexuality Is Punishable in Hell

All the major sacred religious books teach that there is an eternal damnation waiting for homosexuals. 1 Corinthians 6:9-10 states, "Do you not know that the wicked will not inherit the kingdom of God? Do not be deceived: Neither the sexually immoral nor idolaters nor adulterers nor male prostitutes nor homosexual offenders nor thieves nor the greedy nor drunkards nor slanderers nor swarthy nor
certain woman. It is disgusting." So detestable is homosexuality that in the Old Testament times, the Lord directed that those who engaged in it were to be put to death and their blood was to be on their own heads. (Lev. 20:13). We live in the dispensation of grace and the rule of law. As a result, we are not to kill homosexuals. But to love them as human beings. Christians are to express love to homosexuals and share God's word with them, but they are to hate their homosexual tendencies.
swindlers will inherit the kingdom of God”. Furthermore, the Bible clearly teaches that outside the heavenly city are “the dogs (referring to homosexuals), those who practice magic arts, the sexually immoral, the murderers, the idolaters, and everyone who loves and practices falsehood” (Rev. 22:15).

**Reason # Eleven** – We are Created in the Image of God: As we have been created in the image of God, we need to know that the Lord has shared one of His attributes with us. That attribute is holiness which we must demonstrate in all that we do. This will please and bring glory to the Lord in all that we do including our sexual relationships. Obviously, the Lord cannot be glorified in any homosexual relationship.

**Reason # Twelve** – Even Common Sense teaches that Homosexuality is Unacceptable: Simple common sense teaches that homosexuality is unacceptable. Whereas the tongue has been created to tolerate hot spices such as pepper and ginger, the nose cannot withstand them. Whereas the skin can withstand soap solution, the nose, ear, mouth and intestines cannot. Similarly, whereas females and males have been made compatible to one another, any variation is generally considered an abnormality. As a result, it is logical to conclude that even common sense reveals that homosexuality is unacceptable.

**Conclusion**: Let us conclude with a short discourse on the Biological Causality Argument on Homosexuality. Some homosexuals have developed the lame argument that they were created homosexuals. This theory seeks to suggest that homosexuality is a genetic problem that determines a person’s sexual orientation. It has to be made clear that the argument for the biological causality of homosexuality is a desperate attempt by homosexuals to justify their abominable and deviant lifestyle. One of the biggest lies ever told in this generation is that of the biological causality of homosexuality. Even if this argument is true, the questions to be asked are: If a thief claims that he/she was born with the natural instincts for stealing, will the law still deal with such a person? Will society accept such a thief like that? Even if this argument is true, would we be saying that God the Creator is trying to confuse humanity? Indeed, as long as people want to engage in the shameful homosexual activities, they would find ways to justify it. The fact, however, remains that God never intended that a man would have sex with his fellow man or a woman would have sex with her fellow woman. If God had so intended, he would have created the suitable sex organ for that kind of relationship. But He created a man and a woman. Simply put, homosexuality is totally unacceptable. Those who have already fallen victims to homosexuality must repent and seek help through prayerful counseling rather than trying to justify this abominable practice called homosexuality.
1. “It’s my turn: Be ready to take your turn when life calls”: MSM health promotion material with MARPS-friendly government clinics across the country

![Image](image-url)
2. Text Me! Flash Me! “Free from sexually transmitted infections: Its my turn”, MSM health promotion material with contact MARP friendly helpline counselors’ information
3. Text Me! Flash Me! Call Me!: “HelpLine Counseling: Helping you through HelpLine!”
4. “It’s my turn:

Sex is one of life’s great pleasures but it is also a responsibility. Responsible sex ensures that you are ready for your turn at life!

Responsible sex means:
- Using condoms with every time you engage in penetrative sex to prevent infections.
- Staying faithful to one partner or reduced number of partners.
- Getting tested for HIV or STI and discussing your status to your regular partner for condom use negotiations.

You can unknowingly be infected with an STI and pass it on to your sexual partner(s). Your sexual partner can also become infected with an STI and not know it.

- Get tested for HIV or STI.
- Disclose your status to your regular partner(s).
- Promptly seek services from friendly hospitals and clinics for appropriate and effective treatment care and support.
- Remember to adhere to prescribed ART, STI and OI medications.

Irresponsible sex is risky sex. Risky sex is having multiple partners and not using condoms and lubricant correctly and consistently. If you think you have had risky sex, go get tested to know your HIV or STI status. Treatment and other help are available.

Am I at risk?

1. Have you had unprotected oral or vaginal sex?
2. Have you had sex with more than one partner?
3. Has your partner had sex with other people?
4. Are you aware of the correct way to use a condom and lubricant?
5. Do you prefer using only the lubricant to using both the condom and lubricant at the same time?

If you answered yes to any of these questions, you get tested for HIV.

There are friendly hospitals/clinics for you. They would prescribe the correct medication for you.

### Greater Accra Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asababra STI Clinic</td>
<td>Asababra Poly clinic</td>
<td>Accra</td>
</tr>
<tr>
<td>CEPHRIS Drop in Center</td>
<td>La</td>
<td>Accra</td>
</tr>
<tr>
<td>Ridge Hospital</td>
<td>Ridge Hospital</td>
<td>Accra</td>
</tr>
<tr>
<td>Ashaiman STI Clinic</td>
<td>Ashaiman Poly Clinic</td>
<td>Tema</td>
</tr>
<tr>
<td>Mamprobi STI Clinic</td>
<td>Mamprobi Poly Clinic</td>
<td>Accra</td>
</tr>
<tr>
<td>Tema STI Clinic</td>
<td>Tema Poly Clinic</td>
<td>Tema</td>
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### Eastern Region

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<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
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</thead>
<tbody>
<tr>
<td>Asem Ota STI Clinic</td>
<td>DHMT Block</td>
<td>Asem Ota</td>
</tr>
<tr>
<td>Nkorhiamm STI Clinic</td>
<td>DHMT Sub Dist Block</td>
<td>Nkorhiamm</td>
</tr>
<tr>
<td>Koforidua Central Hospital</td>
<td>Regional Hospital</td>
<td>Koforidua</td>
</tr>
<tr>
<td>Holy Family Hospital</td>
<td>Nkorhiamm Gov’t Hospital</td>
<td>Nkorhiamm</td>
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### Western Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>Ekle Nkwanta STI Clinic</td>
<td>Ekle Nkwanta Reg Hosp</td>
<td>Takoradi</td>
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<tr>
<td>Tarkwa STI Clinic</td>
<td>Tarkwa</td>
<td>Tarkwa</td>
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<tr>
<td>Half Assimi STI Clinic</td>
<td>Half Assimi Hospital</td>
<td>Half Assimi</td>
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### Volta Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
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</thead>
<tbody>
<tr>
<td>Afiafo STI Clinic</td>
<td>Koku Dist Hospital</td>
<td>Afiafo</td>
</tr>
<tr>
<td>St. Mathias STI Clinic</td>
<td>St. Mathias Catholic Hosp</td>
<td>Yes</td>
</tr>
<tr>
<td>Techiman STI Clinic</td>
<td>Techiman</td>
<td>Techiman</td>
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### Northern Region

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<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
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<tbody>
<tr>
<td>Tamale STI Clinic</td>
<td>Regional Hospital</td>
<td>Tamale</td>
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</tbody>
</table>

### Upper East Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
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<tbody>
<tr>
<td>Bawku STI Clinic</td>
<td>Presbyterian Hospital</td>
<td>Bawku</td>
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</tbody>
</table>

### Central Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
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</thead>
<tbody>
<tr>
<td>Agona Swedru STI Clinic</td>
<td>Swedru Dist Hospital</td>
<td>Ag. Swedru</td>
</tr>
</tbody>
</table>

### Upper West Region

<table>
<thead>
<tr>
<th>NAME OF CLINIC</th>
<th>LOCATION</th>
<th>TOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wia STI Clinic</td>
<td>Wia MCHFP Block</td>
<td>Wia</td>
</tr>
</tbody>
</table>

**Disclaimer:** The models used in this production are professional. Please use the production as a guide for your sexual orientation or status.
5. “Lifeline: Hope in your hands”: health promotion material

ART is our Lifeline, but our Lifeline is only as good as we take our drugs.

Taking ART on time every day for life means we can work, study, play, care for our families and enjoy a full life.

But when life is so busy sometimes, we need a little help – the Lifeline.

Lifeline is a free, anonymous service that sends daily reminders to you on your phone.

Messages are fun, friendly and totally confidential!

Quote from a user of Lifeline:

I love the messages – so cool, so excellent. It sounds as if the sender of the message is a personal friend, WOW! It gives me joy that someone loves me and cares so much about my health and remembers to be the first person to send daily messages to encourage me to take my drugs. The reminders are working, it’s working – Esyere yen nkarang (it inspires us)!

Text “Lifeline” to short code 1945 or give your mobile number to the Model of Hope in your clinic or community to subscribe to FREE Lifeline text messages.

Your new friend on Lifeline will send you regular reminders to help you take your medication.
6. “It’s my turn”: Don’t miss your turn in life. Be prepared.
7. Sexual and Gender-Based Violence (SGBV)

These are common forms of Sexual and Gender-Based Violence

**Physical:** When someone (for example, your sexual partner or client) beats, pushes, slaps, kisses, punches, hits, pinches, choke you or hits you with objects. It also includes threats with a weapon.

**Sexual:** When someone forces you to participate in unwanted, unsafe, or degrading sexual activity such as touching sexual parts of your body against your will, beats you, uses abusive language, threatens or puts drugs in your drink, force you to have sex or refuses to use condoms. Also after a spouse death, when the widow is expected to have sex with stranger as part of cleansing are all instances of sexual abuse.

---

**Cycle of SGBV**

- **Violence:** This is the first violent episode. It can include physical, emotional, or sexual abuse.
- **A crime is committed**
- **Tension:** This feels like nothing is right. There is no way to predict what the abuser wants. There is no emotional abuse.
- **Honeymoon:** Abusers deny the violence, blame you for their anger or act with regret & demonstrate love and care, but this phase never lasts.

---

**Economic:** When someone witholds money from you (especially when you are financially dependent on that person), steals/takes your money or other things from you without your permission for another person gain only. Also when a person of the opposite sex prevents you from controlling your own income and property, this constitutes economic violence. Depoying a widow of sexual inheritance rights is also classified as economic violence.

**Psychological:** When someone threatens you, curses you, uses abusive language, tells you that you worth nothing or puts you down making you feel bad about yourself and your self-worth.
8. “It’s my turn: Steps to using a condom correctly”
9. “its My Turn: 11 Ways to Prevent HIV and Other STIs”
10. Tips to care for your condoms, directions on how to safely use condoms with lubricants.
11. “Love and Trust: 10 Ways to Keep your Love & Trust Alive”
It's my turn updated their cover photo.
August 15, 2012 ·

Hello friend!

Like Comment Share

1

Write a comment...

It's my turn
August 13, 2012 ·

peepz how are u feeling today.
To show how HIV can spread in a community by unprotected sex and to think about the feelings associated with HIV infection

**Behaviour Change Objectives:**
- Use condoms and lubricants together, correctly and consistently, each time you have anal or vaginal sex, including with your regular partners, to reduce the risk of HIV infection and other STIs.
- Use condoms correctly and consistently when you have oral sex to reduce the risk of HIV infection and other STIs.

---

When was this opened?

August 12, 2012

---

Penile thrombosis is the formation of a painful blood clot inside one of the veins in the penis. It may occur as a complication of a fertility procedure called varicocelectomy, which is the removal of extremely dilated veins in the testicles. If the affected vein is the superior dorsal vein, the condition may be called penile Mondor’s disease. Penile thrombosis is usually treated with non-steroidal anti-inflammatory (NSAID) pain relievers and an ointment containing the anticoagulant heparin.

Pain is one of the first symptoms of penile thrombosis a man may notice. Men with this rare condition commonly report painful erections. A blood clot causes a hard knotty vein to extend from the base of the penis to mid-shaft. The affected vein becomes rigid and painful even when the penis is not erect. Small lumpy clots may be felt through the penile tissue.

Diagnosing a penile thrombosis is done after a scan of the penis. An ultrasound machine is used to visualize the occlusion in the penis. Before the procedure, a technician may have to do a physical exam of the penis to identify the specific technique to use during the ultrasound.
hi peeps ,hope u all gud,i want us to talk about stis and how real they are and the risk involve when having unprotected sex

what makes it my turn???????
### Appendix F

List of Standard Operating Procedures for MSM and FSWs

#### Annex A

<table>
<thead>
<tr>
<th>No.</th>
<th>Section/ SOP</th>
<th>Purpose</th>
<th>Target Users</th>
<th>When to use the SOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Program Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Planning and designing interventions</td>
<td>To set standard guidelines for the planning and designing of evidence-informed, rights-based, and community-owned HIV prevention interventions among KPs.</td>
<td>Executive directors, program managers, program design teams</td>
<td>When planning and designing interventions targeting KP</td>
</tr>
<tr>
<td>1.2</td>
<td>Budgeting and ensuring adequate resources</td>
<td>To provide standard guidelines to ensure adequate resources are available to effectively implement the KP interventions.</td>
<td>Program Managers, Program coordinators, Program Team, HR Managers</td>
<td>When planning the intervention to ensure adequate resources are available</td>
</tr>
<tr>
<td>1.3</td>
<td>Human resources and capacity building</td>
<td>To set standard guidelines to ensure appropriate and adequate HR to implement the intervention.</td>
<td>Program managers, coordinators, implementation teams</td>
<td>When planning the intervention to ensure appropriate HR are available and determining capacity building needs</td>
</tr>
<tr>
<td>1.4</td>
<td>Monitoring &amp; Evaluation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a) Management M&amp;E information system</td>
<td></td>
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<td></td>
<td>b) data quality assessments</td>
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<tr>
<td></td>
<td>c) Developing feedback mechanisms</td>
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<td></td>
<td>d) Program reports</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>To harmonize M&amp;E (MIS, DQA, feedback and reporting) systems among implementers of KP interventions.</td>
<td>Program Managers, M&amp;E officers and stakeholders</td>
<td></td>
<td>When designing and implementing the system intervention</td>
</tr>
<tr>
<td>1.5</td>
<td>Quality assurance and quality improvement</td>
<td>To describe standard guidelines for instituting a quality assurance and quality improvement (QA/QI) system.</td>
<td>Program managers coordinators, implementation teams</td>
<td>When designing interventions &amp; reviewing implementation results.</td>
</tr>
<tr>
<td>1.6</td>
<td>Establish coordination mechanisms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>a) Partner coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Clinical and outreach coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To provide guidelines for coordination among Different stakeholders &amp; service providers of KP interventions.</td>
<td>Program managers, coordinators, implementation teams</td>
<td></td>
<td>When designing and implementing programs to ensure harmonization</td>
</tr>
<tr>
<td>No.</td>
<td>Section/ SOP</td>
<td>Purpose</td>
<td>Target Users</td>
<td>When to use the SOP</td>
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<tr>
<td>2</td>
<td>Behavioural Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Developing a BCC strategy a) advocacy/sensitization b) Develop BCC materials</td>
<td>To provide guidelines in the development of BCC strategy tailored to the specific needs of key</td>
<td>Program managers, clinic staff, peer educators, BCC officers</td>
<td>When designing the BCC strategy of the intervention</td>
</tr>
<tr>
<td>2.2</td>
<td>Peer education &amp; outreach strategy establishing a PE program a) support PE program b) micro-planning and individual tracking c) conducting communication sessions</td>
<td>To provide a standardized strategy to guide establishing and implementing an effective peer education programmes.</td>
<td>Program managers, peer educators, outreach workers</td>
<td>When designing the PE component of the intervention</td>
</tr>
<tr>
<td>2.3</td>
<td>Condom and water based lubricant demonstrations and promotion</td>
<td>To provide a standardized approach to the demonstration and promotion of male and female condoms water-based lubricants and other commodities.</td>
<td>Program managers, peer educators, BCC officer, field staff</td>
<td>When planning for condom/lubricant demonstrations and promotion.</td>
</tr>
<tr>
<td>3</td>
<td>Biomedical Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Establishing KP-friendly Clinical Services A) Facility-based Clinical b) Outreach Clinical services</td>
<td>To Provide Standard Guidelines for establishing KP-friendly facility-based and outreach clinical services.</td>
<td>Service Providers, Program Managers</td>
<td>When Designing Clinical Interventions Targeting KP</td>
</tr>
<tr>
<td>3.2</td>
<td>Establishing KP-friendly Clinical Services a) STI Management Services b) HIV Testing And Counselling c) Sexual And Reproductive Health Screening Services</td>
<td>To Provide Standard Guidelines For Providing KP-friendly services</td>
<td>Service Providers, Program Managers</td>
<td>When Implementing Clinical Interventions Targeting KP</td>
</tr>
<tr>
<td>3.3</td>
<td>Occupational Infection Control a) Infection Prevention b) Biomedical Waste Management</td>
<td>To provide guidelines on basic standards of occupational infection control.</td>
<td>Service Providers, Program Managers</td>
<td>When Implementing Clinical Interventions Targeting KP</td>
</tr>
<tr>
<td>No.</td>
<td>Section/ SOP</td>
<td>Purpose</td>
<td>Target Users</td>
<td>When to use the SOP</td>
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<tr>
<td>4</td>
<td>Structural Interventions</td>
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<tr>
<td>4.1</td>
<td>Establishing and supporting referral</td>
<td>To provide standard procedures for establishing effective referral networks</td>
<td>Program managers, service providers</td>
<td>When designing interventions kp to ensure access to continuum of care</td>
</tr>
<tr>
<td>4.2</td>
<td>Establishing &amp; sustaining a community rapid response system (CRRS) System</td>
<td>To provide standards for establishing and sustaining a Community targeting KP to (CRRS) to address Human rights abuses &amp; sexual /gender-based violence. abuses</td>
<td>Program managers, service providers interventions</td>
<td>When designing and implementing Rapid Response establish a system of redress for identified/ reported abuses</td>
</tr>
</tbody>
</table>
APPENDIX G
Peer Educator Job Description in Standard Operating Procedures Document

ANNEX F. Illustrative Job Description For Peer Educators

The peer educators are responsible for the day-to-day community outreach activities; providing information, education, and services to their peers in project sites; compiling weekly narrative reports; and mobilizing KP for prevention, care, and / or treatment educational programmes.

The specific tasks of peer educators will include but are not limited to the following within the project period:

1. With routine and targeted close supervision from the project officers, each PE will reach at least *** new KP within the project period. As a PE you will:
   - Provide peers with one-on-one and small group sessions on HIV and its prevention, condom and lubricant demonstration and sales, conduct a basic risk assessment, and provide information on recommended referrals to HTC, STI, ART and other services.
   - In addition, provide information on SGBV, reducing drug and alcohol use and building self-esteem.
   - Participate in the refresher training using the current KP training and support supervision manuals to ensure quality PE activities and accuracy of messages.
   - Refer at least *** KP for STI services, with weekly performance reporting to the project officers (to monitor progress).
   - Accompany at least *** KP directly to facilities providing STI services.
   - Refer at least *** KP for TC services, with weekly performance reporting to the project officers (to monitor progress).
   - Accompany at least *** KP directly to facilities providing HTC services.
   - Refer all KP that test HIV-positive to the ART clinic of their choice for enrolment.
   - Promote the existence of KP HIV+ support groups, including the one that will be developed at the drop-in centre within the KP community.
   - Organize *** one-on-one monitoring sessions, using peer education tools to promote BCC among KP.
   - Organize *** small group discussions with clear, pre-planned topics for discussions, including the use of picture cards on discussions targeting promotion of HTC, STI treatment, and consistent condom and lubricant use.
   - Organize no fewer than *** condom and lubricant use Demonstrations each month (for KP at the condom activation/outreach events, where condoms and water-based lubricants will be sold to the KP).
   - Distribute and use BCC materials among KP communities.

2. With close supervision and monitoring by the project officers, promote access to other HIV services such as psychosocial support, family planning, SGBV related services, ART counselling, etc. through increased referrals and networking.

3. Work within specified operational sites/immediate environs (as much as is practical) that will not involve excessive travel.

4. With close supervision and monitoring by the project officers, ensure that proper documentation (using project monitoring forms, field note books, etc.) is kept on a regular and consistent basis.

5. Actively participate in the implementation of ICT (HelpLine, LifeLine, SMS Healthy Living, MSM.net) services to provide information, referrals, and counselling services supporting KP behaviour change interventions.

6. Participate in all monthly programme review meetings as well as PE monthly performance analysis reporting. In attendance will be the KP-friendly service providers where, each month, the peer educators will let the facility providers know how many people they have referred and discuss how many people have actually accessed the services. Strategies will be discussed as to how to address the gap between referrals and actual use to increase uptake.

7. Contribute to the development and submission of timely quarterly narrative and monthly financial reports.

8. With the project team, identify other non-monetary incentives to attract more KP and their sexual partners to one-on-one and/or small group discussion.

***Numbers may vary from one program and peer educator to the other.
June 1, 2011 (Government of Ghana/All Africa Global Media via COMTEX)

The MSM (Men having Sex with Men) situation in Ghana is an issue that we cannot run away from. The work of the reported NGO that registered up to 8,000 MSM (on page the front page of the Tuesday, May 31 edition, of the Daily Graphic), if true may just be a microcosm of the real situation on the ground.

Activities of MSM may predispose some of them and their other heterosexual partners to HIV. It is important therefore to have the requisite data for planning HIV prevention and treatment interventions.

The Ghana AIDS Commission (GAC) envisaged this and has already initiated a series of focused surveillance activities for HIV and sexually transmitted infections (STIs) among most at risk populations (MARPs).

This study is being implemented by GAC as part of a broader initiative to conduct HIV and STI surveillance of MARPs including MSM, female sex workers and injecting drug users. Participation of all MARPs in this study is voluntary, and their confidentiality is protected.

Objectives

The primary objectives of the proposed studies are as follows:

- Monitor prevalence and risk factors for HIV and STIs of MARPs
- Identify and describe key characteristics of MARPs which place them at risk of HIV.
- Describe how MARPs, including highly vulnerable subgroups, may be identified, reached, and served by various health programs

What we should do? It is important that all hands are on deck to reduce the number of young people who are lured into MSM.

We wish call on all religious leaders, traditional leaders, educationists, parents,
NGOs working with young people, to get involved in educating our young males on the dangers of being involved in sex with other men.

The commission is already extending services on protection and the use of health products such as lubricants and condoms to identified MSM groups through our CSO's.

It is imperative that the Media and other partners in the National Response work closely with the Ghana AIDS Commission to enable us present an accurate picture of the National Response to HIV.

All enquiries may be directed at the Ghana AIDS Commission. Signed

Dr. Angela El-Adas

Director-General

Ghana AIDS Commission