THEATRE FOR A CHANGE

Impact Evaluation of the Theatre for a Change Ghana Old Fadama Project

April 2015

Contents

List of Tables and Figures

Glossary

AIDS – Acquired Immune Deficiency Syndrome

FSW – Female Sex Worker

HIV – Human Immunodeficiency Virus

HTC – HIV Testing and Counselling

NPP – Non-Paying Partner

SRH(R) – Sexual and Reproductive Health (and Rights)

STI – Sexually Transmitted Infection

Introduction

The Old Fadama Project was implemented by Theatre for a Change Ghana (TfaC), a registered non-governmental organization in Ghana, between September 2012 and March 2015. The project involved female sex workers (FSWs)[1] in a range of activities, with the purpose of improving the security and wellbeing of this marginalized population. Specifically, the project goal was to facilitate FSWs to empower themselves with the knowledge and skills to protect their health by accessing appropriate health services and to advocate for their rights to live without gender based violence.

FSWs dwelling in Old Fadama and Railways, slum communities in central Accra[2], were targeted by this project due to the multiple and multi-faceted risks they are vulnerable to as practitioners of stigmatised work living in communities with poor infrastructure and resourcing.

Activities as part of the project included sexual and reproductive health and rights (SRHR) behaviour change workshops; peer education; provision of a fund for medical expenses; advocacy for sex workers' rights via interactive drama; alternative income generation training; a small loans scheme; and sensitization and advocacy work targeting justice providers.

Purpose of the impact assessment The purpose of this evaluation is to provide an understanding of the achievements of the Old Fadama Project, as well as identify any shortcomings. The evaluation focuses on the impact the project has had on the lives of the target group. It is expected that this evaluation will contribute to future programme strategy development.

Summary of the project

Project objectives Between September 2012 and March 2015 TfaC implemented the Old Fadama Project. The project goal was to facilitate female sex workers to empower themselves with the knowledge and skills to protect their health by accessing appropriate health services and to advocate for their rights to live without gender based violence. The project was funded by multiple donors, including some multi-year donors. Different time-bound project activities had specific aims and outcomes which contributed to the overall project goal.

Theory of Change TfaC uses uniquely active and participatory tools that promote sexual and reproductive health and gender rights, among vulnerable and marginalized groups. The theory of change which TfaC applies to all projects incorporates three dimensions: individual behaviour change; group based change; and social change. These three aspects correspond to intervention activities and have a cyclical relationship which, together, facilitates empowerment, as visualized in Figure 1.

[1] This report uses the term 'sex work' instead of 'prostitution'. UNAIDS advises against the use of the word 'prostitute' and recommends 'sex worker' as it is deemed non-judgemental (UNAIDS 2011). Additionally, sex workers' rights activists, including Doezema and Kempadoo, note that the employment of "sex work" moves away from a sexual identity towards an income generating activity (Doezema and Kempadoo 1998).

[2] See Annex 1 for a map of the locations of this project.

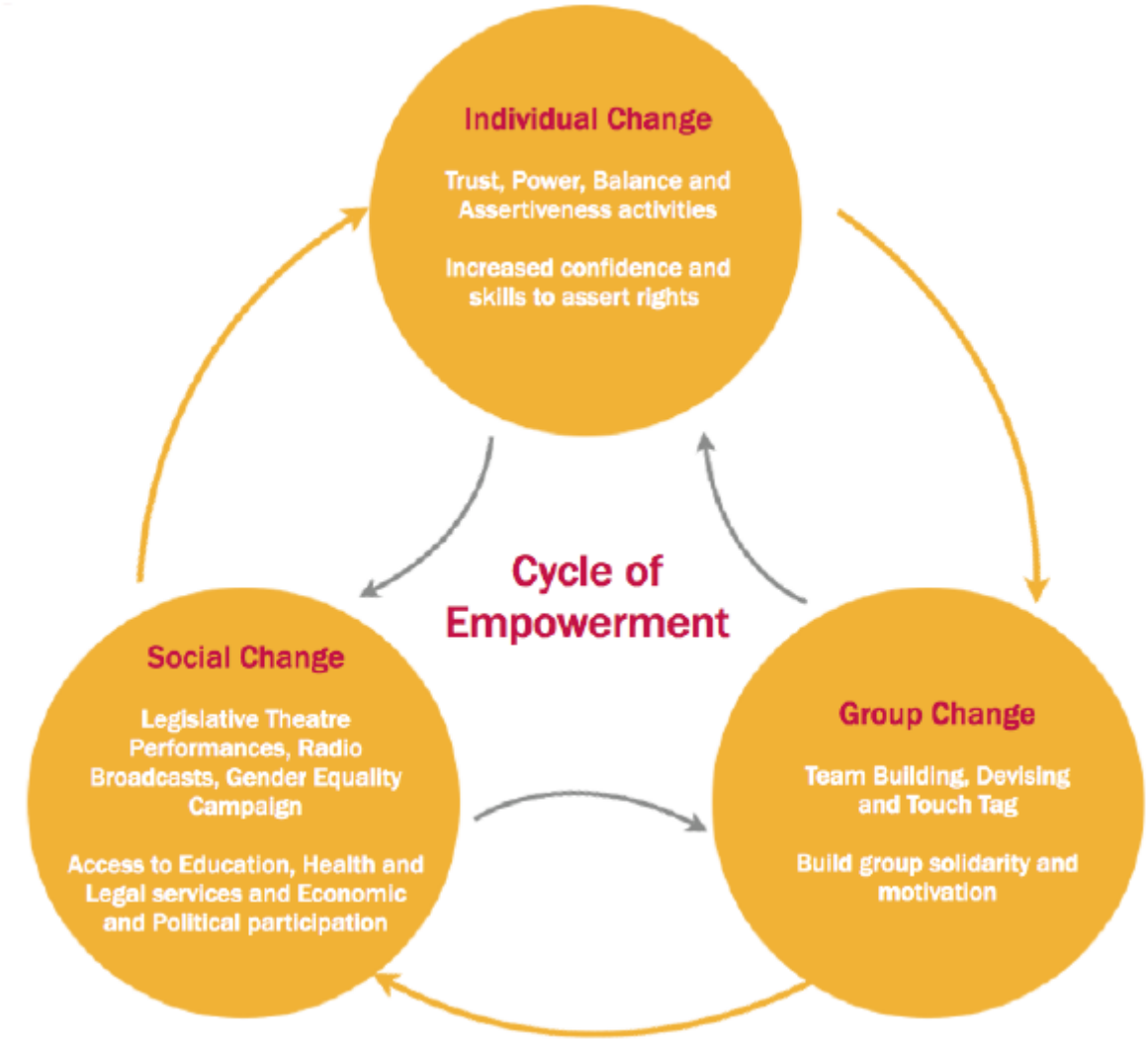

Figure 1 Theatre for a Change: Theory of Change

Target beneficiaries This project directly involved the following groups and individuals in activities:

Community members: FSWs living in Old Fadama and Railways; non-paying partners (NPPs); clients; brothel owners and *magajias* (female managers of FSWs); other community members.

Service providers: Health service personnel; police service personnel; traditional justice providers (Chiefs); vocational skills training providers.

Partner organisations working on the same themes and in the same geographic areas.

Policy makers: The Ministry for Gender, Children and Social Protection.

2 cohorts of core FSW participants were involved in the project. The first cohort involved 10 women regularly between September 2012 and January 2014 (with less regular involvement subsequently); the

second cohort involved 24 women regularly between February 2014 and March 2015. These different groups are referred to throughout this report.

Activities fell under 3 main themes of project implementation: (1) SRHR and general health; (2) gender-based violence; and (3) alternative income generation. Table 1 details all activities that were implemented between September 2012 and March 2015, including which theme the activity corresponded to and the number of people reached.

Project theme	Activity	Frequency	Number of project participants reached	Number of others reached
1, 2	SRHR behaviour change workshops	30	13	-
1, 2	Advocacy training workshops	5	10	
1,2	Advocacy theatre performances	10	12	111 (89 F, 22M)
1,2	Stakeholder meetings	3	10	37 (21 F, 16 M)
1	HTC	2	8	20
1,2	Interactive radio project	1	10	Not captured
3	Income generation skills training	6	9	-
3	Facilitation training	4	5	-
3	Loans programme (1)	-	9	-
3	Loans programme (2)	-	8	-
1	NHIS cards	1	10	-
2	Access to Justice BC workshops	40	24	-
2	Access to Justice performances	3	24	72 (41 M, 32 F)
2	Access to Justice stakeholder meetings, engagement	2	24	36
2	Access to Justice peer education	3 months	20	953 (274 M, 679 F)
1	NHIS cards	1	22	8 children
1	Medical fund	3 months	10 people claimed as of end Feb	-
2	Radio programme, November/December 2014	2	21	25 (touch tag)
1	SRHR workshops	5	21	-
1	HTC	1	20	-
3	Income generation workshops	5	18	-
1	Condom distribution	2 pilots	5	-
	Total		34	1262

Table 1 Activities implemented, Old Fadama Project

Methodology

The data collection methods used for the evaluation were a literature review and qualitative research methods, including participant observation, interactive research exercises, and one-to-one semi-structured interviews. Data collection was carried out in March 2015, when almost all project activities had been completed.[3]

[3] At the time of writing, the Old Fadama Project continues with some activities under the theme 'alternative livelihoods development'- the ongoing loan scheme and the referral of individuals to vocational training programmes.

Both cohorts of core participants were involved in data collection in order to understand impact over the longer term and to explore the effectiveness of a wider range of activities. However, due to their recent involvement in research-intensive project activities, members of the second cohort were not invited to participate in interviews. Due to resourcing limitations, members of the first cohort were only involved in interviews.

Literature Review involved relevant project documentation, a list of which is included as Annex 2. The document review allowed for thorough familiarisation with the project and review of evidenced impact collected throughout the implementation period.

Interactive research workshop 16 women from the second cohort took part in 3 interactive research exercises which explored changes in individuals' lives as a result of their engagement with the project. A past Project Assistant facilitated the workshop with another TfaC staff member, and the exercises were observed by the Project Officer and a non-project staff member.

The workshop was conducted in March 2015 at the James Town Community Theatre Centre, the venue where Old Fadama project activities were frequently conducted. It was chosen as a familiar setting for participants and a safe and relatively quiet environment for conducting activities. Participants received reimbursement for their travel and refreshments, in keeping with the practice of the project.

Table 1 below provides details of the research exercises.

Activity	**Activity detail**	**Activity objective**	**Timing**
Warm-up Activity	Count Up, Count Down: Participants to count sequentially from 1 to 10 and back down to 1. Anybody can say any number but if a number is said by more than one person, participants start from the beginning again.	To encourage participant focus ahead of the workshop.	10 mins
Introduction	Introduction to workshop objectives	To introduce participants to workshop objectives.	5 mins
Body map Activity	Participants to consider how their body represents their participation in the project. *e.g. This is my hand. My hand represents violence. Before the project I used to get into lots of fights. Now I am more able to talk through problems without being aggressive.*	To explore the impact of the project on project participants using embodied method.	10 mins
Timeline Activity	Workshop space to represent timeline of the project, using rope. Facilitator to identify 4 critical points on the timeline: before the participants' involvement in project during the project the current date (i.e. towards the end of participants' involvement in the project) the future Participants to walk timeline, stopping at each critical point. Facilitator to encourage participant reflection and discussion at each critical point on 3 themes: SRHR and general health Violence (from clients, NPPS, community, police etc) Livelihoods	To explore the impact of the project on project participants using recall and reflection.	45 mins

	Prompt questions, if needed: *SRHR and general health* What challenges did you experience in protecting your sexual health before joining the project? How did you deal with health problems before joining the project? How was your sexual and reproductive health when you joined the project? How did you deal with health problems during the project? How is your sexual and reproductive health now? Has anything changed since the beginning of the project? Why? What do you do if you get sick/have SRH problems now? What challenges do you experiences in protecting your sexual health now? What would you like to change in the future to promote your health? *Violence* What did you do [before the project/during the project) when you experienced violence? How you experience violence now? What do you do? What would you like to do in the future if you were to experience violence? *Livelihoods* How/how well did you support yourself before joining the project? Did anything change about how/how well you supported yourself during the project? How do you feel about your ability to support yourself now?Do you make any profit from your work? How do you picture your life in the future?		
Group discussion	Facilitator to lead participant reflection on project activities. *Prompt questions, if needed:* What is the main change you have noticed since you have been involved in the project? What is the main learning that has stayed with you? Which part of the project contributed to this change / learning? Which project activity did you find most useful? Has your involvement in the project affected your relationship with people? Who? How?	To explore the impact of the project on project participants using focus group format.	15 mins

Table 2 Impact Evaluation research workshop plan

One-to-one interviews were conducted with 10 women from the first cohort engaged in the project, some of whom were still currently engaged via the ongoing loan scheme and recent income generation workshops. Interviews were carried out in a space in Old Fadama familiar for interviewees, by a TfaC staff member who had assisted on the Old Fadama Project for 2 months and therefore had developed some degree of trust with participants. Prior to conducting the interviews, the content, organisation and

translation of questions into Twi were discussed to ensure consistency. Responses were recorded in note form and later written up. Interview questions related to matters of general health, SRHR, relationships, and violence, as well as general questions about involvement in the project. Building on previous experience of conducting interviews with this population, structured questions were preferred to ensure comprehensive data collection. See Annex 3 for the complete interview guide.

Justification for methods used The evaluation used a mixed method approach in order to ensure consideration of accumulated evidence and to allow for differences in types and abilities in communication, recollection, reflection and analysis among participants.

Qualitative research methods were used to understand the impact linked to programs aimed at long-term attitudinal and behavioural change on the individual, group and social level. Semi-structured individual interviews and participatory research exercises were the main form of data collection. Quantitative data was collected via review of project documentation.

Previous research with FSWs as part of the Old Fadama programme found traditional data collection tools such as long verbal interviewing and focus group discussions unsuitable for some participants, and utilisation of TfaC's uniquely active and participatory tools[4] effective for research purposes. The use of participatory and embodied methods in research is especially relevant in work with populations living precarious lives, with low education levels, and who are conventionally marginalized by society and disempowered in conventional research processes (c.f. Dewey and Zheng 2013; O'Neill 1996).

Limitations of the evaluation Time and staffing constraints were a significant limitation in carrying out research with participants. Staff involved in data collection activities could have benefited from more preparation, especially because none were specifically trained in research methods. Language was also a constraint, given the multiplicity of languages spoken in Ghana and the employment of non-Twi speaking staff; this necessitated the engagement of staff with limited experience of research or knowledge of the project.

Additionally, participants' recent and past involvement with research activities via this project may have shaped their responses – i.e. familiarization with the project's goal and anticipated outcomes may have influenced their responses to questions and research exercises. The small number of participants made this difficult to avoid, since sampling was not possible. Finally, despite extensive trust-building work

[4] Theatre for a Change uses uniquely active and participatory tools in across its work, both in project activities and in research, monitoring and evaluation, drawing on the work on Augosto Boal and Robert Chambers. Participatory and embodied methods have proven to be particularly effective in education and advocacy work concerning sensitive subjects including sexual and reproductive health knowledge and in working with marginalised, often illiterate, populations.

between TfaC staff and participants since the outset of the project, the sensitivity of the subjects dealt with may have distorted responses from participants.

Findings

This section analyses the appropriateness of the project to addressing identified needs; its effectiveness at achieving specific outcomes; and the potential for the sustainability and replication of the project. Findings of the impact evaluation are organized according to the following themes: Relevance, Impact, and Sustainability and Replicability.

4.1 Relevance

Selection of beneficiaries and site In sub-Saharan Africa, 37% of FSWs are living with HIV– a figure 3 times the global HIV prevalence among FSWs (Baral et al. 2012).The HIV prevalence rate among FSWs in Ghana was 11.1% in 2011 (GAC 2014), much higher than the national HIV prevalence rate of 1.3% in 2013. Greater Accra presents the highest rate of prevalence. Together, FSWs, their clients and NPPs contribute 31.1% to HIV incidence (Amenyah 2012) and are therefore a strategic target for SRHR interventions. FSWs are a main target identified in Ghana's National Strategy for HIV Prevention (GAC 2011), meaning that the Old Fadama Project was well aligned to wider HIV prevention strategy.

Environmental factors in Old Fadama put FSWs living and working in the settlement at particular risk of HIV and gender-based violence. The estimated 80,000 residents of Old Fadama (People's Dialogue 2009: 1) have limited access to essential services and infrastructure such as education, health services, secure housing, road access, sanitation, and law enforcement, all of which increase vulnerability to poor SRH and violence. As areas where migrants and mobile populations live, work and pass through, Old Fadama and Railways, like other informal settlements, can increase vulnerability to high risk sexual behaviours[5]. With just one other organisation working regularly in Old Fadama to support FSWs specifically, this project involved a very much under-serviced and hard to reach population.

Project design built upon TfaC's experience working with vulnerable and marginalized populations, especially women and girls, for over 10 years. Specifically, it was informed by a project aiming to empower FSWs to improve their health and advocate for their rights implemented by TfaC Malawi. Building on this model as well as the TfaC theory of change, the project developed 3 main areas:

SRHR and general health Of the estimated 52,000 sex workers in Ghana, 11.1% were living with HIV in 2011 (GAC 2014). FSWs experience acute vulnerability to sexually transmitted infections due to factors including the stigmatization and criminalization of sex work; violence; and poverty. The population also experiences poor access to healthcare services due to factors including stigmatization and discriminatory treatment among health service personnel and patterns of mobility and migration. (ASWA 2011). This is

[5] The 'spaces of vulnerability' approach is outlined in International Organisation for Migration, 'Emerging Good Practices in Migration and HIV Programming in Southern Africa.' IOM: 2011.

especially so for the residents of informal settlements where healthcare services are limited, access and sanitation are poor.

Situational analysis and baseline research for this project found gaps in and between SRHR knowledge, skills and behaviours among FSWs in the target communities. It also found that the absence of health care facilities in the community exacerbated barriers to FSWs' access to appropriate health care services. These needs were addressed by a range of project activities: behaviour change workshops; advocacy via interactive theatre and radio to health service personnel; and the provision of HTC and STI screening services to participants.

Access to Justice Violence in its multifarious forms exacerbates SRH risks, and the stigma associated with sex work is one of the most significant barriers to effective HIV/AIDS prevention and treatment. For example, threatened or actual violence can force FSWs to engage in unprotected sex, increasing the risk of sexually transmitted infections; rape can cause injury and long term physical and emotional harm; stigmatization of sex work can dissuade FSWs from accessing healthcare services[6].

Research for the Old Fadama Project consistently identified a gap between participants' knowledge of their legal and human rights and their enjoyment of such rights. Specifically, all participants knew that they are entitled to report an act of violence, but many expressed reluctance to do this and recalled unsuccessful past attempts. Baseline research in 2013 recommended that education about relevant legislation and legal mechanisms available to FSWs could help to address this gap (TfaC 2013). With this evidence, the project developed behaviour change activities to educate FSWs about their right to live free from gender-based violence and interactive theatre and radio performances to advocate for the protection of FSWs' rights.

However, it was found that FSWs' enjoyment and protection of their rights was limited by the behaviours and attitudes of justice providers, including the Police Service and Chiefs. Specifically, baseline research by the Human Rights Advocacy Centre and TfaC found that FSWs in Old Fadama experienced extortion, abuse, harassment, arrest without cause, and mishandling of cases at the hands of the police service (HRAC and TfaC 2014), confirming earlier research in 5 regions of Ghana with 150 commercial sex workers (HRAC 2011).The project therefore implemented sensitization workshops with police service personnel and traditional justice providers (chiefs) to educate these stakeholders about FSWs' rights and best practice in working with FSWs in the justice system.

Alternative income generation Financial constraints are a main driving factor for women to enter sex work (Euser 2012). A 5 year study evaluating an empowerment programme with FSWs in Bangalore, India, found that financial insecurity increases vulnerability of FSWs, in terms of their health, safety and economic situation, as women can be pressured into high interest loans from money lenders, and take additional risks to earn money such as sex without a condom (*Ibid*.). Findings of a situational analysis for the Old Fadama Project coincided with this research, as all FSWs interviewed cited money as the main reason for entering into sex work and reported that as sex workers they faced further financial constraints, including the need to earn a decent income, keep their money safe and access mainstream financial

[6] C.f. International HIV/AIDS Alliance (2008) for an overview of the intersections of HIV transmission and violence.

services (Lorraway 2012). Participants also expressed constant stress due to the need to earn money to survive and provide for their children, resulting in anxiety, depression and insecurity (*Ibid.*).

Greater income security and viable alternative sources of income were found to be necessary in order for core participants to fully realise behaviour change in the area of SRHR and general health as well as accessing services, towards the goal of improving security and wellbeing. For example, some participants reported that they could not afford to visit a clinic or hospital, compromising their wish to seek appropriate healthcare; some reported that they were reliant upon NPPs for income, limiting their negotiation power and ability to leave abusive relationships; some reported that their ability to change their behaviours was limited by their living conditions in Old Fadama, but that they could not afford to live elsewhere. It was for these reasons that alternative income generation activities were designed: loans scheme; income generation workshops and (forthcoming) referrals to vocational training.

Evidence base Several pieces of research were carried out into the needs of participants as well as the impact of the project (see Annex 2), providing solid evidence which was used to inform programme design including themes and targets. Baseline and endline research provided information for the design and evaluation of specific activities. However, little research was conducted with FSWs who were not involved in the project which would have provided more comprehensive baseline data and contextual information. Some project activities such as the income generation workshops and loan scheme in 2013-2014 lacked a strong evidence basis beyond information collected informally through interaction with participants. Additionally, some programming did not engage consistently or deeply with research and guidance about best practice available within the development sector, due in part to lack of resourcing for research and development activities.

Methods The project used a variety of methods to bring about change on the individual, group and societal levels, in the framework of the TfaC Theory of Change (see Figure 1, p. 4).

Behaviour Change workshops used a variety of participatory methodologies, including Interactive Theatre, enabling participants to enact and embody ideas and concepts, rather than absorb them by traditional, instructive means. Participants were encouraged to share real life experiences and explore how voice, body and space are used in relationships. By understanding the patterns of behaviour that put them at risk, participants are equipped to make changes to develop safer and healthier relationships (including with clients, partners, family and community members). The first cohort of FSWs participated in behaviour change workshops focused on SRHR whilst the second cohort were primarily focused on GBV and access to justice, followed by a shorter series of workshops on SRHR.

Interactive theatre was used to take stories of FSWs to community members and service providers to advocate for sex workers' rights. The TfaC 'touch-tag' methodology involved audience members in direct dialogue with FSWs to think about possible changes in their own actions and behaviours. Interactive theatre is a popular method for education in public health interventions, championed by researchers and practitioners for its ability to communicate across linguistic, cultural and educational boundaries and facilitate greater participation, especially on sensitive or 'taboo' themes (c.f. Chambers 1997).

Radio advocacy was used to take the stories of FSWs to their peers and the general public, to raise awareness and reduce stigma about sex work. As with interactive theatre, the method involved listeners in direct dialogue with FSWs to understand the realities of FSWs' lives and the impact of their own actions and behaviours. Resource persons also provided information and guidance related to the themes of the stories.

Peer education served to multiply the reach of the Old Fadama project beyond the core participants. Peer education is globally popular as a key method for public health interventions, especially with populations who are hard to access, and especially across Africa (Kelly et al. 2006). Peer educators are believed to have better access to the target population and the method is itself held to be empowering, as individuals take the tool of education into their own hands and work with their peers (Mason-Jones et al. 2010).

Service provision and support for access to services supported SRHR and general health behaviour change. TfaC engaged a professional nurse to offer HTC to FSWs as part of behaviour change workshops, since there is limited access to the service within the Old Fadama and Railways communities. National Health Insurance Scheme (NHIS) cards were also obtained on behalf of 32 core participants. These cards entitle the holder to access some health services for free or at a reduced cost at participating clinics or hospitals. Since costs are still incurred by the holders of NHIS cards for consultations and medication, a medical fund was established to reimburse participants, thus reducing the barriers for participating FSWs to access appropriate healthcare.

Targets The Old Fadama Project evolved through learning from participants, gathering evidence, and forging partnerships with service providers and donors. The identification of individuals and groups to target with project activities was therefore an ongoing process involving TfaC, participating FSWs, partner organisations and donors.

The target population of this project was FSWs dwelling in the Old Fadama and Railways communities. Selection of participants used a peer referral method, whereby FSWs from the project identified other potential participants; project staff also conducted outreach in the community in order to build a trusting relationship with the target group. Whilst this supported the project's principle of being participant-led and facilitated important trust-building, it meant that there was limited initial profiling of new participants to assess individual needs and capacities.

Evidence shows that FSWs' vulnerability to poor health and lack of rights protection are inextricably linked to actors in their communities (UNAIDS 2014). Therefore, NPPs, *magajias*, brothel owners and community members were included in stakeholders meetings and interactive theatre performances; they became familiar with project staff through ongoing visits to the communities and some involvement in data collection for research. Repeated recommendations in research pieces to involve NPPs were not responded to in programme design beyond inviting NPPs to community performances and interacting with them during community outreach visits. This was due to the limitations of deliverable activities agreed with funders, whose preference is to reach identified Most at Risk Populations directly (therefore excluding NPPs from direct or deep participation in interventions).

4.3 Impact

The main purpose of this evaluation is to understand the impact the Old Fadama Project has had on the lives of the target groups. In order to effectively understand the impact of this project, the evaluation relates to the project goal of 'facilitating participants to empower themselves to protect their health by accessing appropriate health services and to advocate for their rights to live without gender based violence.' In order to evaluate the impact of the Old Fadama Project, this report considers the achievement of intended outputs and results, in relation to the indicators presented in the logical frameworks developed for the project.

Due to the evolving character of the Old Fadama Project, outcomes and outputs were updated through the course of the project. A project-wide logical framework was developed in 2014 to incorporate activities funded by different donors and focused on different areas of intervention. The outcome indicators in this project-wide were as follows:

SRHR and general health

1. *% of FSWs reporting consistent condom use with both clients and non-paying partners*
2. *% of FSWs who demonstrate correct condom use in a workshop setting*
3. *% of FSWs who have tested for HIV in the past 6 months*
4. *% of FSWs who have tested for STIs (other than HIV) in the past 6 months*
5. *% of FSWs who disagree with the statement 'using contraception will stop you getting pregnant in the future'*
6. *% of FSWs using long term family planning methods*
7. *% of FSWs agreeing with the statement 'women have the right to say no to unwanted sex'*
8. *% of FSWs who disagree with the statement 'STIs/AIDS are caused by witchcraft'*
9. *% of FSWs agreeing with the statement 'HIV can be transmitted by unprotected vaginal sex'*

Gender-based violence

10. *% of FSWs who report feeling able to go to the police in a case of abuse*
11. *MoU signed with the police*
12. *Number of police stations with FSW-friendly IEC materials on display*

Alternative income generation

13. *Number of businesses currently running*
14. *% of women who have taken loans reporting currently running a business*
15. *% of women who have taken loans reporting making a profit*

Overall impact Since September 2012, at least 1,262 people have been reached by the project[7]. 609 FSWs were reached by project activities, including 34 core participants and facilitators. 4 brothel owners and 64

[7] This number is likely to be an under-representation. As indicated in Table 1, the number of people reached by one interactive radio was not captured; for both radio broadcasts the number of listeners was not captured. Data for the number of audience members was also missing for some interactive theatre performances.

magajias were reached in the Old Fadama and Railways communities. Additionally, health service personnel from one facility, 20 police service personnel, and 12 chiefs were reached by advocacy activities. For the breakdown of numbers of people reached by all project activities, see Table 1 (p.5).

Attrition from the project numbered 3 FSWs in 2013, who withdrew at different times from behaviour change and advocacy activities. One FSW from the first cohort who undertook training as a facilitator did not continue in this capacity in 2014, but remained involved in the loans scheme. Another participant who trained as a facilitator withdrew from this role and other activities in the last quarter of 2014.

SRHR and general health Asked what positive changes have occurred as a result of engagement with the project during one-to-one interviews, 3 out of 10 participants mentioned changes in their health, demonstrating impact achieved and recognised in this area. This section details findings regarding impact against specific SRHR outcomes.

1. *% of FSWs reporting consistent condom use with both clients and non-paying partners.*

Consistent condom use with both clients and NPPs was identified as a key strategy for preventing transmission of HIV and STIs. Whilst there is evidence of a high rate of condom use by FSWs with clients (Adu-Oppong 2007), research suggests that low use between FSWs and NPPs is common (Cote 2014; Walden 1999), a factor which can increase vulnerability to HIV and STI transmission if NPPs have multiple partners. Old Fadama Project baseline research found that 86 per cent of respondents had never used condoms with NPPs (TfaC 2013).

During one-to-one interviews for this impact evaluation, participants were asked what, if anything, they did to protect their sexual health. In response 90% of women identified condom use, with 3 women citing improved knowledge about how to use a condom for better protection. Responses to the question of what, if anything, they did to protect their sexual health, and whether this had change during the course of their engagement with the project, included the following:

'Condom use to protect myself from sicknesses and pregnancy. Yes through the workshop, it prompted me to intensify the measures of protection because I got to know the STIs which scared me most.'

'Condom use because of diseases. [I] did not know the proper way to wear the condom to avoid bursting.'

'Condom use because of sickness […] I didn't know how to wear it and also got to know about STIs.'

'I use condom because I don't want to be infected. Yes, I learnt a lot of things.'

Despite this positive change, negotiating condom use with NPPs was found to be an ongoing challenge by research conducted in September 2014, wherein factors including a partner's use of alcohol and drugs, as well as threatened and actual violence were evidenced as limiting participants' abilities to ensure the use of male condoms. This is in addition to discussion with participants about the distinction between NPPs and clients which is sometimes made by non-use of condoms with the former. Whilst participants' use of condoms with clients increased via behaviour change activities, their use with NPPs was still a challenge. A similar result was found by a state-wide survey in Karnataka, India, among a sample of 1,512 FSWs who are part of a sex worker collective: those who were part of the collective were more likely to report

condom use with clients but were no more likely to use condoms with NPPs as compared to those who were not a part of a collective (Halli et al. 2006). Therefore, programming has had some positive impact upon FSWs' use of condoms, but there remain barriers to consistent use with all sexual partners which require further exploration in the context of discussion about relationships as well as health risks.

2. *% of FSWs who demonstrate correct condom use in a workshop setting*

Correct condom use was developed as a key outcome of SRHR activities under this project as it is central to ensuring that consistent use of condoms is effective protection against HIV, STIs and unwanted pregnancy.

Asked during interviews what positive changes had occurred as a result of involvement in the project, 2 participants said that the project helped them to 'protect' themselves during sex, with reference to specifics of condom use such as opening a condom on the zig-zag edge and washing one's hands before opening.

100 per cent of FSWs from the 2 cohorts were assessed as having improved their knowledge of correct condom use. 1 woman borrowed a model penis to demonstrate correct condom use to others in her community; 2 had participated in pilot schemes to distribute condoms in their communities; and others contributed additional guidance to facilitators about correct condom use. As the testimonies above illustrate, participants identified their own learning in this area and felt more confident about their use of condoms, indicating effectiveness in achieving this outcome.

3. *% of FSWs who have tested for HIV in the past 6 months*

Regular testing for HIV is crucial to preventing transmission and to accessing treatment where necessary. It is especially crucial for individuals with multiple partners and undertaking risky sex, such as sex workers.

During one-to-one interviews 8 out of 10 participants from the first cohort reported that they had tested for HIV in the past 6 months. All 20 of the second cohort had tested during the same period, at a project workshop. This contrasts with 29 per cent of the first cohort reporting having tested in the past 6 months at the baseline in 2013 and 30 per cent of the second cohort reporting the same in baseline research in September 2014.

That 80 per cent of participants who had not been directly involved in SRHR activities with the project for over a year reported having been for HTC in the past 6 months suggests that their behaviour in this regards has seen long term positive change. However, whilst offering HTC at project workshops is an effective way of facilitating participants in behaviour change workshops to translate their learning into action, it risks being unsustainable. This is because such a strategy relies upon the continuation of other activities and, more importantly, does not provide a regular or permanent service (nor a permanent location) for women to seek follow-up advice, repeat testing, or refer others to. Incorporating HTC into other project activities also risks compromising the principle of voluntary HTC, because project participants may believe that they will not be able to enjoy the benefits of other aspects of programming unless they undertake HTC.

4. *% of FSWs who have tested for STIs (other than HIV) in the past 6 months*

Regular STI screening helps to reduce the risk of complications that can be caused by STIs, such as impact on fertility and increased vulnerability to HIV.

The situational analysis for this project found that 57 per cent of participating FSWs had never been screened for STIs (Lorraway 2012). In the current research, 1 of 10 participants from the first cohort had been screened for other STIs in the past 6 months, at a project workshop. All 20 of the second cohort had received screening during the same period, at a project workshop. This reflects the lesser availability of STI screening services as compared to HIV testing. The one drop-in centre for FSWs in the Old Fadama community does not routinely offer STI screenings, and outreach workers from the centre only offer HTC. Thus, although increased awareness of STIs was evidenced by research for this report, and was often a factor in participants' use of condoms, limited access to screening facilities meant that education alone was insufficient to fully achieve this outcome. Direct service provision, or advocacy for the provision of such services is required to fulfil this outcome in the long term.

5. *% of FSWs who disagree with the statement 'using contraception will stop you getting pregnant in the future'*

36 per cent of participants from the second cohort disagreed with the statement' using contraception will stop you getting pregnant in the future' at endline research conducted in January 2015. This was a 25 percentage point positive increase, despite the actual number of participants indicating disagreement with this popular misconception remaining low. Reasons for this include misunderstanding of the statement as well as persistence of belief in the misconception. For example, one woman narrated the story of a friend who had used a 5-year contraceptive implant but did not remove until 10 years, at which point it could not be found and it thus continues to prevent her becoming pregnant.

These results are consistent with research into the low and declining uptake of contraceptive use over time in Ghana. Research published in 2014 with 91 women in Ghana confirmed the findings of the national Demographic and Health Survey, that fear of side effects, especially those perceived to impair fertility, are the leading cause of non-use of modern contraception in Ghana (Hindin et al. 2014). More extensive education to challenge myths and misconceptions about long-term family planning methods is clearly necessary in order to achieve impact.

6. *% of FSWs using long term family planning methods*

3 of 10 participants from the second cohort reported that they were using a long term family planning method when asked if they do anything to prevent unwanted pregnancy in one-to-one interviews. Of those who were not using such a method, 4 mentioned their use of short term family planning methods (male and female condoms and the calendar rhythm method); one participant reported that since involvement with the project, she had started to use emergency contraceptives. Of the 8 who had NPPs, 7 had discussed family planning with their partner. 4 reported that their NPP was unsupportive about them using family planning methods; 3 reported positive or neutral responses from their NPP.

During one-to-one interviews for baseline research in September 2014, some women reported negative attitudes towards and fear about long-term family methods. It was found that barrier contraception

methods were overwhelmingly preferred. Time restrictions in programming meant that education about family planning methods was not extensive or in-depth. This, in combination with the fact that such methods are more difficult to access than male condoms (and female, to a lesser extent) meant that programming had a limited impact on the uptake of long-term family planning methods.

One notable success story regarding this outcome was one participant who reported that she had ceased doing unsafe abortion as a result of knowledge gained from the project. She was pregnant at the time and planned to seek family planning services after giving birth. Unsafe abortion was found to be widespread among FSWs by the situational analysis for this project (Lorraway 2012), and so more extensive education about this theme could be beneficial.

7. *% of FSWs agreeing with the statement 'women have the right to say no to unwanted sex'*

The first sexual encounter of 2 in 10 women in Ghana is forced (Gender Studies and Human Rights Documentation Centre 2015). Sex workers are acutely vulnerable to forced sex, both from clients and NPPs, due to intersecting factors including the stigma associated with their work and the conditions of work. This outcome indicator therefore aimed to capture change in FSWs' knowledge of their legal and human rights.

An interim assessment of the project in July 2013 found that agreement with the statement, 'women have the right to say no to unwanted sex' had declined since baseline research at the start of the project. It was not clear, however, whether this decline was owing to a change in opinion/knowledge or due to a lack of clarity about the statement offered. The statement was not offered to participants in data collection for this report because its phrasing was not considered an effective way of capturing knowledge and attitudes regarding consent; rather, observation and open questions were used to explore this indicator.

Improvements in confidence and abilities to communicate generally serve to enable FSWs to assert their rights. Positive changes in confidence were noted during participant observation, and were also identified by participants from both cohorts during research exercises and interviews. Asked in a group discussion to identify some of the main changes that they have seen in themselves, 2 women spoke about now being assertive, as a consequence of their learning from the project. Other spoke about knowing their rights and having greater confidence.

During research exercise 2, one participant talked of learning 'how to behave when your husband rapes you' during the project. Although this does not evidence an improved ability to refuse unwanted sex, this statement demonstrates that the individual feels better equipped to deal with unwanted sexual encounters.

8. *% of FSWs who disagree with the statement 'STIs/AIDS are caused by witchcraft'*

The correlation between belief in popular myths about HIV/AIDS and stigma and discrimination of HIV positive persons had been well evidenced (for example, Letamo 2003), including specifically myths around witchcraft spreading the virus (Adjei and Darteh 2013), as has the link between stigma and discrimination and the limited use of HIV services (Muyinda et al. 1997). As well as the relationship to stigma, belief that

HIV/AIDS can be caused by witchcraft can also impact upon individuals' sexual behaviours. Analysis of the Ghana 2008 Demographic Health Survey found that men and women who believed that witchcraft and other supernatural means can cause AIDS were less likely to have used condoms at last sexual intercourse, controlling for other socioeconomic and cultural variables (Tenkorang et al. 2011).

During research in July 2013 all participants in the first cohort disagreed with this statement (a 40 percentage point positive difference from baseline research in September 2012), as did all from the second cohort at endline research in January 2015 (an 82 percentage point positive difference). Education about myths and misconceptions about the transmission of HIV were therefore shown to be effective at achieving this outcome.

9. *% of FSWs agreeing with the statement 'HIV can be transmitted by unprotected vaginal sex'*

Education about HIV/AIDS was central to SRHR the curricula of behaviour change workshops, as accurate knowledge is considered a prerequisite to positively transforming behaviors around safer sex.

All participants from the second cohort agreed with the above statement at both baseline and endline research in September 2014 and January 2015, demonstrating existing basic knowledge about the relationship between risky sexual behaviours and HIV transmission. Baseline research with the first cohort of core participants showed that 70 percent were aware of the relationship between unprotected sex and the risk of HIV transmission. This knowledge research, however, was found to coexist with inaccuracies, knowledge gaps, and belief in myths and misconceptions, as detailed above. Research for this report found accurate basic knowledge of modes of HIV transmission among FSWs, as well as understanding of the relationship between HIV and AIDS.

Improved access to healthcare

No outcome indicator was developed to describe the change that the project hoped to bring about in FSWs' confidence to access and actual access to appropriate health services. However, several activities contributed to change in this area: the provision of NHIS cards to 32 FSWs and 8 of their children; the establishment of a medical fund used by 10 FSWs at the time of writing; behaviour change workshops focused on improving confidence in accessing services at clinics and hospitals; and advocacy targeting health service providers.

Asked during interviews what they did the last time they were sick, 7 out of 10 members of the first cohort said that they went to hospital. 5 of these women said that this was different from their behaviour prior to engagement with the project, citing the NHIS cards and learning from the project as reasons for the change. 3 out of 10 women said that they bought drugs from a pharmacy, 2 of them explaining that this was because their NHIS cards had expired. Thus, the sourcing of NHIS cards which entitle the holder to free and reduced services at some clinics and hospitals, were a significant factor in improving to FSWs' access appropriate healthcare.

An unexpected outcome of the project has been an improvement in maternal health among FSWs. 4 core project participants gave birth during the project's implementation period; all of them sought maternal

health services as a result of the knowledge and support of the project. However, some of these individuals could not recall how many times they had attended antenatal services, and some said that they had ceased to attend prior to giving birth. Incorporation of this theme into the curriculum of behavior change workshops, as well as work with antenatal service providers could help to improve maternal health among this population.

Whilst the provision of NHIS cards and a medical fund has had demonstrated positive impact in the short term, the initiative has not been sustainable, as the project has been unable to replace expired cards and participants have not done so themselves. Additionally, during the implementation period, the only clinic in Old Fadama was closed, meaning that community members must travel outside to access healthcare services. Integrated service provision (HTC, STI screening, GBV services at the same site) has been recommended as an effective strategy for improving FSWs' health (Dhana 2014). Facilitating access to affordable healthcare in the long term, as well as a focus on spending on health are suggested for the project to strengthen sustainability in this area.

Gender based violence Project activities aimed at improving FSWs' knowledge of their legal and human rights; specifically, they focused on FSWs' rights to live without violence and to achieve redress for abuse. This was the theme of activities in 2014 especially, which involved the second cohort of FSWs as well as other stakeholders including the police and chiefs in the community. Impact against outcomes under this theme is explored in this section.

10. % of FSWs who report feeling able to go to the police in a case of abuse

Interview respondents were asked, 'How comfortable do you feel going to the police?' and 'Do you trust that the police will listen to you and help you to secure justice/safety?' Responses varied greatly, from feelings of mistrust and fear of police, to the expression of trust and comfort reporting to the police. The 8 respondents who were largely comfortable going to the police said that they felt confident that their cases would be dealt with satisfactorily; 2 of these said that satisfactory treatment was conditional on paying the police a bribe. Half of respondents mentioned the police as an available option if they experienced physical violence during open inquiry. This contrasts with the overwhelming confidence to report cases to the police expressed by cohort 2 participants in research exercises.

In open questions about their main learning from the project during a group discussion, participants from cohort 2 offered the following comments relating to reporting abuse to the police:

'I know how to report when not treated well.'

'I now don't pay money to the police when you need their help.'

'I have been very confident in accessing justice both in the chief and police.'

'I have been able to report abuse to the police'

'I have learnt that if I can't write a statement and its being taken by the police, the police have to read it to me for her me know what he has written.'

Endline research for project activities related to improving access to justice for FSWs by the Human Rights Advocacy Centre in November 2014 found that participants had gained knowledge about their right to report violence against them, and had specific knowledge about procedures and actors involved in the process of reporting. For example, respondents knew about their right to review their statement as recorded by the police and knew to refer to the Police Professional Standards Bureau if they did not receive satisfactory treatment from police personnel. This research also confirmed findings of the impact evaluation, that participants' relationship with, and trust in, the police had improved. The greater focus on improving FSWs' access to justice in 2014 activities has contributed to achieving this outcome, including for FSWs reached by peer education about their legal rights.

11. *Memorandum of Understanding (MoU) signed with the police*

The TfaC Theory of Change holds that empowerment requires change on the levels of the individual, group and society. The Old Fadama Project targeted the police with advocacy for the full protection of FSWs' rights at the social (institutional) level, including their right to report abuse and receive fair and equal treatment in the justice system. An MoU was not achieved between TfaC and the police due to the short time period which the organization had to build a relationship and the lack of expertise about advocacy around institutional change. However, significant progress was made towards this outcome. Outputs contributing towards this outcome include the involvement of 20 police service personnel in sensitization workshops and ongoing communication between police service personnel and TfaC.

The project reached police personnel from across Greater Accra, but it proved challenging to engage personnel from the Old Fadama police station. Considering the challenges TfaC encountered of working on the institutional level with the police, targeting advocacy activities and relationship building at a specific station may enable the project to better achieve the goal of empowering FSWs in select communities to live without gender based violence.

12. *Number of police stations with FSW-friendly Information, Education and Communication (IEC) materials on display*

IEC materials aimed at raising FSWs' awareness of their rights to non-discriminatory treatment by community members and police service personnel were developed by a project participant and partner organisation. These were disseminated to FSWs via peer education, and to police personnel for display in stations. In addition, information about legal aid services were developed and distributed for display in police stations. Due to logistical challenges, it was not possible to verify whether these materials had been or still were on display in stations.

13. *Improved self-confidence and safety*

No indicator was developed specifically around the improvement of self-confidence, self-advocacy or experiences of safety/unsafety. However, data was collected relating to this outcome in order to more fully understand the effectiveness of the project in achieving its aim to improve the safety and wellbeing of FSWs.

Self-confidence and self-advocacy were indirect results of advocacy activities as well as the use of the Interactive Theatre methodology which provided participants with opportunities to perform on stage and engage directly with people whom they have identified as having influence on their lives. Positive changes in interpersonal relationships were noted by several participants from the first and second cohorts, including 'quarrelling' less with partners and friends; being able to apologize or forgive; having better relationships with family members; greater confidence in communicating with clients. Additionally, core participants occasionally meet in the community and exchange practical support such as food or planning for their businesses.

Several core participants from both cohorts stated that they felt like role models in their communities as a result of engagement with the project. This is a significant change from their experiences of stigmatisation and feelings of being silenced in their communities, as expressed during baseline research and the early stages of the project. One participant noted as a main outcome of her engagement with the Old Fadama Project that her relationship with her community has improved thanks to peer education activities.

Despite positive changes in FSWs' self -confidence and advocacy skills, asked how safe she feels in her community, one participant said, 'Not very safe because Old Fadama is a very violent place.' This response confirms observations as well as findings from research in June 2014 that the Old Fadama community is generally experienced as a hostile and unsafe place for FSWs where theft and physical violence are frequent (HRAC and TfaC 2014).The specific environmental factors which produce and sustain violence require further research and attention; assisting FSWs to move away from environments that endanger them may require consideration in future programming in order to improve FSWs' abilities to protect their rights and live without gender-based violence.

Alternative income generation activities were developed in response to needs expressed by project participants. 2 loans schemes; income generation training workshops; and planned referrals to vocational skills training contributed to outcomes under this theme. Impact against outcomes relating to alternative income generation are detailed in this section.

14. Number of businesses currently running

6 women from the first and second cohorts reported that they were currently running a business (meaning that 6 business were currently running). Examples of businesses they were involved in included the sale of second-hand clothing; sale of perishable goods; and a manicure shop. It must be remembered that the consistency of business operation is flexible due to market fluctuation, the availability of goods, the amount of capital accessible to individuals, as well as environmental factors.

All women interviewed said that their main source of income had changed during the project implementation period; 7 of 10 attributed this change to involvement in the project (the education they had received and/or the loan scheme). Of those not currently involved in a business, one woman said that she currently relies upon her boyfriend for income, a situation which presents potential risks.

Research concerning women's work in the informal sector in Ghana suggests that alternative income generation within this sector presents vulnerabilities of its own. Gendered segregation and women's lower income within the sector (c.f. Chen 2010); poor working conditions; the risk of theft or confiscation of property, especially in the illegal settlement of Old Fadama (c.f. Apprey 2011); limited access to social security and pensions; and health risks are some factors contributing to women's vulnerability within the informal sector. Considering these factors, any intervention to facilitate FSWs' development of capital and skills to enter the informal sector must be carefully researched and planned to mitigate vulnerability.

15. % of women who have taken loans reporting currently running a business

Of the 8 women who received a loan almost 1 year ago in April 2014, 4 reported that they were trading; these reports were verified by the Project Officer. Most of these women had changed their business since first receiving a loan, evidencing both the flexibility of the informal sector and a lack of thorough research into the market. Participants discussed the impact of the loan scheme upon their lives with positivity during the evaluation research workshop and interviews.

The 8 women who received a loan in April 2014 had each repaid between 4 and 17 percent of the total borrowed, with the mode at 8 per cent (4 women). No loan repayments were made in the 5 months since October 2014. Research into the loans scheme conducted in 2014 highlighted the potential risks to participants because they were not able to repay the loans from businesses (TfaC 2014a). These risks – that participants might re-enter sex work, engage in risky behaviours or borrow from other sources - had not been addressed at the time of writing.

This slow rate of repayment is consistent with research concerning microfinance projects with poor women in general, and income generation interventions with female sex workers in particular. A study of 4 such interventions across Africa by the Global Network for Sex Work Projects found that none had been successful because '[they did] not have built-in strategies that support the sustainment of the alternative income-generating activities that the programmes encourage[d] sex workers to undertake' (NSWP 2014: 16).

16. % of women who have taken loans reporting making a profit

Asked if they are able to meet their everyday needs, 4 women interviewed responded positively. The reasons cited for why others were unable to always meet their everyday needs were payment of school fees, child care, and being short on money due to selling on credit. Almost all women said that they were able to save some money, but this was not consistent over time. Some women mentioned saving money that they receive as an allowance for attending project activities, indicating that the project has had a direct, but unsustainable, contribution towards improving participants' abilities to save.

4.4 Sustainability and Replicability

Opportunities The Old Fadama Project has included a variety of targets, activities and methods which have been tested over 2 and a half years, providing scope for replication of some aspects, allowing for a variety of internal organizational and external environmental and individual factors.

The development of a trusting relationship between TfaC and a core group of FSWs has potential to sustain and expand the project. The training of 5 FSWs as facilitators and of one participant as a Project Assistant in particular provides scope for some activities to be led by community members, with further training. Such a direction is supported by evidence from other FSW-led initiatives, that SRHR outcomes and sustainability are maximized when sex workers are involved in 'the design and implementation of policies and programmes for which they are the intended beneficiaries' (UN 2015: 66). However, the mobility of FSWs generally and of people dwelling in informal settlements in particular, is a possible threat to FSW-led activities, and would need to be considered in developing such activities.

The development of relationships between TfaC and community members, including brothel owners and *magajias* also promises to improve scope for sustainability and replication as the important task of community entry and trust building has been successfully achieved, and contacts for outreach to FSWs have been established.

The collection of data over 2 and a half years and analysis of this provides a body of evidence to inform future programming with FSWs, whether in Old Fadama and Railways, or elsewhere. Knowledge and skills accumulated by TfaC staff will be easily transferred to replicate projects or project strands.

Limitations Sustainability of impact in the area of SRHR and general health is in part dependent upon service providers. This research found that FSWs accessed HIV testing and STI screening primarily via the Old Fadama Project and secondarily via outreach programmes in the community run by other organisations. If such services cease it is likely that FSWs' frequency of accessing such services will decline. As has been noted above, the provision of a medical fund and NHIS cards has been effective, but its sustainability and reach is limited; indeed, 2 women reported during data collection that they were unable to visit a clinic or hospital the last time they were ill due to the expiration of their NHIS cards.

Translation of the project to other geographic areas is one possible route for replication of the project. The sex work industry in Greater Accra, as for Ghana as a whole, is characterized by mobility and flexibility, meaning that different geographic areas become 'hot spots' for sex work at different times. Replication of some of activities in such areas would facilitate greater effectiveness towards achieving the project goal.

Replicability of the project risks limitation due to the limited documentation of some activities and processes, as found by the literature review process of this evaluation. Recording the content of behaviour change workshops and interactive theatre performances, for example, requires systematization in order to assist future implementation and the development of tools.

Conclusion and Recommendations

The Old Fadama Project has achieved positive impact as a whole, contributing towards the goal of facilitating female sex workers to empower themselves with the knowledge and skills to protect their health by accessing appropriate health services and to advocate for their rights to live without gender based violence. Evaluation of the achievement of specific outcomes shows mixed levels of effectiveness, however. Below are highlighted some of the main challenges to effective achievement of outcomes and

suggested recommendations for how these may be addressed, as well as general recommendations for the future of programme management.

Achievement of impact in the area of SRHR and general health was considerable, in terms of improved knowledge and behaviours around accessing appropriate health services. However, the unsustainability of activities that have achieved service access outcomes highlight the need for more long-term solutions. Integrated service provision including STI screening and treatment, HIV testing and counseling, access to antiretroviral drugs, access to long term family planning, GBV services and general health care are necessary to ensure sustainable impact in the area of FSWs' health and wellbeing. Either direct provision of such services or advocacy targeting Ghana Health Service and/or private providers are possible options for future programming.

Achievement of outcomes under the theme of gender-based violence were limited by institutional factors within the police service as well as organizational capacity in the area of advocacy. Although impact has been made in FSWs' knowledge of their rights and confidence to report abuse, institutional change is needed at the level of the police in order to ensure that FSWs receive appropriate treatment when reporting and enjoy the full legal protection for their rights. More targeted advocacy may assist TfaC in achieving outcomes in this area – for example, working with selected police stations or providing or training legal advisors in the community.

FSWs' experiences of violence were found to be in some ways linked to the environment of Old Fadama and Railways - insecure housing, common theft, limited support networks, among other factors. Housing insecurity in particular is a significant barrier to achieving the safety and wellbeing of FSWs in these communities. It was noted in project reporting at the start of 2014 that FSWs wishing to flee abusive partners might be prevented from doing so due to lack of funds. This was the reason for the development of the loans scheme; however, the limited success of this initiative suggests that an alternative approach to improving housing security might be beneficial – for example, partnering with a women's shelter or identifying affordable accommodation.

Achievement of outcomes under the theme of alternative income generation were limited by poor research and planning. Although participants reported that involvement in the loans scheme had produced significant change, the scheme is unsustainable in its current state. Urgent planning about the future of loan repayment is necessary. Additionally, more thorough research and capacity assessment is required for any future interventions in this area in order to mitigate the vulnerability that women are exposed to within the informal sector.

On the level of programme management, this impact evaluation identified some areas for strengthening. In general, greater resourcing for research and development would ensure that project strategy is based in evidence and programme design is informed by best practice in the field. Specific areas for further research have been highlighted above, but include research about the wider context of gender relations and SRHR in the selected communities and about the informal economy and market in the selected communities. In order to strengthen ongoing evaluation and learning, improved documentation of content of behaviour change workshops and advocacy theatre would be beneficial. This research, for

example, found limited documentation about the content of such activities and relied upon observation and narrative from project staff. Additionally, profiling of participants and agreed process for recruitment of participants are recommended to ensure the relevance of the project as well as to assist individual change to be better tracked.

Finally, it is recommended that TfaC Ghana define its advocacy aims with regard to improving the safety and wellbeing of sex workers. This may include consideration of a stance regarding the legal status of sex work. TfaC Ghana is advised to review recommendations provided by the global report for the International Conference on Population and Development Beyond 2014, which calls on States to 'decriminalize adult, voluntary sex work to recognize the right of sex workers to work without coercion, violence or risk of arrest.'(United Nations 2014: 66).

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Annex 1: Map of project site

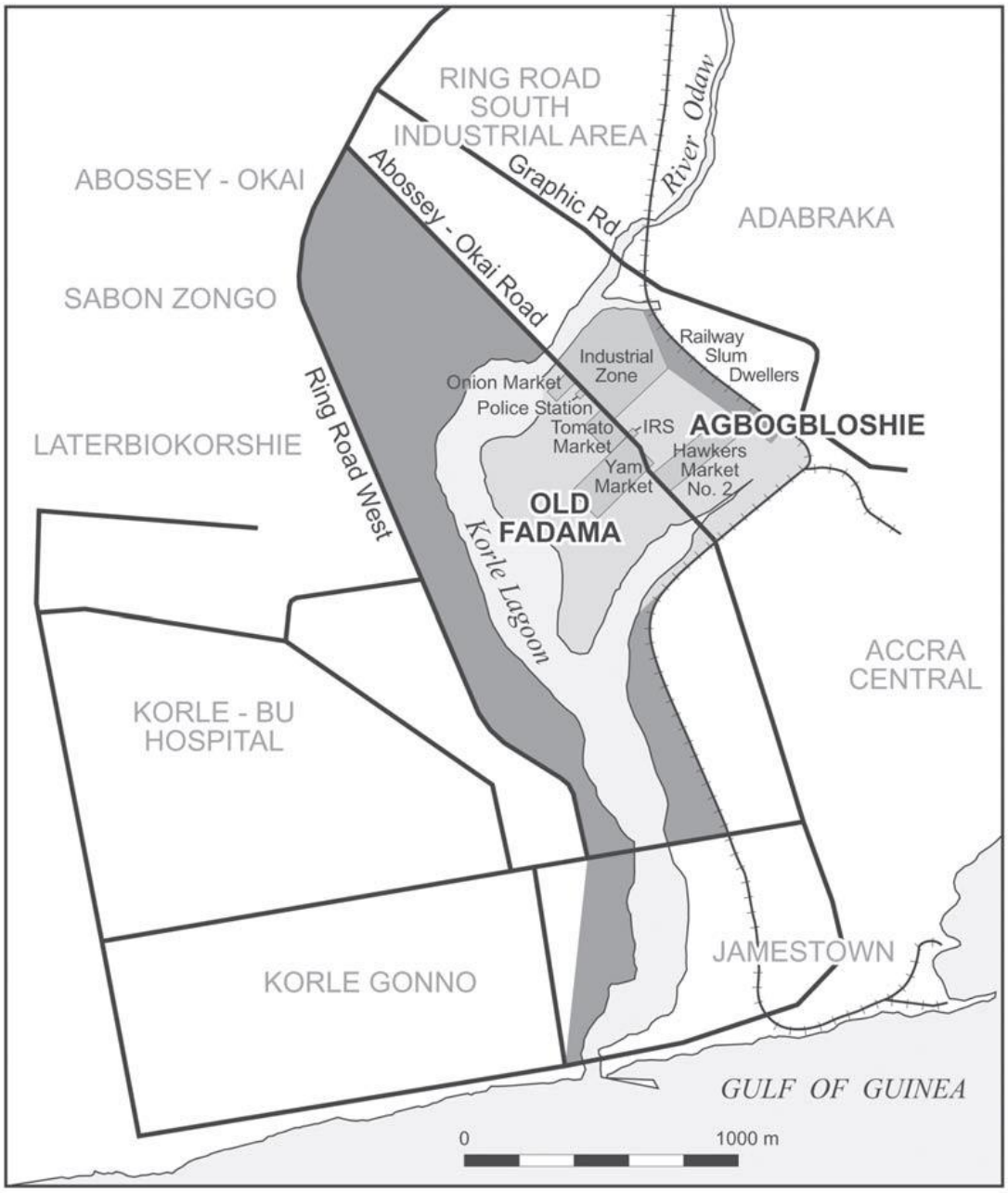

Figure 2 Map of Old Fadama and Railways communities in context. Source: Grant (2006)

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Annex 3: Old Fadama Impact Evaluation Interview Guide for interviewers

Purpose

- To understand what changes have occurred in participants' lives since the beginning of their involvement with the TfaC Old Fadama Project.
- To understand what changes can be attributed to participation in the Old Fadama Project.

Please explain the purpose of the interview to the interviewee, informing them that responses will be confidential. Please inform the interviewees that they are free to refuse to answer any question. Request consent to proceed.

Questions are arranged according to 7 themes:

Profile

1.1 Name

1.2 Age

1.3 Number of biological children

1.4 Number of dependents

1.5 Marital status

1.6 Where do you live now? Where else have you lived since you became involved in the project? If you lived outside Old Fadama, why did you move back?

General

2.1 What activities of the Peace and Love Club have you participated in? *Note how easily interviewees were able to recall their participation.*

2.2 What positive changes have occurred for you as a result of engagement with the project?

2.3 Have there been any negative consequences / changes as a result of involvement with the Peace and Love Club?

Livelihoods

3.1 Are you able to meet your everyday needs? If not, what are the main challenges?

3.2 What is your main source of income? Has this changed since when you first engaged with the Peace and Love Club? What contributed to this change?

3.3 To what extent are you able to save money? Has this changed since when you first engaged with the Peace and Love Club? What impacts your ability to save/not save?

Health

4.1 What did you do the last time that you got sick? Is this any different from what you did when you first engaged with the project? What has contributed to this change?

4.2 How comfortable do you feel going to the clinic or hospital?

4.3 The last time you visited the clinic or hospital, how satisfied were you with the service? Why?

4.4 If you drink and/or smoke, how, if at all, does it affect your life? Is this any different from what you did when you first engaged with the project? What has contributed to this change?

SRHR

5.1 What, if anything, do you do to protect your sexual health? Why? Is this any different from what you did when you first engaged with the project?

5.2 (Please do not tell me the result) Have you tested for HIV in the last 6 months? Where?

5.3 (Please do not tell me the result) Have you been screened for STIs in the last 6 months? Where?

5.4 What, if anything, do you do to prevent unwanted pregnancy? Why? Has this changed since you first engaged with the project?

(Only if the respondent is in a relationship)

5.7 Do you discuss your sexual health and family planning with your partner? What is his reaction? Is this any different from when you first engaged with the project?

(Only if the respondent has given birth since first engagement with the project)

5.8 What did you do to look after yourself and your baby during your pregnancy? (If you went for ante natal services? How many times?) What factors contributed to those choices?

Relationships

6.1 Have you discussed anything about the project with your partner (current or past)? What was his reaction? Has he been supportive of your involvement in the project?

6.2 How do you see yourself in the community? What, if any, changes have occurred in the way that you interact with people there? Are people aware of your involvement in the project? If so, how does that make you feel?

6.3 How safe do you feel in the community? What makes you feel safe/unsafe?

6.4 Do you meet with other participants/members of the Peace and Love Club outside project activities? What kinds of support do you give/receive?

Violence

7.1 Have there been any changes in your experience of violence since you first engaged with the Peace and Love Club? If yes, what changes (e.g type, frequency)? What brought about the changes?

7.2 What do you normally do if you experience physical abuse? How confident are you in your ability to respond in the way you choose?

7.3 What do you normally do if you experience verbal abuse? How confident are you in your ability to respond in the way you choose?

7.4 How comfortable do you feel going to the police? Do you trust that the police will listen to you and help you to secure justice/safety?

7.5 Have you reported any case to the police since you first engaged with the project? (Yes) Did you receive satisfactory treatment? (No) Why?