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IMPACT OF COVID-19 ON ECONOMIC SOCIAL AND CULTURAL RIGHT IN GHANA - DEC. 2020

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ABBREVIATION/ACRONYMS

ACRONYMS	MEANING
CAMFED	Campaign for Female Education
CEDAW	Committee on the Elimination of Discrimination Against Women.
CESCR	Committee on Economic, Social and Cultural Rights.
CRPD	Convention on the Rights of Persons with Disabilities
CRC	Cyclic Redundancy Check
DOVVSU	Domestic Violence and Victims Support Unit
GES	Ghana Education Service
GHA	Ghana Hotels Association
GHS	Ghana Health Service
GPRTU	Ghana Private Road Transport Union
GRTCC	Ghana Road Transport Coordinating Council
GTA	Ghana Tourism Authority
ICCPR	International Covenant on Civil and Political Rights
ICERD	The International Convention on the Elimination of Racial Discrimination.
ICESCR	The International Covenant on Economic, Social and Cultural Rights

ICU	Intensive Care Unit
MMDAs	Metropolitan, Municipal and District Assemblies.
MCEs	Municipal Chief Executives
MoH	Ministry of Health
NADMO	The National Disaster Management Organization
NBSSI[1]	National Board for Small Scale Industries
NCCE	National Commission for Colleges of Education.
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PWDs	Persons With Disability
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UDHR	Universal Declaration of Human Rights
UNESCO	The United Nations Educational, Scientific and Cultural Organization

[1] National Board for Small Scale Industries (NBSSI) now known as the Ghana Enterprise Agency

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1.0 Introduction[1]

In keeping with the Commission's mandate to assess the general observance of human rights, the Commission examined the general impact of the COVID-19 pandemic on the Economic, Social and Cultural rights of the citizenry, particularly those in vulnerable situations.

Economic, Social, and Cultural Rights (ESCRs) are a type of human rights that guarantees the conditions needed to live a life of dignity, where everyone can achieve wellbeing, realize their potential, and have the opportunity to find happiness and fulfilment.[2] ESCRs include the rights to adequate food, adequate housing, education, health, social security, water and sanitation, work and to take part in cultural life, States have a duty to respect, protect and fulfil economic, social and cultural rights[3].

These rights provide a range of protections and entitlements, such as:

- The right to health, which includes guarantees such as access to healthcare, healthy environmental conditions, and protection against epidemic diseases.
- The right to education, which includes the obligation to provide free and compulsory primary education, and accessible secondary and higher education, among other aspects.
- The right to an adequate standard of living, which (among others) includes aspects such as food security, adequate housing, and access to clean water and dignified sanitation.
- Cultural rights, which includes the right to participate in cultural life and to share in and benefit from scientific advancement.
- The right to a healthy environment.
- The right to social security, which includes adequate protection in the event of unemployment, sickness, maternity, disability and old age or other limits on livelihood in circumstances beyond one's control.

[1] This section draws on highlights of the findings of this research presented by CHRAJ on Human Rights Day, 10th December, 2021. See the Appendix for the full statement.
[2] https://www.cesr.org/what-are-economic-social-and-cultural-rights
[3] https://www.ohchr.org/en/human-rights/economic-social-cultural-rights

The research was conducted on the basis that Ghana as a State party to the Convention on the Economic, Social and Cultural Rights, was required to take a range of concrete and targeted measures to respond to the COVID-19 pandemic to mitigate the impact of the pandemic on those who were likely to be most affected[i]. The enforcement of Restrictions Act, 2020 (Act 1012) and the imposition of Restrictions Instrument, 2020 (E.I 64) provided for the imposition of restrictions in the event of the imminence of an emergency, disaster or similar circumstances to ensure public safety, public health and protection[ii].

The research therefore assessed the impact of the COVID-19 pandemic on ESCRs and how the enforcement of these restrictions affected the various respondent groups.

1.1 Background

The first case of COVID-19 on the continent of Africa since the virus was confirmed in Asia in late December 2019 was reported on February 14, 2020. By May 13, cases had been reported in all 54 countries.[4] At the end of April 2020, the number of COVID-19 infections had exceeded 2.8 million cases worldwide, with the death toll nearing 195,000 and 210 countries and territories affected.[5] As a result, a growing number of nationwide or local initiatives were employed to prevent the spread of the deadly virus; full or partial lockdown measures were implemented all around the world, affecting more than 5 billion people.[6]

The impact of the COVID-19 pandemic on African economies and livelihoods was heavy on informal workers, health[7] and education[8] and other sectors. The impact was felt well before it reached the shores of the continent. There was a falling demand for Africa's commodities; capital flight from Africa, a virtual collapse of tourism and air transport associated with lockdowns and border closures.

COVID-19 imposed a further burden on an already weakened health infrastructure, coupled with lack of physicians and inadequate number of hospital beds. Limited access to COVID -19-related supplies and equipment, such as test kits, PPE, ventilators and pharmaceuticals, overwhelmed health systems.

[4] United Nations (May 2020). Policy Brief: Impact of COVID-19 in Africa, page 7
[5] Johns Hopkins University Center for Systems Science Engineering, https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e
[6] ILO Monitor: COVID-19 and the world of work (third edition).
[7] United Nations (May 2020). Policy Brief: Impact of COVID-19 in Africa, page 2
[8] The Commonwealth (2011). The Impact of COVID-19 on Education Systems in the Commonwealth, page xxvi

COVID-19 brought about a sudden unexpected disruption in education worldwide. Within weeks of the outbreak, millions of children, young adults and mature learners were out of school and university. In sub-Saharan Africa, close to 90 percent of students do not have access to household computers, and school closures have left over 330 million learners of all levels and over 8.5 million teachers, unable to learn or teach from home. To cope with this unforeseen and unusual situation, educational institutions resorted to 'emergency remote teaching' to ensure continuity in the teaching and learning process. While mobile phones could support young learners, around 56 million lived in areas that were not served by mobile networks, and access numbers were consistently worse for girls and women. Even where computers were provided, power supply was unreliable[9].

The imposition of full or partial restrictions on movement as well as emergency measures also led to the abuse of some citizens. [10] The emergency measures adopted by different African countries to combat the pandemic presented an opportunity for violations of human rights. The imposition of full or partial restrictions on movement and public gatherings impacted the freedom of movement and association. Countries such as Malawi, Kenya, Nigeria, Zimbabwe and Rwanda had militarized the enforcement of limitations on public gatherings, resulting in killings, brutality and abuse of citizens.[11]

1.2 Objectives

The research aims to provide an account of the human rights situation of the persons in Ghana, particularly those in vulnerable situations, during the COVID-19 pandemic.
Specifically, the research sought to assess:

- The impact of the COVID-19 pandemic on the rights to health; education; water and sanitation; decent work and adequate standard of living; as well as cultural rights. The rights to health, water and sanitation etc., of prisoners and detainees in formal and informal detention facilities whose freedom of movement was legally or culturally restricted were also of interest. This was on account of the rate at which infectious diseases could spread in closed and restricted settings and yet the difficulty of accessing such institutions.

- Human rights violations arising from the enforcement of Act 1012 and the Executive Instruments (E.I 64) on COVID-19 Safety Protocols.

[9] United Nations (May 2020). Policy Brief: Impact of COVID-19 in Africa, page 19
[10] African Declaration on Internet Rights and Freedoms. (November, 2020) The impact of COVID-19 on digital rights in Africa, page 19
[11] African Declaration on Internet Rights and Freedoms. (November, 2020) The impact of COVID-19 on digital rights in Africa, page 19

1.3 Scope and methods

The study considered respondents from groups of individuals and institutions across the 16 regions of Ghana as the study sought to ascertain the impact of the COVID-19 pandemic on the Economic, Social and Cultural rights in Ghana (particularly, persons in vulnerable situations).

Field officers comprised a senior officer each from the 16 regional, two (2) sub-regional, and 173 district offices of the CHRAJ. Field officers[12] were required to visit selected institutions in both the formal and informal sectors of the country. Within the formal sector, health institutions, educational institutions, MMDAs, and formal detention facilities were targeted. Concerning the informal sector, the research targeted informal detention facilities, deprived communities, public transport stations, informal settlements, markets, hotels (or guest houses), salons and barbering shops.

Respondents comprised administrators and health workers of hospitals, patients, head teachers, teachers, students, administrators of hotels/guest houses, hoteliers, operators or owners of hair salons and barbering shops, employees of salon and barbering shops, chairmen or station masters and drivers of public transport stations, Officer In Charge and inmates of prisons, market leaders and traders of markets, co-ordinating directors of MMDAs, regional and district commanders of the Ghana Police Service, members of deprived communities (slums), informal settlers, caretakers and dwellers of camps for persons accused of witchcraft as well as oversight priests and dwellers of trokosi shrines (*See Appendix D: Tables 4 – 6*).

Additionally, the officers of the research department of the Commission (Head Office) visited key oversight institutions for interviews. Prior notice was sent to institutions across the country to inform them about the research activity either directly or through their heads as well as regional and district directors of CHRAJ. The field officers also obtained the consent of hospital administrators as well as head teachers before interviewing patients and students respectively.

The field officers sought the consent of interviewees where it was necessary to record or take pictures. Field officers were however advised not to target faces but scenes that will strongly complement their responses.

[12] Prior to the exercise, field officers participated in a virtual training on research tools, data collection and data input utilising google forms. Criteria for selecting respondents and their respective institutions were discussed at the training session.

Data collection which spanned the period from October to November 2021, employed questionnaires, Key Informant Interviews (KII), and one-on-one interviews. A total of 4,098 respondents were interacted with from 165 districts across the 16 regions of Ghana. The completed questionnaires and interviews across the country were submitted through a web application software (*google form*) for analysis.

Descriptive statistics and charts were employed in the analysis and representation of the quantitative data. The analysis of the qualitative data involved a thematic approach. This analytic approach was based on open coding, which involved the process of breaking the data down into themes for the purpose of comparison and categorisation.

2.0 Summary of findings

This section presents a summary of findings of the study in line with the impact of COVID-19 on ESCRs; the rights to health, education, decent work and adequate standard of living, water and sanitation as well as cultural rights. The impact of COVID-19 on ESCRs on formal and informal detention facilities in Ghana was also assessed. Finally, findings on the enforcement of imposition of restrictions Act, 2020 (Act 1012) and E.I 64 are also represented

The Right to health

The ICESCR requires State parties to the Convention, to take steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases". From March to December 2020, apart from hospitals and centres designated for the treatment of COVID-19, intake of patients reduced in 96.5% of health institutions. However, intake started improving in 2021.

Right to Education[13]

The Right to Education includes the availability and accessibility of functioning educational institutions and programmes in sufficient quantity. The pandemic had a severe impact on the right to education. As a result, by late March, almost all educational facilities in Ghana had been closed. Subsequently, a significant number of schools shifted to distance or online learning, or radio and television learning, to ensure continuity of education.

[13] Article 13 of the Covenant

However, a great number of schools, especially those in deprived communities, lacked the necessary infrastructure for distance or online learning and many low-income homes could not afford the cost associated with the online learning.

Right to adequate standard of living

The research assessed the effect of the pandemic on persons and groups in vulnerable situations such as the self-employed and workers in non-traditional and the informal economy[14]. These include open market traders, barbers and hairdressers, street vendors or hawkers, drivers and station masters in the private road sector, and basic conditions of livelihood of those living in deprived communities and informal settlements[15].

Interactions with workers in the informal sector and non-traditional businesses revealed that, there was a substantial reduction or loss business revenue. The ban on social gatherings impacted them more disproportionately than others. Many workers in the informal sectors were laid off whilst others had their earnings reduced substantially.

According to the Ghana Hotels Association (GHA), some hotels, particularly in Accra and Kumasi, closed down temporarily during the peak of the COVID-19 pandemic. Also, about 92% of hotels experienced booking cancellations and a marked drop in the number of customers. Seventy-one hotels and five guest houses collapsed because of the pandemic.

The pandemic also extended the existing inequalities, and disproportionately affected women and persons in low-income jobs. For example, more women than men who work(ed) in service occupations including domestic work, restaurant services, open market, and hospitality industries that required face to face interaction were hard hit by the layoffs.

Places of Formal Detention (Prisons and Police cells)

Prisoners and detainees were of particular interest, given the rate at which infectious diseases could spread in such closed settings. In the wake of the pandemic, and in accordance with Article 72(1) of the 1992 Constitution, the President granted amnesty

[14] See Committee on Economic, Social and Cultural Rights, General Comment No. 18 (2006) on the right to work, E/C.12/GC/18, paras. 6, 7, 11, 12, 19 and 31.
[15] UNSDG (2020) COVID-19 and Human Rights. We are all in it together. UN Sustainable Development Group (UNSDG)

to 794 prisoners[16] resulting in a reduction of the prison population. Court attendance as well as visits were suspended. Recreational, educational activities, and vocational workshops were curtailed, and some facilities resorted to in-door games only. Some inmates were granted bail, while some were transferred to other facilities to ease congestion. Also, the Ghana Police Service and the Ghana Health Service worked together to ensure that detained persons were tested before they were admitted to a prison facility.

Stigma and Discrimination

For fear of stigmatisation, approximately half of the respondents said they would not want members of the community to know about their COVID-19 status.

Enforcement of Act 1012 and E.I 64 on COVID-19 Safety Protocols

Pursuant to Act 1012 and E.I 64, measures were taken to contain the spread of COVID-19, including the lockdown in March 2020. The measures introduced were considered timely given the public health risk that the pandemic poses. However, the implementation of the law saw some excesses on the part of the security personnel. A total of 1,604 individuals were arrested for not adhering to the COVID-19 safety protocols.

Some of the respondents claimed they were victims of human right violations, while others claimed they witnessed violations such as flogging, beating and insults by security personnel who sought to enforce the COVID-19 safety protocols.

Mitigating Measures by the State

The interventions employed by the Government, which included provision of PPEs, free water and power, hot meals, food items, stimulus package, among others helped various respondent groups to recover from the negative impact of the pandemic to some extent.

3.0 Main Findings

This section presents detailed findings of the study in line with the impact of COVID-19 on ESCRs; the rights to health, education, decent work and adequate standard of living, water and sanitation as well as cultural rights. The impact of COVID-19 on ESCRs of formal and informal detention facilities in Ghana was also assessed.

[16] President grants Amnesty to 794 prisoners – Business Ghana

Finally, findings on the enforcement of imposition of restrictions Act, 2020 (Act 1012) and E.I 64 are also represented.

3.1 The Right to Health

Article 12(1) of the ICESCR requires State parties to the Convention to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12(2)(c) of same obliges State parties to take steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases". These include equal and timely access to basic preventive and curative goods and services, such as screening, diagnostic tests, personal protective equipment, ventilators, oxygen related drugs and treatments as well as an adequate system of urgent medical care.

In this regard, the right to health of the citizenry was assessed in this research. Hospital administrators, health workers, patients, as well as identified groups were interacted with. The identified groups included, schools, people living in deprived communities (slums), and informal settlers[17].

Two thousand, four hundred and seventeen persons (2,417), comprising hospital administrators (152), health workers (383), patients (251), head teachers (335), teachers (574), students (579), informal settlers (50) and deprived community members (93) were selected nationwide for interactions.

3.1.1 Accessibility

Accessibility has four overlapping dimensions: Non-discrimination, Physical accessibility, Economic accessibility (affordability), and Information accessibility[18]. The research focused mainly on physical and economic accessibility.

All administrators of the health institutions visited indicated there were appropriate facilities put in place to make their facility accessible to and available for use by a person with disability (PWD). Majority of the patients 242 (97.6%) affirmed that, the health facility was accessible to PWDs.

In terms of proximity, majority of the participants from the identified study groups (patients - 52.6%, informal settlers – 74.0%, deprived community (slums) – 57%),

[17] The research categorized Prisons and Police Cells as formal detention facilities whereas trokosis and camps for person accused of witchcraft were categorized as informal detention facilities.
[18] General Comment N0. 14(12)(b) (2000) of CESCR

indicated that they had access to a health care facility (hospital/clinic/CHPs) close to where they reside.

To ascertain the level of closeness to health facilities, the research further explored how long it took to access a health care need from the nearest health institution. The study revealed that, the majority of 130 (51.8%) of the patients visited the hospital facility via automobile. Also, a majority of 131 (52.2%) patients often spent less than 20 minutes before reaching the health facility. Similarly, a majority of informal settlers[19] 29 (58.0%) and those living in deprived communities[20] 57(62.6%) often spent less than 30 minutes to access a health facility (*See Figure 1*).

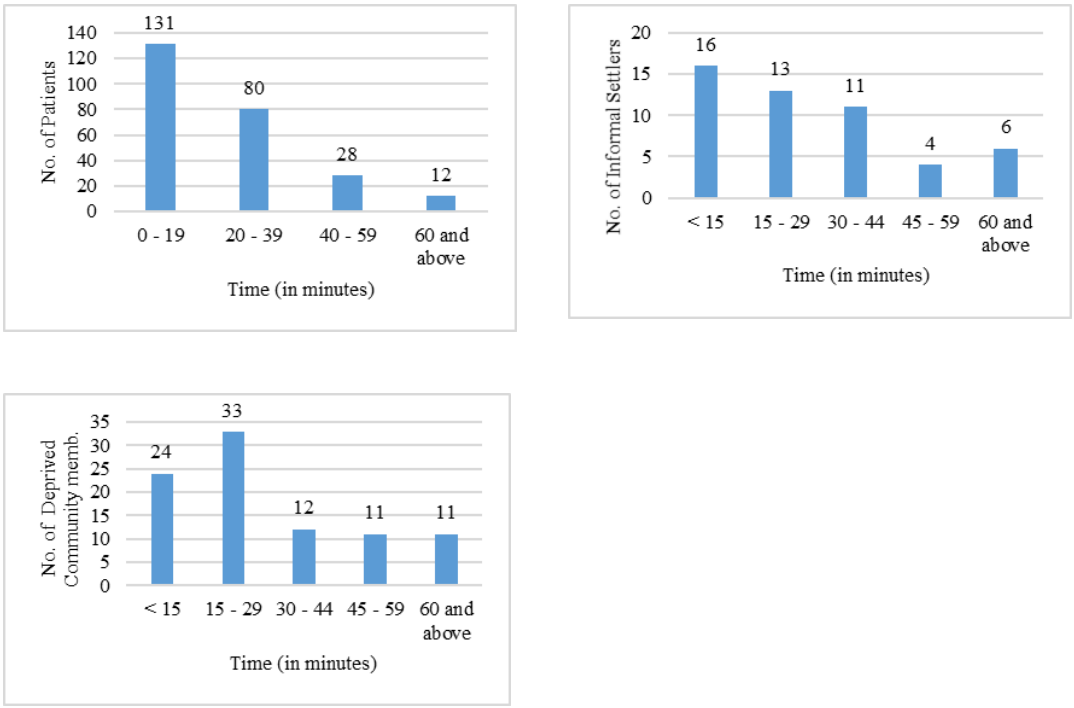

Figure 1: Time taken to access health facility

The accessed health facility was the closest health care provider for most 132 (52.6 %) of the patients. The remaining patients who accessed the facility despite it not being the closest gave the following reasons:

[19] Informal settlers are inhabitants who often have no security of tenure of land or dwelling and for that matter they squat or rent informally. These inhabitants usually lack the basic services and infrastructure. Their housing may not comply with planning and building regulations and is often situated in geographically and environmentally sensitive areas

[20] a contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services.

- It provided better services;
- It was the only government and preferred hospital available;
- Had preference for private hospital over the government hospital;
- It provided special services for pregnant women;
- They were referred from other hospitals;
- It had been a family hospital;
- Their health conditions were first treated or managed there;
- The only clinic in their community did not have adequate resources and equipment for antenatal care;
- It was a bigger health care facility;
- It was recommended to them by someone;
- They provided service on time.

Furthermore, the amount of time spent at the hospital before being attended to was taken into account. Though the time spent varied, majority 181 (72.1%) of the patients spent less than an hour before being attended to. Of these, majority 114 (63.0%) were attended to within 30 minutes. However, 7 (2.8%) spent more than 4 hours at the facility before receiving treatment (*see Figure 2*).

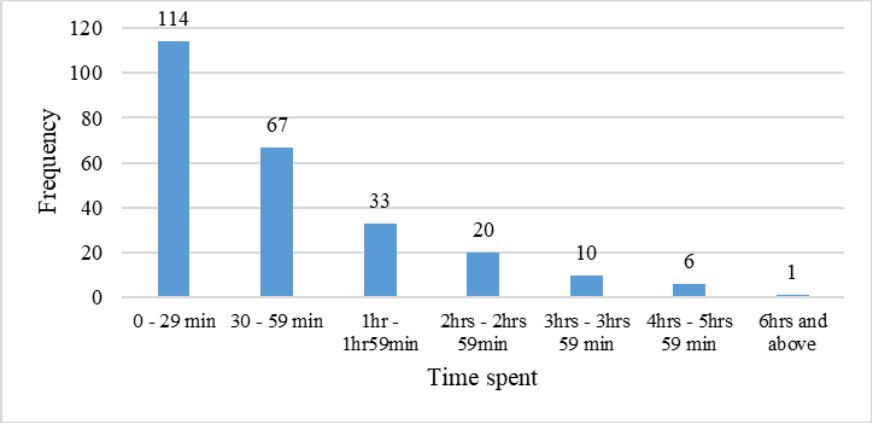

Figure 2: Time spent at the hospital before Receiving Treatment

When asked whether they received the treatment they sought for, a large majority of 238 (96.4%) patients answered in the affirmative. Most of the patients (87.1%) further affirmed that the health care provider disclosed the full details of their health condition to them. In terms of patient's satisfaction on services provided, a majority of 237 (95.2%) expressed satisfaction.

In terms of economic accessibility, the majority of 27 (54.0%) informal settlers said treatment was not within their financial means. Unemployment or low daily wage,

high cost of drugs/medication, distance to health facility, cost of transportation to the facility, and inactive NHIS card were the identified challenges.

Majority 56 (61.5%) of the respondents from the Deprived communities (slums) also indicated that seeking professional medical care and treatment was not within their financial means. However, 35 (38.5%) could afford a professional medical care and treatment.

Twenty-nine (31.9%) of those who indicated they could not afford to seek professional health care attributed their challenges to unstable job and low income/financial constraints. Other respondents 16 (17.6%) raised concerns that seeking professional health care was very expensive.

> *Sometimes, I find it difficult to foot my medical bills at the hospital, particularly when I visit the facility in Duori Community for medical attention.*
> [**Duori Kpaanguon – Upper West region**]

> *The drugs and laboratory services are very expensive even with health insurance.*
> [**Lakeside – Oti region**]

Nine of the respondents raised concerns that the NHIS did not cover all drugs and this was a major constraint.

> *By my age, I am enjoying some exemption at the healthcare facilities, however, there were many instances I had to struggle for money to foot medical bills, since some drugs are not available in the facility (health care) as well as not covered under the NHIS.* [**Duori Kpaanguon – Upper West region**]

Twenty percent of informal settlers for fear of contracting COVID-19 preferred not to access healthcare, unless in critical conditions, while 6.0% resorted to herbal treatments.

> *I suddenly developed fear of seeking medical attention at the hospital. This was the period we heard rumors about some front liners at the hospitals were being infected with the pandemic, how much more an ordinary person like me. As a result, I had to adopt other unapproved methods of treating my ailments during the period, which could be very dangerous.*
> [**Anlo Comm. Settlement, Jirapa, Upper West region**]

About a quarter of respondents (23.0%) from the deprived communities in fear of contracting COVID-19 could not access health care from the health facilities.

Some were advised to stay home unless their condition was critical. Other challenges included delays at the facility, discrimination (every patient was suspected by the health workers of carrying the COVID-19 virus) and inability to meet all the requirement of COVID-19 preventive measures.

> *We had difficulty in accessing health care. Everybody was suspected at the health center by health workers. I suffered skin disease during the COVID-19 and when I got to the hospital the officials were afraid to get close to me, so they used a dry stick to touch my body and prescribed medication without taking my vitals.* **[Nalerigu – North East region]**

3.1.2 Availability

Availability gives consideration to underlying determinants of health such as safe and potable drinking water and adequate sanitation facilities[21], hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs[22]. This report assessed the doctor- patient ratios and the adequacy of ambulance services, health facilities as well as essential drugs.

Daily, an average of 68,674 out-patients and 16, 485 in-patients were recorded as against 27,208 health workers across the 152 health facilities interacted with.

Official information from the Ministry of Health indicates that the doctor to population ratio was 1:6,355 as per the last assessment done in 2020 by the Ministry as against the international standard of 1:1,000.

A little above half (56.4%) of the hospitals surveyed offered ambulance services. However, 68.4% of these hospitals did not have functional ambulances as at the time of visit.

Hospitals without functional ambulances conveyed patients to referral hospitals either via government ambulance service, private ambulance service or through commercial public transportation. In some cases, relatives transferred their patients via their own private vehicles. Also, hospitals that had functional ambulances depended on ambulances services from other private hospitals when the number of referrals were many.

[21] Safe and potable drinking water and adequate sanitation facilities are discussed in subsequent sections.
[22] General Comment N0. 14(12)(a) (2000) of CESCR.

A vast majority; 91.3%, 90.0%, and 91.4% of hospitals had adequate facilities for consultation, examination and treatment respectively. However, few hospitals were reported not to have enough facilities for consulting. For instance, the Kumasi South Hospital in the Kumasi Metro of the Ashanti region did not allow for any privacy when examinations were conducted because there were two doctors in each consulting room. Also, Bechem Government Hospital in the Tano South Municipal of the Ahafo region has only two consulting rooms for four Physician Assistants. At the time of visit, there were no doctors or physician assistants available for consultation at Essiama Health Center, in the Ellembele District of the Western region.

3.1.2.1 Essential Drugs in Healthcare Institutions

Essential medicines are those that satisfy the priority health care needs of a population. They are selected with due regard to disease prevalence and public health relevance, evidence of efficacy and safety and comparative cost-effectiveness. They are intended to be available in functioning health systems at all times, in appropriate dosage forms, of assured quality and at prices individuals and health systems can afford.

The majority of hospitals (91.8%) had all essential drugs on hand at the time of the visit; however, 11 health institutions lacked essential drugs such as malaria drugs, paracetamol, multivitamin tablets, septrin syrup, ferrous sulphate, amoxic lav, Azithromycin, Vitamin C, Amlodipin 5/10mg, Nifedipine 20mg, Ibrufen 200/400mg, Lisinopril 10/20mg, and metronidazo 200/400mg.

Impact of the pandemic on supply of essential drugs to health care institutions

Close to half (49%) of the health facilities visited indicated that COVID-19 affected the availability of essential drugs. Reasons provided were as follows:

- The closure of the national borders, airports and seaports restricted the import of essential drugs that led to the shortage of supplies from manufacturers to these health facilities;
- There was shortage of drugs such as vitamin C due to the increase in demand;
- The purchasing power of some health facilities reduced because of the reduction of revenue as a result of the drastic reduction in the number of patients visiting the hospitals. Hospitals such as the Narh Bita Hospital in the Tema Metropolis of the Greater Accra region and the Ami Memorial Hospital in the Tarkwa Nsuaem district of the Western region had a reduction in

revenue and its corresponding reduction in purchasing power during the period.

Hospitals that were negatively impacted in terms of the availability of essential drugs had to rely on other health facilities that had stored enough drugs before the COVID – 19 pandemic struck. Others such as the Nkwanta South Municipal Hospital in the Nkwanta South district of the Oti region had to go to the open market when their regional medical stores were unable to supply.

3.1.2.2 Availability of Health facility/first aid box in Schools

Schools

The proportion of SHS 108 (75.0%) with an infirmary was relatively higher than that of JHS 26(13.6%). However, the majority of both JHS 167 (87.4%) and SHS 120 (83.3%) schools had access to first aid box, though some schools [33 (17.3%) JHS and 10 (6.9%) SHS] had their first aid boxes poorly stocked (*see Figure 3*).

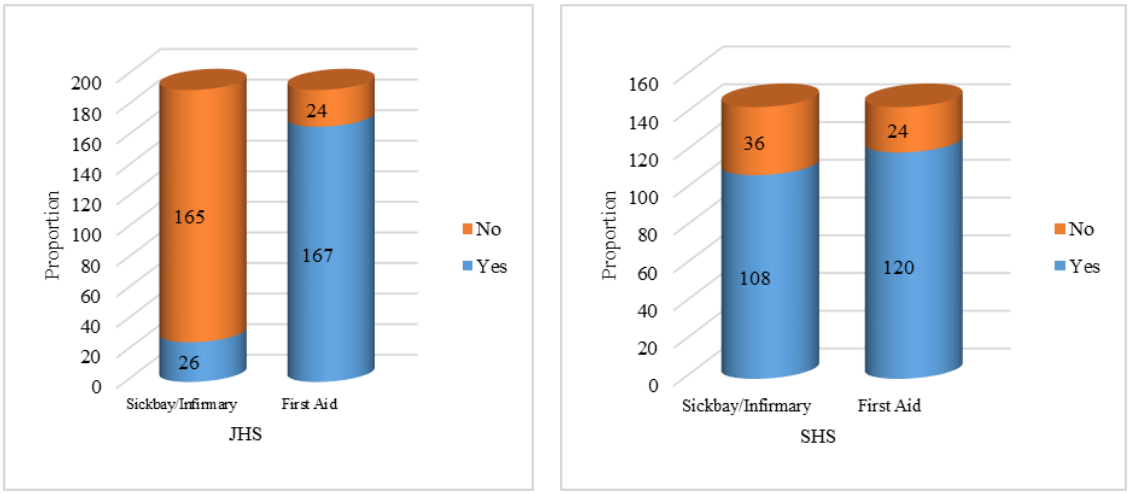

Figure 3: Proportion of Schools with Health facility/first aid box

Furthermore, the proportion of SHS 86 (59.7%) with regular access to a nurse or health assistants was relatively higher as compared to JHS 29 (15.2%).

3.1.3 Incidence of COVID-19

The research further assessed the number of COVID-19 cases as well as deaths recorded by the various respondent groups considered in this study.

Majority (57.7%) of hospitals interacted with indicated that their staff contracted COVID-19, whereas in 65.5% of the hospitals, at least a patient tested positive to COVID-19.

Severely infected persons were isolated and referred to the COVID-19 team. Asymptomatic patients were asked to self-isolate and given treatment. About 4.0% of hospitals recorded deaths of health workers, whereas 30.2% recorded deaths of patients as a result of COVID-19 infection. No COVID -19 related new-born deaths were recorded in any of the hospitals visited.

More students and teachers of the Senior High Schools than Junior High Schools got infected (*see Figure 4*).

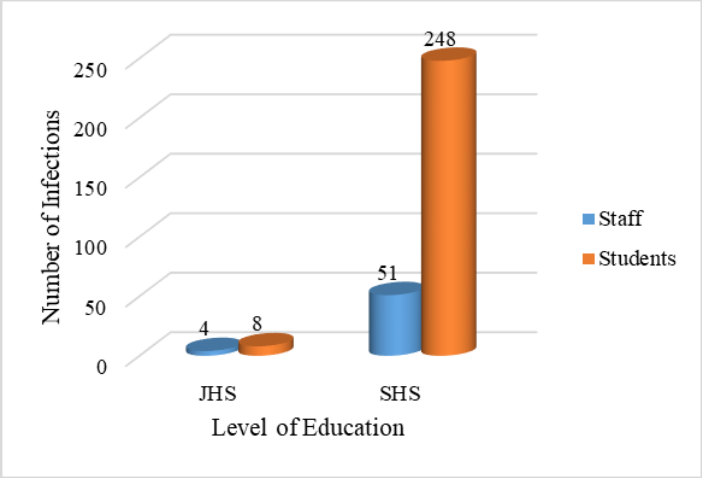

Figure 4: Number of Staff/Students who contracted COVID-19

Persons who contracted the virus were either isolated in a sickbay/infirmary or sent to the hospital for treatment depending on the severity. In some cases, officials of the Ghana Health Service or an affiliate hospital were contacted for further actions. Suspected cases of COVID-19 were handled by school administrations through the following means;

- Referral to the district or the nearest hospital
- Isolation at the sickbay or an available room
- Notifying health authorities
- Referral to GHS

None of the schools recorded a COVID-19 related death of a staff or student.

Twelve traders from various markets reported that their markets recorded positive cases of COVID-19 with a total of three (3) related deaths.

IMPACT OF COVID-19

3.1.4 Impact of COVID-19

3.1.4.1 Impact of COVID-19 on Service Delivery in Health Care Institutions

Intake of Patients

Interactions with a representative from the Ministry of Health indicated that the pandemic exposed the inadequacy of health care infrastructure nationwide. The hospitals (especially those in the hot spot areas) were overstretched, and as a result the President gave a directive that only persons in critical health conditions could visit the hospitals, an indication of the inadequacy of health care infrastructure nationwide.

The respondent further indicated that before the pandemic, there were few Intensive Care Units (ICUs) in the country. The State therefore had to establish more units to meet the demand. Demand for services was restricted as people who were not in need of in-patient services had to resort to over-the- counter services (pharmacies). On the contrary, hospital administrators from 96.5% of the health facilities interacted with indicated that the intake of patients reduced from March to December, 2020. Only five hospitals; three from the Eastern Region, and one each from the Ashanti and Ahafo regions respectively had no change in the average number of patient intake. However, between January 2021 and November 2021, the percentage of hospitals indicating a reduction in patient intake reduced to 61.2%. The reason given was that the fear of contracting COVID - 19 had waned, making more patients confident to visit hospitals.

During the period, prices of some medications such as zinc tablet, vitamin C and immune boosters shot up.

Number of Recorded Teenage Pregnancies

One third (33.3 %) of the hospitals visited recorded a decrease in number of teenage pregnancies, whereas 29.0% recorded an increase; 12.3 % hospitals had no change over the period March to December, 2020. However, at the beginning of 2021 to November 2021, a higher proportion of hospitals (61.5%) recorded an increase in teenage pregnancies as compared to 38.5% who recorded a decrease.

Management of Wards

The government directive during the onset of COVID-19 to run a shift system to reduce the numbers on duty put some strain on health workers because staff needed to work extra to cover for those who were not on duty or were infected with the virus. However, from November 2021, work in 60.4% of hospitals normalized.

Working hours

Some institutions introduced a 12- hourly shift instead of the previous eight (8) hours. This meant long working hours for staff; 26.4 % of hospitals fell in this category. Another 9.1% had a decrease in working hours also as a result of the shift system, whereas 63.6 % had no change in working hours. From November 2021, 21.2% of hospitals had their 12-hourly shift system reverted to eight (8) hours and 18.5 % of hospitals whose working hours decreased reverted to normal working hours.

Visits

From March to December, 2020, most (92.4 %) of the hospitals restricted the number of visitors to their facilities. For instance, at the Kibi Government Hospital in the Abuakwa South district of the Eastern region, one visitor per patient was allowed from 5:30 am to 6:00 am and 4: 30 pm to 5:00 pm respectively. Ten (10) health institutions made no changes to the visiting schedule, they only insisted on observing the COVID-19 protocols. From November 2021, most hospitals had reverted to the normal times of visit but ensured strict adherence to COVID-19 protocols.

Staff Strength

A little under half (45.5 %) of the health institutions did not experience any change in their staff strength. 34.8 % realised a decrease in their staff strength because some of the health workers got infected and had to undergo treatment. By November, 2021, the staff strength had normalized.

Interactions with MoH revealed that a number of hospitals requested for Critical Nurses (nurses that work in Intensive Care Units). All nurses who specialized in critical nursing were offered employment by the State. In this regard, the Ministry intends to place more emphasis on critical nursing in the next academic year.

Capacity building for staff was severely impacted as universities (especially those abroad) were closed down and hence In-Person trainings were not possible.

Salary / Allowances

Interactions with MoH pointed out that frontline health workers were given exemption from payment of tax on their employment emoluments for a three-month period and they were awarded an additional allowance of 50% of their basic salary per month for a four-month period. These were further extended for another three-month period.

A daily allowance of GH₵150 was offered to those who undertook contact tracing, and an insurance package of GH₵350,000 for frontline workers though not all frontline workers were processed for this package. The reason could be that there was no clear definition of frontline workers and hence other health workers (including accountants, administrators, etc.) submitted their documents to be processed.

A total of 21.6% of interviewees stated that salaries of frontline workers including doctors and nurses increased as a result of tax reliefs and allowances given to frontline workers. Another 12.9% indicated that health workers had their salaries unchanged. 14.1% of health workers who were paid from the hospitals' internally generated funds realised a decrease in their salaries due to a reduction in revenue as a result of fewer patients over the period. From November 2021, salaries had reverted to the Pre COVID-19 period and staff paid through internally generated funds were enjoying normal salary.

Medical Supplies

Demand for medical supplies was generally high during the period of the pandemic, for instance, persons under Intensive Care Unit (ICU) utilised more oxygen than the normal consumption rate before the pandemic. A COVID-19 patient could utilise as many as 20 big cylinders of oxygen. More attention was given to COVID-19 related sicknesses at the expense of other treatments such as cancer, TB, HIV, malaria etc.

During the period, 37.6 % of health institutions visited had a reduction in medical supplies mainly due to import restrictions whereas 45.3% realised increase in medical supplies especially PPEs and 16.2% experienced no change in medical supplies. From November 2021, 69.0% of hospitals which previously experienced reduction in medical supplies indicated that they could now access medical supplies but complained of the high cost of such supplies.

Policies for Extended Sick leave and Child Care for Staff

The majority (64.5%) of health institutions had paid extended sick leave policy for staff; 83.5% of these hospitals as part of their policy covered those who had contracted COVID-19. All who were infected with the disease were on paid sick leave and they continued to enjoy their salaries whilst in isolation.

3.1.4.2 Impact of COVID-19 on the Health Care Needs of Vulnerable persons

Health Institutions

Turn-out of vulnerable groups such as Children, Pregnant Women, Nursing Mothers, the Aged, Persons with Disability (PWDs), Persons with HIV/AIDs and Persons with Underlying Health Conditions to hospitals was low because they reportedly feared contracting COVID-19. Mothers who contracted the virus were taken away from their children leaving these children with no motherly care for a period.

According to MoH, vulnerable groups (especially the aged population and children below 5 years) were prone to diseases and required medical attention. However, with emergence of COVID-19 and the lock down of certain parts of the country, some services were put on hold. He furthered that access to maternal services (+1 visit- meaning one visit) increased from 74.2% in 2019 to 79.2% in 2020. However, (+4 visits – meaning four or more visits) maternal services decreased from 59.1% in 2019 to 55.9% in 2020. This could be attributed to the lock down and the fear of contracting the disease at the hospitals. The ideal number of visits within the 9 months is 6 but the least allowed number is one.

Special Measures by Health Institutions to protect vulnerable groups

Special measures were arranged by 72.1% of health institutions for Children, Pregnant Women, Nursing mothers, the Aged, Persons with Disability, Persons with HIV/AIDs and Persons with Underlying Health Conditions.

Apart from making sure the COVID-19 protective protocols were observed, these group of persons were given preferential treatment and not made to join queues. Other hospitals had special consultation days for pregnant women and persons with underlying health conditions, so they were not lumped with the other patients. Wheelchairs were also made available for use at various facilities visited.

Also, at Maamobi in the Ayawaso North district of the Greater Accra region, the Salvation Army Urban Aid Clinic waived medical bills for those who could not afford.

Vulnerable Persons in Deprived Communities and Informal Settlements

Persons in vulnerable situations, including pregnant women, elderly, terminally ill and children could not visit the hospital for fear of contracting COVID-19 virus and as a result, some resorted to over-the-counter services.

According to some pregnant women and elderly persons, they found it difficult to breathe through the nose mask although it was a safety requirement for entry to most health facilities.

3.1.4.3 Impact of COVID-19 on the Right to Physical and Mental Health of PWDs

In 85.1% of health institutions visited, services were rendered for Persons with Disability (PWDs) and 74.8% of the hospitals provided services for persons with intellectual, sensory or mental disability. However, 10.8% of hospitals had a reduction in visits by persons with intellectual disability. These reductions were due to the fear of contracting COVID-19 disease.

Various measures were taken to ensure PWDs access healthcare. These include providing telephone lines for persons and their families to call healthcare officials and visits to these patients at home. For instance, health officials of the Friday's Memorial Clinic in the Suhum district in the Eastern region, visited these patients at their homes.

3.1.4.4 Impact of COVID-19 on Right to Maternal Health

A total of 131 (93.1%), 115 (82.1%) and 129 (91.7%) of the hospitals provided prenatal, neonatal and postnatal services to clients, respectively. Generally, the impact of COVID-19 on such services included;

- A decline in attendance for fear of contracting the virus.
- Such services of care in respect of their facilities were overwhelmed due to incidence of complicated cases.
- Relocation of Unit.
- Staff contracted COVID-19 leading to reduction in staff strength and more waiting time

- Neonatal care unit was joined with other units
- Inadequate space for services as a result of social distancing
- Reduced attention to patients
- Limited care to emergencies
- Imposition of restrictions and long waiting time for clients due to observation of protocols

Some measures put in place by health institution to mitigate the impact of COVID-19 on maternal health included[23];

- Some facilities kept records of clients; hence it would call the patients when their time for visit was due;
- Some facilities held regular and intensive education on COVID-19 for its clients. Sensitizations were done both at the hospital and through the media;
- Some hospitals employed home visitation to extend its services and education;
- Complicated cases were referred;
- Counselling was offered for clients;
- Some services were moved to the open.

3.1.4.5 Impact of COVID-19 on National Health Insurance Scheme (NHIS)

The majority 134 (89.9%) of health institutions visited were accredited NHIS service providers. Of the 134, 31 (23.1%) indicated the pandemic impacted on service delivery under NHIS. For instance, there was shortage of drugs and other consumables.

There were different views regarding whether or not NHIS covered treatment of COVID-19. Majority 58 (43.3%) of the hospital administrators indicated the scheme did not cover COVID-19, whereas others indicated that services covered treatments partially and fully.

According to hospital administrators who indicated that the NHIS covered treatment partially, the aspects covered included;

- Facility user fees, Folders and cards, Consultation, Examination, admission and some medications (especially those that fell within the NHIS approved list of medicines);

[23] These mitigating measures are in keeping with maternal health provisions. Other mitigating measures are outlined in the report.

- Asymptomatic aspect;
- Infusion, essential drugs (including Azithromycin);
- Laboratory;
- Initial treatment given to all sick persons.

However, the MoH explained that because COVID-19 is a new Public Health Disease and not part of the NHIS package, the government had to pay for treatment.

> *The State has the duty to pay for treatment of public health diseases because such diseases can easily spread*. **[MoH]**

Government created a portal for hospitals (especially public hospitals) that were treating COVID-19 to submit claims for reimbursement. Claims were submitted from the hospitals to the Ministry but the reimbursement was not done due to financial constraints and as a result, the claims portal was shut down. Representatives from the hospitals came for meetings on this until the Ministry asked the NHIA to bear the cost of treatment. A team (from NHIA) had submitted its preliminary report and it was yet to receive inputs from various stakeholders. Once all the stakeholders agreed to it, it would be added to the benefits under NHIA, the MoH representative added.

Receiving treatment under the NHIS

243 (96.8%) of the patients were registered under NHIS. The remaining few gave the following reasons for not registering under the scheme;

- Rarely visited the hospital;
- Had private health insurance;
- Card missing, hence inactive.

Of those who were registered under the NHIS, 226 (93%) had their subscription active. The remaining few who had not renewed their subscription gave the following reasons;

- Could not afford the renewal fee;
- Missing card;
- Renewed the subscription that same day, hence the card would be active in 30 days after renewal;
- Busy schedule, hence, had not gotten enough time to go for the renewal;
- Forgot about the renewal;

Of the 226 patients who had active NHIS subscription, 222(98.2%) actually accessed healthcare under NHIS. The few who did not, cited the following reasons;

- Health insurance did not cover drugs;
- The hospital did not provide services under NHIS;
- Services under the scheme was not provided in a timely manner;
- Payments were required even after using the card;
- Some lab tests and medications were not covered by NHIS.

Also, 32 (61.7%) of informal settlers had registered with NHIS, of these 28(87.5%) have their subscriptions being active. The remaining 18(36.0%) said they had not renewed with reasons that:

- They do not fall sick;
- They do not have money to register;
- They have not had time to go and renew;
- They do not know the relevance because they will still pay some money at the hospital;
- The NHIS does not serve the purpose for which it has been made;
- Registration process is stressful.

Furthermore, 79 (86.8%) of the respondents in the deprived communities (slums) had registered with the NHIS of which 51 (64.6%) were active. In assessing reasons for not registering under NHIS, some of the community members were of the view that the NHIS is not effective. However, for others, they were willing to register but were faced with some challenges which included financial constraints, proximity to NHIS offices, and the long queues for registration.

Seventeen (17) out of the 28 community members who had not renewed their NHIS registration attributed this to financial constraints.

> *I have financial challenges now. I am currently looking for money to go and renew.* [**Duori Kpaanguon – Upper West region**]

> *My financial situation has gone down for a long time now so I can't afford it yet; I rely on traditional medications anytime I don't feel well.* [**Brekuku - Oti region**]

Some community members were challenged physically by their health condition and also financially and could therefore not present themselves at the registration centres to be registered:

I gave it to someone to renew it in town for me but he hasn't found the time and may be money to do so and I am unable to go there personally because of my health condition and financial constraints. [**Lakeside, Oti region**]

3.2 Right to Education

States are the duty bearers under international human rights law and hold the principal responsibility for the direct provision of the right to education. Through ratification of international human rights treaties, governments undertake to put into place domestic measures and legislation compatible with treaty obligations and duties[24]. General comments 13 of the International Covenant on Economic, Social and Cultural Rights provides an analytical framework to consider State obligations concerning the right to education. Ghana has ratified the International Convention on Economic, Social and Cultural Rights and most provisions of this treaty has been incorporated into its domestic laws.

Concerning the right to education, respondents included Ghana Education Service, Ghana Federation of Disability Organization, Caretakers and dwellers of camps for persons accused of witchcraft, as well as head teachers, teachers and students of Junior and Senior High Schools.

In all, 335 schools comprising 191 (57.0%) and 144 (43.0%) Junior High and Senior High Schools respectively, were visited in 16 regions. The majority of the schools visited were in the Ashanti region 51 (15.2%), followed by Eastern region 48 (14.3%) whereas the least was in North East region 4 (1.2%). Three hundred and thirty-five (335) head teachers, 574 teachers and 579 students were interviewed making a total of 1,488 respondents in 16 regions and districts nationwide. Other respondents included one respondent each for Ghana Education Service and Ghana Federation of Disability Organization. In all, 1,490 respondents were approached to be interviewed. Figure 5 depicts the number of schools visited across the country.

[24] State obligations and responsibilities on the right to education. https://www.unesco.org/en/education/right-education/state-obligations-responsibilities

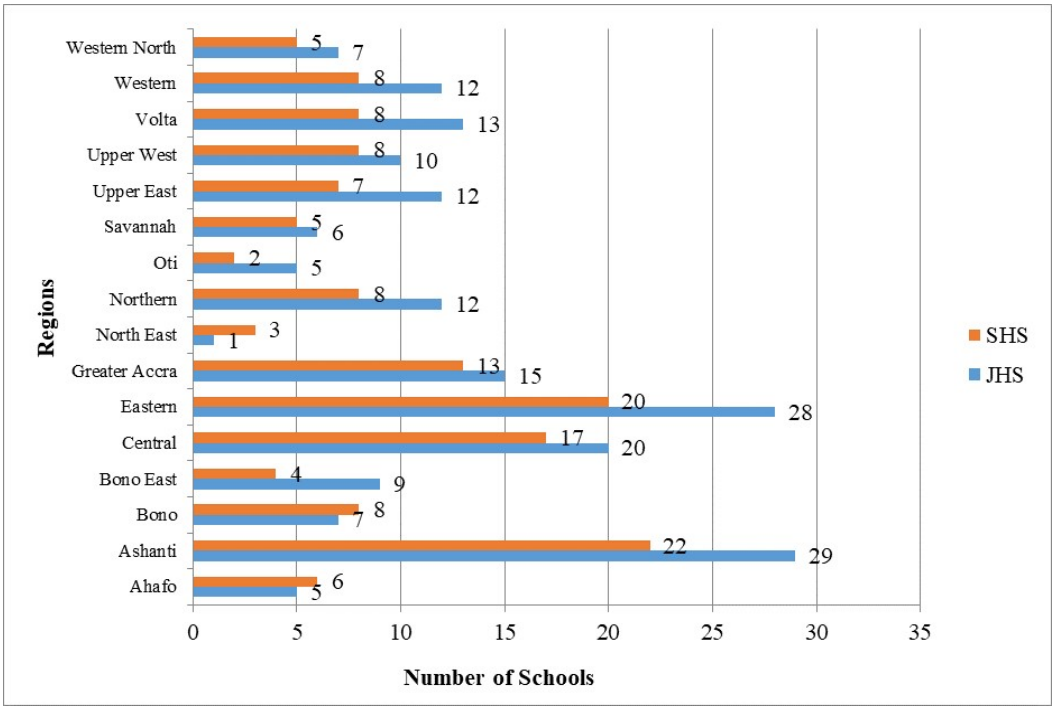

Figure 5: Number of schools visited across the country

3.2.1 Availability

General comments No. 13 (2) 6 (a) provides that, functioning educational institutions and programmes have to be available in sufficient quantity within the jurisdiction of the State party. For example, all institutions and programmes are likely to require *buildings* or other protection from elements, *sanitation facilities* for both sexes, *safe drinking water*, *trained teachers* and other facilities such as a *library* and *computer facilities*. In terms of availability, the study focused on physical structures for accommodation purposes.

Accommodation

Schools visited were day, boarding or mixed. All the Junior High Schools visited had facilities to serve day students. Of these 19 (9.9%) had facilities for boarding students.

The majority of SHS schools, 116 (80.6%) served mixed (boarding and day) students whereas the remaining were either solely day or boarding.

Of the schools with boarding/dormitory facilities, a high proportion of Senior High Schools 57 (45.2%) relative to Junior High Schools 4 (21.1%) were affected by the pandemic.

The following indicates how the COVID-19 affected school accommodation in various schools:

Senior High Schools

- The following schools had to convert some classrooms or dining halls into dormitories due to limited space to ensure social distancing:
  - Lawra SHS, Lawra municipal, Upper West region;
  - Obiri Yeboah Senior High/Technical School, Assin Foso municipal Assembly, Central region;
  - Dormaa Senior High School, Dormaa Central municipal, Bono region;
  - Adidome Senior High School, Central Tongu district, Volta region;
  - Keta Business College, Keta municipal, Volta region;
  - Victory International School, Bekwai municipal, Ashanti.
- Some parents withdrew their children from boarding for the fear of their wards contracting the virus;
- To some extent, the double track system reduced accommodation problems in some schools.

Junior High Schools

- For some schools, there were insufficient rooms to accommodate students due to social distancing.

Table 1 represents some measures put in place by school administrations to mitigate the impact of COVID-19 on accommodation.

Table 1: Measures to Mitigate Impact of COVID-19 on Accommodation[25]

JHS	SHS
• Extra classrooms were created • Dormitories were fumigated • Unused rooms were converted into dormitories	• Dining halls were converted into dormitories • Shift systems were introduced • Unused rooms were converted into dormitories • Some boarders who lived within the community were asked to be day students so as to make room for those who lived outside the community • Temporal structures created

Feeding

Regarding the number of times boarders were fed in a day, students of Junior and Senior High Schools were fed three times except in 12 Senior High Schools where students provided or purchased their own meals. Head teachers of Junior and Senior High Schools indicated the meals served were standard and nutritious. Only one school (Adanwomase SHS of Kwabre East district in the Ashanti region) said meals served students were sub-standard.

In terms of quantity, a majority of 230 (69.5 %) students indicated the food was adequate.

3.2.2 Accessibility

General comments No 13 (2) 6 (b) provides that educational institutions and programmes have to be accessible to everyone, *without discrimination*, within the jurisdiction of the State party. Accessibility has three overlapping dimensions: *Non-discrimination, physical accessibility* and *economic accessibility*. This study focused on physical accessibility of schools.

Schools were accessible to both sexes without discrimination. A total of 15,597 (51.3 %) of the students at the JHS were females and 14,806 (48.7%) were males.

[25] These mitigating measures are in keeping with the Impact of COVID-19 on Accommodation in Schools. Other mitigating measures are outlined in the report.

At the Senior High Schools, majority 104,010 (51.9%) of the students were males and 96,317 (48.1) were females.

Of the schools visited, 60(32.6%) and 70(50.4%) of Junior High and Senior High Schools respectively had PWDs admitted in such schools. The form of disabilities could be classified as physical, intellectual, sensory and mental disabilities. There were relatively more persons with physical disability in both Junior and Senior High Schools than the other forms of disabilities. This was closely followed by 'intellectual disability' in the case of Junior High Schools and 'sensory disability' in the case of Senior High Schools (*See Table 2*).

Table 2: Types and Number of PWDs in schools

Types of Disability	**JHS**	**SHS**
Physical disability	66 in 34 schools	121 in 60 schools
Intellectual	63 in 22 schools	8 in 6 schools
Sensory	21 in 16 schools	77 in 9 schools
Mental	19 in 13 schools	5 in 5 schools

3.2.3 Impact of COVID-19 on mode of Teaching/Learning

All Junior High and Senior High Schools employed face-to-face method of instruction before the pandemic, however, only 3 (0.9%) employed both online and face-to-face. With the emergence of the pandemic, the number of schools combining face-to-face with online education increased significantly to 61 (18.1%).

Interactions with students revealed the preferred mode of teaching was the face-to-face after experiencing both methods of instruction. A large majority, 313 (96.6%) and 228 (95.4%) of Junior and Senior High School students respectively preferred the face-to-face mode of teaching (*see Figure 6*).

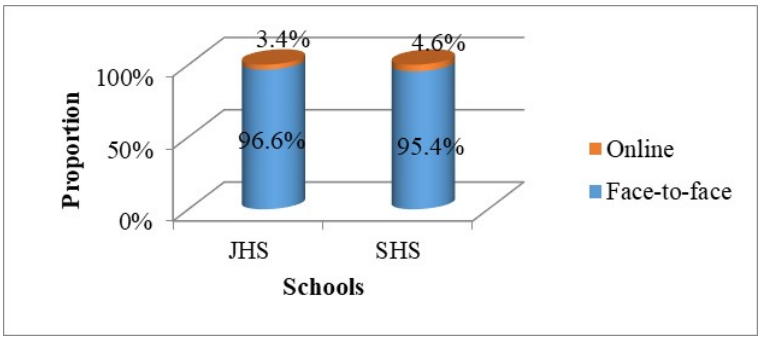

Figure 6: Preferred Mode of Teaching

The reasons given for preference for the face-to-face mode of teaching and learning included:

- It enhanced easy learning and was very cost effective;
- Students were much familiar with the face-to-face mode of teaching hence introducing the online was strange and difficult to adopt by many students;
- Some students did not have the required resources such as laptops and internet bundle for online teaching;
- It promoted better student-teacher relationship;
- It promoted inter student interaction and relationship.

Reasons why others preferred online method of teaching included:

- It aided illustration and demonstration of diagrams and concepts;
- Students could easily refer to notes, have access to recordings and study in the comfort of their homes;
- They were able to do internet exploration of subjects for better understanding;
- It improved their ability to use the computer.

Challenges faced with face-to-face method

- Students sometimes found it difficult to ask questions in the classroom;
- Without masks, students were not allowed to stay in the classroom;
- Persons who covered long distances to school were often affected in terms of lateness and absenteeism;
- Congestion in class and insufficient furniture.

Challenges faced with Online Education

- Lack of computers for the teachers:
  - Smart phones were used by some teachers to aid teaching and learning;
  - In most cases, teachers and students complained of inadequacy of computers;
  - Some schools had no computer laboratory (e.g., New Abirem LA 'A' Basic School in Birim North District, Eastern region);
  - Congestion in class and insufficient furniture.
- Lack of computers for pupils:
  - Most students had no access to computers;
  - Some students used their parent's smart phones for studies.
- Unstable, poor or unreliable internet connectivity;
- High cost of internet data bundle;
- Low level of participation since most students do not have computers. Poor internet connectivity also impacted negatively on the level of participation.

3.2.4 Impact of COVID-19 on other areas of education

The impact of COVID-19 on the educational sector in the areas of enrolment, attendance, teaching, learning and class size were further assessed.

Enrolment

Majority 165 (49.5%) of the head teachers indicated that enrolment declined as a result of the pandemic. 80 (24.0%) mentioned the pandemic had little or no impact on it. For 88 (26.4%) schools, enrolment was completed before the pandemic.

Interactions with the Ghana Federation of Disability Organizations revealed that enrolment of PWDs into schools had its difficulty even before the pandemic. The emergence of the pandemic further heightened the situation.

Attendance

Generally, school attendance reduced due to the temporary closure of schools. Some students of four (4) schools did not return to school from the COVID-19 break whereas some parents of eight (8) schools withdrew their wards from school. Teachers of six (6) schools lamented that the long break contributed to teenage pregnancies. It also contributed to lateness to school.

For instance, the head teacher of St. George Catholic SHS, indicated the school practiced physical distancing in buses that conveyed the students to school, hence the bus was not able to carry the usual number of students per trip.

> *Attendance dropped because 120 students failed to return to school*
> [**Head Teacher, Asankrangwa SHTS, Amenfi West Municipal, Western region**]

Teaching

Teaching was done on a shift basis in 28 (19.5%) Senior High Schools. Seven (7) private school teachers refused to attend school because of non-payment of salaries. Where classes were held in sessions for different groups of students per class, teachers lamented that it increased workload and prolonged teaching. Besides the workload, the long break resulted in the inability to cover the entire syllabus. Contact hours also increased.

Generally, teachers were uncomfortable with the use of facial masks during teaching as they had to shout in order to be heard by students. Some teachers of four schools were not punctual as they feared contracting the virus.

According to the Ghana Federation of Disability Organisation, most schools were not well resourced with materials to aid teaching and learning for PWDs. Also, poor internet access and requisite platforms for teaching and learning affected PWD(s) attendance at school. The practice of social/physical distancing left some PWDs to their fate, although they needed some kind of physical assistance by care givers.

Learning

With the emergence of the pandemic, students had to be given more assignments whereas group work was discouraged to limit physical contacts. According to the GFD, online learning was quite a challenge for PWDs because some of the platforms were not accessible to them.

Class size

Class sizes were reduced as a result of the need for social distancing. For most schools, classes that held 50 or more students were made to accommodate a maximum of 30 students. More classrooms had to be created to accommodate students.

3.3 Cultural Rights

Cultural rights are human rights that aim at assuring the enjoyment of culture and its components in conditions of equality, human dignity and non-discrimination. Cultural Rights are also rights related to art and culture, both understood in a broad sense. The objective of these rights is to guarantee that people and communities have access to culture and can participate in the culture of their election. They are rights related to themes such as language; cultural and artistic production; participation in cultural life; cultural heritage; intellectual property rights; author's rights; minorities and access to culture, among others[26].

The UNESCO Declaration on Cultural Diversity affirmed that culture should be regarded as: "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs." The right to participate in cultural life has both individual and collective elements; they may be exercised as an individual, in association with others, and within a community or group. States should pay particular attention to the cultural rights of minority and indigenous groups, among others, and provide opportunities for them to both preserve their culture and shape cultural and social development, including connection to language, land and natural resources.

Article 26 (1) of Ghana's constitution provides that "every person is entitled to enjoy, practice, profess, maintain and promote any culture, language, tradition or religion subject to the provisions of this Constitution".

3.3.1 Impact of COVID-19 on Cultural Rights

This section of the report presents the impact COVID-19 pandemic had on the cultural rights of various respondent groups, including Ghana Muslim Mission, Christian Council of Ghana, amongst others. This section includes the impact the ban on social and cultural activities such as funerals, weddings, religious gatherings etc., had on the revenue of persons in the informal sector.

[26] *UNESCO Declaration on Cultural Diversity*

3.3.1.1 Faith Based Organisations

As part of the study, CHRAJ interacted with Ghana Muslim Mission, Christian Council of Ghana and Ghana Pentecostal and Charismatic Council on how the pandemic affected the cultural rights of its members.

According to respondents, attendance at mosques and churches was greatly affected by COVID-19. Activities of all kinds for these religious groups ceased especially during the lockdown.

After the lockdown, attendance at services were still low because the time for services was reduced to two hours. Many people feared that they might contract the virus if they came to the mosque or church. This greatly affected contributions and offerings.

As a result, the use of online modes of running church services was mostly employed by the churches. Prior to the pandemic, some churches according to the Christian Council of Ghana, never employed such modes for services but because of COVID-19, they had to adjust in order to be able to reach their members. The Ghana Muslim Mission indicated that this mode did not work for their usual Friday prayers because of their inability to pray together online.

3.3.1.2 Informal Sector

In assessing the impact of the pandemic on the informal sector, traders, road transport operators, deprived community members, informal settlers, hair dressers and barbers were interacted with.

Three (3) respondents got emotionally affected as they could not get the opportunity to socialise, sympathise or support their friends and loved ones due to the ban on social gatherings. Eighty-one (81) respondents also indicated they could not meet in various sports arena to support their preferred teams whereas six (6) resorted to watching football on TV.

In the area of religious gathering, the closure and restrictions on the service affected their spiritual life since some could not participate in the online service.

Likewise, the ban on funerals affected 156 respondents. Where funerals were performed in compliance with the restricted number of sympathisers, it led to low donations.

3.4 Right to decent work, and adequate standard of living and housing

The right to an adequate standard of living requires, at a minimum, that everyone shall enjoy the necessary subsistence rights: adequate food and nutrition, clothing, housing and the necessary conditions of care when required. Similarly, Article 11 ICESCR provides that, everyone has the right to 'an adequate standard of living for himself and his family'. Under Article 27 CRC, 'States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development'. Under Article 14 of CEDAW, 'States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas [...] to ensure [...] the right [...] to enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications [....]'. Article 28 CRPD sets out the right to an adequate standard of living and social protection without discrimination on the basis of disability.

This section of the report assessed how the pandemic affected the right to work and the standard of living of persons and groups in vulnerable situations such as self-employed and workers in non-traditional and the informal economy. These included open market traders, barbers and hairdressers, hotels and guests houses, drivers and station masters in the private road sector, as well as people living in deprived communities and informal settlements.

Interviews conducted were on account that State parties to the Convention on the Economic, Social and Cultural Rights must put in place measures to identify and mitigate the impact of the pandemic on persons who are particularly vulnerable in terms of being self-employed workers, those in non-traditional and the informal economy[27] such as barbers and hairdressers, traders in the open market, drivers and station masters in the private road sector, as well as those living in deprived communities (slums) and informal settlements[28].

3.4.1 Traders and Open Markets

The effect of the period of lockdown as well as local assembly's directives on traders as measures to reduce to incidence of COVID-19 were assessed.

[27] See Committee on Economic, Social and Cultural Rights, general comment No. 18 (2006) on the right to work, E/C.12/GC/18, paras. 6, 7, 11, 12, 19 and 31.
[28] UNSDG (2020) COVID-19 and Human Rights. We are all in it together. UN Sustainable Development Group (UNSDG)

Traders operating within or outside the lockdown regions of the country were affected by the directive in the areas of income, number of customers, working hours, supply of goods, among others.

Income

The ban on social gatherings such as funerals, weddings, religious gatherings, sporting activities, closure of beaches etc., caused a decline in usual revenue of traders. In compliance with the ban on social gatherings, some union or association leaders suspended their usual meetings where major decisions were taken.

Also, most 95 (84.1%) of the traders recorded a decrease in sales during the period of lockdown. They indicated that the usual active buying and selling witnessed drastic daily reductions. Their main concerns were as follows:

- Income generation decreased because there was reduction in sales;
- Some of the goods got rotten because the customers could not go to the market.

Number of customers

The lockdown had an impact on trading activities because the number of customers dropped dramatically in most 102 (85%) of the country's markets. However, 4 (3.3%) traders had more customers trooping in to buy from them. For instance, a trader noted that the number of customers was not affected much because new customers moved from the locked down cities to buy foodstuffs in large quantities.

Working Hours

The working hours for majority 39 (41.5%) of traders in markets visited were reduced in order to limit contact hours whereas others remained unchanged.

Supply of Foodstuff to Various Markets

In general, there was irregular supply of foodstuffs to the various markets in the lockdown regions, especially during the lockdown. In some cases, supply of goods ceased as traders had challenges in accessing their supplies from suppliers. For instance, in the Weija-Gbawe Municipality, there was a decrease in supply of goods which was attributed to the cumbersome nature of carting of goods from rural areas to the urban centres due to snap checks by the police.

Running of Shifts

The directive to run shift affected the traders negatively as most of them lost their customers. Some suffered losses as their perishable goods went bad. As part of the shift system, some traders had to sell at the market only twice a week, paving way for others to sell in their place on days they were absent, thereby creating inconveniences. The Metropolitan, Municipal, District, Assemblies (MMDAs) also recorded low revenue from the markets.

Moving to New Location

The directive to relocate some traders to ease congestion also affected most of the traders in terms of sales and convenience. For some, there were no provisions for sheds and storage facilities. The cost of relocating was also burdensome. Again, most of the traders lost touch with old customers as well as debtors (*see Figure 7*).

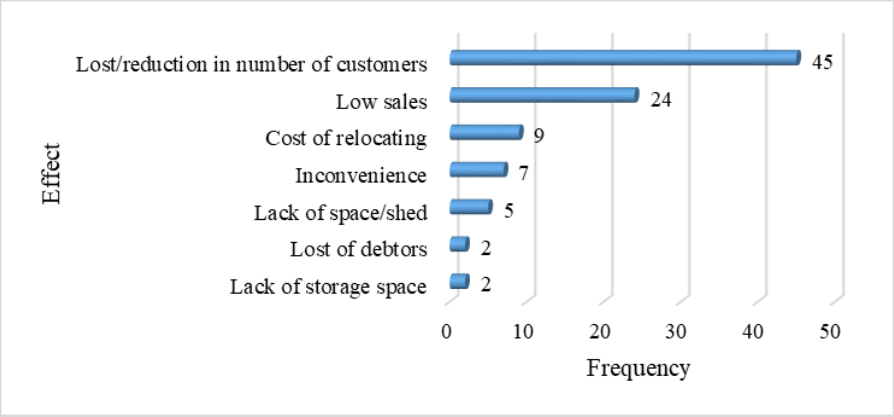

Figure 7: Effects of Moving to New Location

Closure of non-food markets

The closure of non-food markets affected both the traders and customers. With traders, their source of livelihood was affected. The closure threw others out of business completely. Regarding customers, some basic items were not easy to come by when shops were closed.

3.4.2 Barbers and Hairdressers

Income

Almost all hairdressers and barbers who were in the lockdown regions experienced a reduction in income. A barber lamented: Daily sales was affected, because of low patronage

[**Barber, Amasaman, Greater Accra region**]

Salary of workers

Salaries of some workers remained unchanged whereas others had their salaries slashed.

> *Before COVID-19, I was paying my workers 100.00 cedis per week but it dropped to 30.00 cedis per week.* [**Hairdresser, Kwaebibirem, Eastern region**]

Number of workers and Customers

There was a reduction in the number of workers as there was low patronage for services during the lockdown. This resulted in low income; hence some workers could not be paid and were therefore laid off. However, some hairdressers and barbers did not downsize.

Working Hours

Generally, working hours reduced for barbers and hairdressers because there were fewer customers to attend to while some closed down their shops during the lockdown.

Supply of Goods

Four (4) hairdressers received no goods from their suppliers whereas others received limited quantities.

3.4.3 Hotels / Guest Houses

The Ghana Hotels Association (GHA) indicated that some hotels, particularly in Accra and Kumasi closed down temporarily during the peak of the COVID-19 pandemic. This was corroborated by the Ghana Tourism Authority (GTA) who noted that seventy- one (71) hotels and five guest houses collapsed as a result of COVID-19. Some of these hotels could not resume operations afterwards. The research exercise revealed that the following areas were also affected by COVID-19 pandemic.

Number of staff

According to the association, a significant number of hotels/guest houses had no choice but to lay off some workers due to inadequate revenue to pay salaries.

This was corroborated by the majority 138 (70.8%) of hoteliers interacted with. The Ghana Tourism Authority added that 4.7% of staff were laid off, whereas 3.7% resigned since the inception of COVID-19.

Hotel Revenue

According to the GTA, there was a drop of 56.5% in the income of hoteliers in the country. About 92% of hotels experienced booking cancellations and a marked drop in the number of customers. The GHA in corroboration, added that the restriction on movement affected their business and revenues.

Most 180 (92.3%) of the hoteliers interacted with indicated that their revenue reduced drastically between March and December, 2020 due to the sharp drop in the number of their customers.

Figure 8 depicts the trend of the average number of clients per month spanning January, 2019 to August, 2021with respect to sex received from 80.8% of the hotels/guest houses visited.

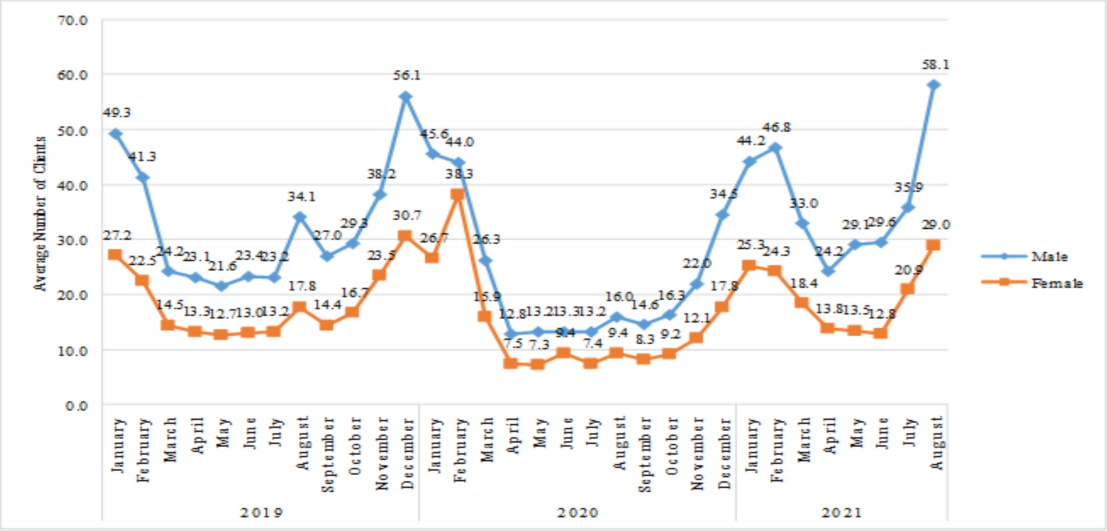

Figure 8: Average number of Clients/Customers from Jan 2019 to Aug 2021

From Figure 8, the average number of clients recorded by hotels/guest houses across the country over the three-year period considered, were on a steady decline within the first quarter (January to March) and increased steadily in the last quarter (October to December) each year. The average number of clients recorded between April and August/September appears to remain the same (with a slight increase). Also, the average number of clients recorded in 2019 and 2021 was higher than those recorded in 2020. The lower average number of clients recorded in 2020 could be attributed to

the inception of COVID-19 where some hotels/guest houses had to shut down due to low patronage.

While the majority 100 (51.3%) of the hoteliers interacted with did not experience any change in revenue from January to August, 2021, 73 (37.4%) of them recorded an increase, whereas 22 (11.3%) recorded a decrease in revenue.

Staff Working Hours

About half of the hoteliers interacted with stated that there was a decline in the working hours of staff between March and December 2020. Some adopted the shift system as a result of the low patronage in their hotels/guest houses. Meanwhile, some indicated the pandemic had no impact on the working hours of staff. Yet, for a few, there was an increase in staff working hours as fewer staff had to contend with a bigger workload.

Salary of workers

According to the Ghana Tourism Authority, payment of employees' salaries was the topmost challenge encountered by most hotels/guest houses during the period of lockdown. The Ghana Hoteliers Association mentioned that some of the hotels/guest houses retained some workers but had to reduce their salaries by 30% to 60%, depending on the strength of the facility. This was corroborated by 91(46.9%) hotel managers who gave the indication that workers' basic salaries had to be reduced by 50% in order to keep business in operation. Also, 90 (53.9%) of the hoteliers explained that workers' salaries were reduced to prevent redundancies between March and December, 2020. Notwithstanding, some respondents said salaries of workers were not affected by the pandemic.

Furthermore, the majority 143 (73.3%) of the hoteliers stated that there was no change in the salary of workers from January to August, 2021. However, 37(19.0%) said there was an increase in the salary of their staff since there was an increase in their revenue over the period.

3.4.4 Drivers and Station Masters in the Public Transport Sector

In view of the precautionary directives by His Excellency, the President Nana Addo Dankwa Akuffo-Addo on the Coronavirus (COVID-19), and subsequent consultations with the Ghana Private Road Transport Union (GPRTU), the Ghana

Road Transport Coordinating Council (GRTCC), VIP, VVIP, amongst others, Road Transport operators issued a press release indicating that[29];

1. All Passenger Carrying Vehicles including Taxis seating 1-3 passengers on a row shall seat not more than 2 passengers on a row;
2. All passenger carrying vehicles seating 1-4 passengers on a row shall seat not more 3 passengers on a row; and
3. All passenger carrying vehicles seating 1-5 passengers on a row shall seat not more than 3 passengers on a row.

In assessing the impact of COVID-19 on drivers, the effect of the period of lockdown as well as COVID-19 related directive by the President and sector unions to reduce number of passengers were examined.

Income

The lockdown affected the revenue of drivers across the country, though the directive was not nationwide. All the drivers interacted with indicated their revenue got affected. Some drivers stopped working during the period whereas those who worked had few passengers. Those who worked remarked that the reduction in passengers was because their usual clients were mostly public workers and market women who could not go to work or market during this period. Some stations were also closed down.

Though there was a directive to reduce the number of passengers and which transport unions complied with, there was no increase in fares and this had a negative effect on the revenue of the drivers over the period. Some stations resorted to a shift system due to the reduction in the intake of passengers.

Number of Passengers

The number of passengers reduced drastically over the period of lockdown as people could not travel beyond or into the lockdown areas. Traders were the common passengers at the time. In most cases, drivers had less than half of the capacity of their vehicle.

[29] https://citinewsroom.com/2020/03/commercial-vehicles-ordered-to-carry-fewer-passengers-to-curb-spread-of-covid-19/

Working Hours

Drivers within the lockdown areas could not operate their normal hours in a day due to the stark fall in the number of passengers. Those operating at the stations could stay for several hours before they would get passengers to convey. Some drivers had to go on break until the lockdown was over.

3.4.5 Deprived Communities

The impact of the pandemic on housing, food security and work of deprived communities were assessed.

Housing/Shelter

In terms of accommodation, the pandemic had varying impacts on occupants. The following were some experiences as narrated by respondents;

> *My room which I rented out has since not been paid for by the tenant since her business broke down in 2020.* [**Brekuku – Oti region**]

> *I had to perch with someone due to the slow nature of business as a result of the pandemic, hence unable to get my own accommodation.* [**Brekuku – Oti region**]

Food security

Majority 71 (76.3%) of the community members interacted with indicated that they had low income over the period and this affected their food security. Respondents across the country witnessed high cost and shortage of foodstuff. For this reason, feeding households was quite challenging for some breadwinners and hence reduced the regular food consumption or fell on others including churches for support.

Work

Regarding the impact of the pandemic on work and livelihood, 31 respondents expressed that they experienced a reduction in their sales/income due to low patronage. Also, the ban on social gatherings had an adverse effect on buying and selling. The pandemic also limited job opportunities as some had to close down their businesses or put in some restrictions.

3.4.6 Informal Settlements

For this category of people who had to squat or rent informally, the pandemic had an impact on them in several ways, especially concerning their sleeping places, movement, feeding, work, among others.

Housing / Shelter

There was varying impact of the pandemic on the accommodation of settlers. Some respondents indicated the pandemic had little or no impact on their accommodation. For those that felt the impact on accommodation 11(22%), they indicated that rent was increased or they were evicted for failure to make payment.

Movement

Informal settlers mentioned their movement was either curtailed or restricted especially during the lockdown period although the core of their businesses revolved around movements.

Food security

Being able to afford meals was a challenge for almost all the settlers.

Work

While some settlers said their daily sales reduced, others lost their source of livelihood entirely. Some also suffered loss of customers whereas others alleged being constantly harassed by the Police whiles working.

3.5 Mitigating Measures against incidence and impact of COVID-19

The International Covenant on Economic, Social and Cultural Rights (ICESCR), requires state parties to take immediate steps to ensure that the minimum content of its provisions are met, even in cases of emergency (Article 2 (1)). As a state party, Ghana is required to take a range of intentional, concrete and targeted measures to respond to the COVID-19 pandemic and to mitigate the impact of the pandemic on those who are likely to be most affected[30] particularly persons in vulnerable situations.

[30] Ibid. para. 12; general comment No. 14 (2000) on the highest attainable standard of health, E/C.12/2000/4, para. 65.

3.5.1 Health Sector

The majority (80.1%) of hospitals sampled received support through the Ghana Health Service and the Regional Health Directorate. These included relief packages in the form of tax exemption, insurance for core staff and 50% of salary as top up. The State through the Ministry of Health provided protective gears (including surgical and face masks), vaccines, oxygen- filled cylinders, body bags among others to end users. Frontline workers were also vaccinated against the virus.

The president announced free transport for health workers. The Ministry came out with an emergency preparedness plan (a plan to fight the pandemic). The following were some of the measures taken by the state to mitigate the impact of COVID 19:

- Risk Communication Strategy was employed to educate the public through the NCCE, MOI about the disease and issues in relation to the virus;
- The rolling out of Agenda 111;
- Ghana Centre for Disease Control being put in place to ensure pandemic preparedness and emergency situations
- Establishment of National Vaccine Institute being discussed at the Presidency to facilitate local production of vaccine
- Establishment of Infectious Disease Control Centre at Amasaman, Ga-East.

Several hospitals also received support from Government of Ghana, Ghana Health Service, Ghana Christian Council, Banks, Members of Parliament, District Assemblies, Zoomlion Ghana Limited, Chiefs, philanthropists, pharmaceutical companies, churches, ActionAid, World Vision Ghana, NCCE and CHRAJ. Support received included provision of PPEs, Ventilators and oxygen, sensitization, fumigations, medical equipment and cash. Also, MoI, MoE, NCCE, Ministry of Water and Sanitation as well as the Local Government Ministry provided sensitization via various mediums. World Bank, WHO and MTN also supported with vaccines.

Regarding provision of PPEs, ventilators, sensitization programs and giving of cash to hospitals, majority of administrators ranked the provision as satisfactory, poor, satisfactory and poor respectively.

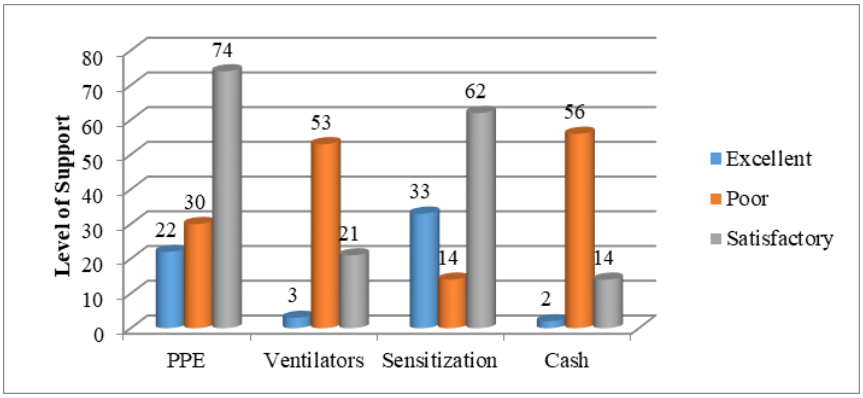

Figure 9: Level of Satisfaction with Support Received

A vast majority (88.5%) of hospitals employed measures to mitigate the impact of COVID-19 on service delivery. Measures taken included the adherence to the COVID-19 protocols namely social distancing, wearing of nose mask, checking of temperature, restriction of visits to in-patients, hand washing with soap among others. Others included the policy of "No Mask no entry" and the fumigation of health facilities and their environs. In the wards**, t**he number of beds were reduced to ensure physical distancing. Posters were placed at vantage points to prompt staff/patients/visitors on strict observance of COVID-19 protocols.

Special measures were arranged by 71.1% of hospitals for Children, Pregnant women, Nursing mothers, the Aged, Persons with Disability, Persons with HIV/AIDs and Persons with Underlying Health Conditions. Apart from making sure the COVID-19 protective protocols are observed, these group of persons were given preferential treatment and not made to join the queue. Other hospitals had special consultation days for instance for pregnant women and persons with underlying health conditions so they are not lumped with the other patients. Wheel chairs were also made available for use at various facilities visited. The Salvation Army Urban Aid Clinic at Maamobi in the Ayawaso North district of the Greater Accra region, waived bills for those who could not afford medical bills.

3.5.2 Education Sector

The GES issued guidelines for the reopening of schools after the temporary closure. These guidelines were sent to all schools (basic and Senior High Schools). GES further provided orientation for its regional staff on "Ghana COVID-19 Response for Educational Institutions". The regional office of the GES in turn trained its District/Circuit officers who also oriented head teachers, senior house

masters/matron, guidance and counselling coordinators as well as health coordinators of schools.

Most (90.7%) head teachers of both Senior and Junior high school indicated that the State had put in place necessary measures to address the impact of the pandemic.
Some of the measures mentioned were as follows:

- Supply of PPEs, including nose masks, thermometer guns, veronica buckets, tissues, liquid soap and sanitizers;
- Fumigation of schools;
- Free water supply for a period;
- Provision of meals;
- Sensitization on the pandemic;
- Back to school campaigns and reduction of contact hours;
- Reduction of class size;
- Temporary closure of schools;
- Monitoring of some schools by Ghana Education Service and Ghana Health Service.

Similarly, majority (92.4%) of schools put in place measures to mitigate the impact of COVID-19 in schools. The measures instituted by individual schools included:

- Sensitization on the pandemic and awareness creation through distribution of flyers, and issuing of notices;
- Formation of COVID-19 task force, Committees or teams to enforce compliance with the protocols;
- Fumigation of schools;
- Provision of PPEs;
- Cancellation of visiting hours;
- Suspension of sporting and entertainment activities;

Several organizations also offered support to schools since the inception of COVID-19. Support received included provision of PPEs, sensitization programs on the pandemic, fumigation and cash donations. Organizations and personalities that provided such support are the Government of Ghana, District Assemblies, NCCE, CHRAJ, UNICEF, CAMFED, World Vision, NADMO, Catholic Relief Services, Municipal Health Directorates, some Members of Parliament (MPs), Municipal Chief Executives (MCEs), etc.

According to a respondent of the Ghana Education Service, some teachers and students blatantly refused to observe the COVID-19 protocols. Most schools in the rural areas did not believe that COVID-19 was real and others only wore face masks when in school.

Physical Observation of Compliance with the Protocols in Some Schools

- Students and teachers were not in face mask;
- Veronica bucket was without water;
- Bucket with water but no soap;
- The available classroom could not make it possible for social distancing to be observed

3.5.4 MMDAS

As part of the directives for lockdown, measures (such as running shift, moving some traders to new locations, and closure of non-food markets) were taken to reduce congestion in various markets in the Greater Accra and Kumasi.

All 102 MMDAs indicated they supported markets with PPEs and sensitizations since the inception of COVID-19 while 31 MMDAs were able to advance some cash support to the markets. The District Assemblies further indicated that the COVID-19 safety protocols such as social/physical distancing, wearing of face masks, hand washing, use of sanitizer, checking of temperature and sensitization were taken to reduce the incidence of COVID-19 in the various markets.

Other measures included, fumigation/disinfection of market places, institution of a shift system to ease congestion. Some assemblies like the Kwabre East Municipal, Ga-West, and Amasaman Assemblies built boreholes in the markets to make provision of water for handwashing.

Various organizations; public, private, NGOs and other individual groups provided some form of support to the assemblies. Such support included sensitization, PPEs and cash. NGOs like CAMFED, GIZ, World Vision and ActionAid, also provided PPEs, liquid soap, hand sanitizers, cash etc. Other institutions like Goldfields Ghana, AngloGold Ashanti Iduapriem Mine as well as churches and mosques equally provided some support.

3.5.5 Traders

142 (57.0%) traders indicated the State had instituted measures to mitigate the impact of COVID-19 on trading. These measures included; Distribution of PPEs, Installation of Poly Tanks, Free water/electricity/food supply, Fumigation of markets, Loan facility, Directives/policies (running of shift, moving some to new location), Sensitization, Enforcement of COVID-19 protocols and Vaccination.

Eighty-two (82) of the respondents benefited from various measures put in place by government to mitigate the impact of COVID-19. The benefits included PPEs, free water and electricity supply, loans and food items.

One hundred and eight (108) respondents indicated that there were measures taken by their association to mitigate the impact of COVID-19 on drivers. The measures included provision of PPEs, enforcement of COVID-19 protocols, sensitization, financial support, implementation of policies such as running shift, and cleaning exercises.

Seventy-six (76) of the respondents benefited from PPEs, sensitization, and financial support by the market association to mitigate the impact of COVID-19. Some markets also received support from CHRAJ, MMDAs/MMDCEs, and NADMO, present and past MPs, GHS/MoH, Hospitals, NGOs, Churches, Politicians, Banks, NCCE, Private companies and individuals, among others.

3.5.6 Barbers and Hairdressers

The State provided support such as PPEs, fumigation of shops, loans as well as the free provision of water and electricity. Some of the measures taken by their association according to barbers and hairdressers included sensitizing them on the protocols, sharing of PPEs, and helping them to secure loans. The National Board for Small Scale Industries (NBSSI) also gave relief stimulus packages to some barbers and hairdressers.

3.5.7 Road Transport

243 (70.8%) respondents indicated that their association had put in place measures to mitigate the impact of COVID-19 on its members. Most of the stations provided PPEs for their members to reduce the incidence of contracting COVID-19. The COVID-19 protocols put in place by the State were also duly enforced. Some of the stations

introduced a shift system to reduce overcrowding. Also, a number of sensitization activities were organised for the drivers on the safety protocols. In order to lessen the financial burden on the drivers, station booking fees and tickets were reduced. Financial support as well as foodstuffs were also provided to drivers in dire need. Thirty drivers indicated their household had received some support from CHRAJ, MMDAs/MMDCEs, and NADMO, present and past MPs, GHS/MoH, Hospitals, NGOs, Churches, Politicians, Banks, NCCE, Private companies and individuals, among others.

3.5.8 Hotels / Guesthouse

A substantial number, 169 (89.4%) of hotels and guest houses instituted measures to mitigate the impact of COVID-19 at their establishments. Most of them stated that the COVID-19 protocols were strictly followed by clients and staff; Veronica buckets and hand sanitizers were provided, and adherence to social /physical distance was promoted. Some hotels/guest houses also had thermometer guns to check the temperature of their customers.

Eighty-one (41.5%) of hotels/guest houses received PPEs, Veronica Buckets, tissue paper, soap, sanitizer, and liquid soap from Ghana Tourism Board, NCCE, GTA, District Assemblies, Ghana Health Service (GHS), Vector link (NGO), UNICEF and World Vision. The Ghana Health Service and the NCCE provided education and sensitization to some of the hotels on the spread as well as information on the impact of COVID-19. Some district assemblies also fumigated the hotels/guest houses in order to minimise the spread.

The Ghana Hotel Association (GHA) served as an advocate, meeting with the President and informing the public about the impact of COVID-19 on the hotel industry. The GHA supplied PPEs to their members regularly fumigated some hotels in order to minimize the spread of COVID-19. The GHA organized free training on the protocols and its importance for their members. In terms of financial support, they sought support from government so that hotels could pay salaries.

The Ghana Tourism Authority (GTA) said various sums of grants were provided for various tourism enterprises so as to alleviate the impact of the pandemic on their business operations. They also issued guidelines and protocols to be followed by all tourism enterprises in order to minimize the impact of COVID-19 on tourism enterprises. There was periodic monitoring by GTA to ensure operators adhered to these guidelines and protocols.

The GTA indicated they provided to hotels 1850 pieces of Veronica buckets, 44 pieces of temperature guns, 915 boxes of nose masks, 1832 rolls of tissue papers, 367 boxes of liquid soap, and 273 boxes of sanitizers in order to minimize the spread of COVID-19 in the tourism enterprises. In terms of sensitization, the GTA together with its regional offices organized a number of sensitization programmes for all tourism enterprises across the country.

3.5.9 Informal Settlements and Deprived Communities (Slums)

Informal settlers and deprived community members benefitted from some mitigation measures taken by the State. These included free water supply and electricity, hot meals, PPEs, sensitization, fumigation and vaccination against the virus. Regarding food, others received uncooked food items, gari, rice, beans, oil and sardines. These foodstuffs were served once a week. Similar support was received from Government, political parties, and private organizations/individuals.

3.5.10 CHRAJ

In contributing towards the anti-stigmatization fight, CHRAJ (head office), in collaboration with the United Nations Development Programme (UNDP), embarked upon a series of anti-stigmatisation and discrimination activities in selected communities; Nima, Mamobi, Madina, Old Fadama and Agbogbloshie. The selection of specific anti-stigmatisation activities was influenced by the outcome of a rapid pre-assessment exercise carried out in these communities. As part of the anti-stigmatisation activities, CHRAJ conducted a number of community training and sensitization activities including Training of Trainers (ToT), radio and TV talk shows, design and circulation of jingles, use of mobile vans in circulating anti-stigmatisation content, among others.

Furthermore, during the voter registration exercise, CHRAJ issued a press statement calling for the suspension of the voter registration exercise in the Eastern region as well as the scheduled registration exercises by both the Electoral Commission (EC) and the National Identification Authority (NIA). This press statement was released when Ghana had recorded 9 (nine) confirmed cases of COVID-19 infections traceable to persons who had travelled outside the country and returned to Ghana as residents or citizens.

As part of measures to reduce the impact of the pandemic, CHRAJ regional and district offices conducted COVID 19-related stigma and discrimination sensitization programmes, ensured compliance with the safety protocols, and also ran a shift system. The offices further ceased the opportunity to create awareness to the public that Commission's offices were still open to the public during the lock down. The public was assured of their safety when they came to lodge complaints. They were also informed of other modes of lodging complaints such as by telephone, written complaints etc.

3.6 Impact of COVID-19 on places of Formal and Informal detention[31]

3.6.1 Places of Formal Detention (Prisons and Police Cells)

Prisoners and detainees were of particular interest given the rate at which infectious diseases could spread in such closed settings as well as probable difficulty of detention facilities accessing interventions employed by the Government such as PPEs, free water and power, and other stimulus packages Therefore, as part of the 2021 SOHR, the impact of COVID-19 on places of formal detention including Police cells were assessed across the country.

3.6.1.1 Prisons

A total of 35 detention facilities were visited. Thirty-three Officers in Charge (OICs) as well as 120 inmates across 15 regions (except for Western North) of Ghana were interviewed (*see Figure 11*). The monitoring team examined and observed general conditions in the facilities. Staff from CHRAJ's head office also interacted with Ghana Prisons Service headquarters in Accra to ascertain the impact of COVID-19 on prisons.

[31] Findings pertaining to Formal (Prisons and Cells) and Informal (Shrines and camps for persons accused of witchcraft) detention facilities were treated as stand-alone and were not represented under the thematic areas of health, education etc.

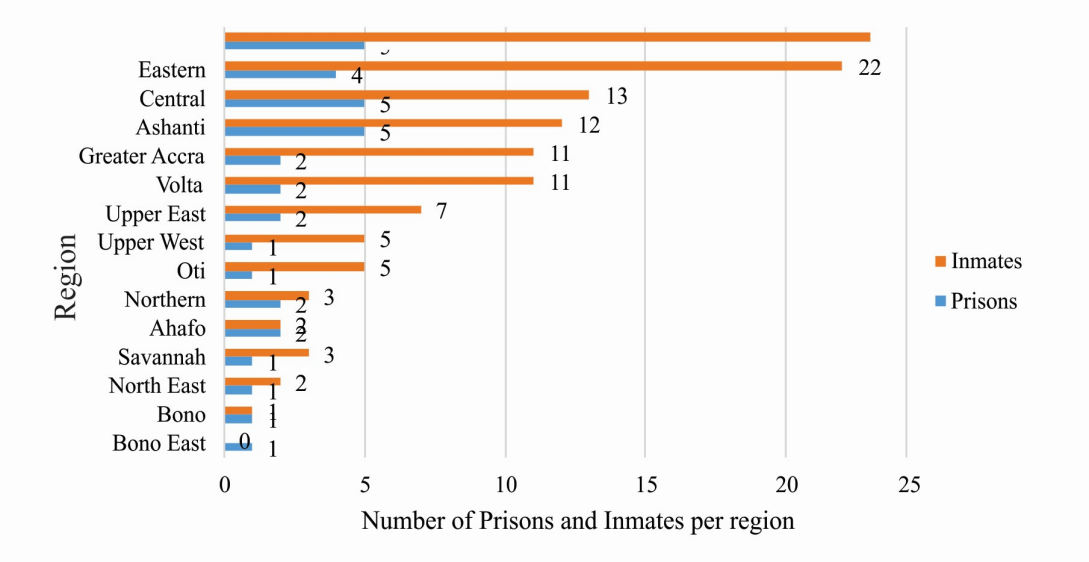

Figure 10: Number of Prisons and Inmates per Region

As depicted in Figure 11, the highest number of five (5) prisons/OICs with 23 inmates were interviewed in the Western Region followed by five (5) each in the Central and Ashanti regions with 13 and 12 inmates respectively. At least one (1) OIC each in the Bono, Bono East, North East, Upper West Volta and respectively were interviewed.

3.6.1.1.1 Impact of COVID-19 on Operation of Prison

COVID-19 had an impact on various aspects of the operations of the Prisons concerning inmates and staff (officers) including the number of convicts or remand prisoners in cells in terms of out of cell time for inmates, feeding, health care, recreation, rehabilitation and re-integration of inmates, as well as staff working hours, staff strengths etc. These are discussed in the subsequent subsections.

Accommodation of Inmates

Responses from the head office of the Ghana Prisons Service indicated that, one of their greatest challenges had always been accommodation of inmates and yet a bigger accommodation challenge confronted the service in the era of COVID-19. The structures that house inmates are not purpose-built because they had been inherited from the colonial era and were presently weak.

Given the very high numbers and yet limited space available, it was nearly an impossible task to ensure social distancing among inmates. The COVID-19 pandemic posed a threat to inmates who in the past had to grapple with infectious diseases such as Tuberculosis, Hepatitis etc.

From interactions with the OICs of the selected prisons, 16 mentioned that the number of convicts had decreased as a result of the effect of COVID-19 from March 2020. At the James Camp Prison, the cells were big enough to allow for inmates to maintain social/physical distancing and so it did not affect the number of inmates. However, there was congestion at the Koforidua and Tarkwa Local prisons. Five (5) of the prisons recorded an increase in the number of inmates. The Ghana Prison Service, Sekondi in the Western region served as a referral centre for COVID-19 suspected cases, therefore they recorded an increase in the number of inmates.

> *There was an increase in the number of convicts. Because our facility became a COVID-19 centre, most convicts from all the districts in the region were brought here.* [**OIC, Ghana Prisons Service, Sekondi-Western region**]

Interaction with OICs revealed that of the 35 prison facilities visited, the number of remand inmates decreased in 8 prisons and increased in 7 prisons between March, 2020 and November, 2021. At the Sekondi Minimum Security Central Prison, there was an increase in number of remand prisoners as a result of most people breaking the COVID-19 protocols and other minor offences being committed in the wake of COVID-19. It was also revealed that at the peak of COVID-19, there were no admission of remand prisoners at certain facilities.

Accommodation for Staff

The staff of the service also faced challenges with their accommodation. They were required to stay within close proximity to the prison facility but that was not so because of the limited accommodation for staff. A number of staff were therefore compelled to stay far away from the facility and were unable to attend to emergencies and other related demands. It was difficult to even reach them by phone in times of emergency.

Working hours

Sixteen of the OICs at the various prisons stated that COVID-19 did not affect working hours of staff as their working hours remained the same. However, at 15 of the prison facilities, their working hours reduced due to the adoption of shift system. For instance, at the Yendi Local prison, it was revealed that working hours were reduced from eight (8) hours to four (4) hours.

Number of visitors and visiting hours

Interactions with the representative from the head office of the Ghana Prisons Service revealed that a directive had been made to reduce visits to the various prison facilities. In this regard, majority (32) of the prisons visited had reduced the number of visitors and visiting hours and in some cases, visits were suspended in keeping with the directive. Five (5) of the prisons suspended visits entirely at the peak of the COVID-19. These actions and directives were to reduce the number of human interactions inmates had with persons from the outside world to prevent the infection of COVID-19. Majority (66.7%) of the inmates interacted with attested to the fact that the number of visits and visiting hours had reduced.

However, the number of visits remained the same with respect to the number of visitors as well as visiting hours for three (3) of the prison facilities, though upon condition that the COVID-19 protocols were duly followed. For instance, at the Sekondi Central Prison, the OIC indicated that inmates were allowed to see their relatives and other visitors only on condition that they complied with the COVID-19 protocols (hand washing, social distancing and the wearing of face masks).

Out of cell time for inmates

According to a representative from the head office of Ghana Prisons Service, inmates were given more out of cell time to ensure that they received enough fresh air due to the overly crowded nature of cells which could serve as a breeding ground for infections.

In our interactions with the OICs of the selected prisons, 18 indicated there was no change in the number of hours the inmates spent outside their cells and this was confirmed by majority (54.2%) of the inmates. It was revealed that in some prison facilities, the out of cell time was between ten (10) to twelve (12) hours. They were mostly allowed out at 6:00am and locked up at 5:30pm. In 12 of the prison facilities, however, the out of cell time was rather decreased and this was confirmed by 40.0% of the inmates.

Remand Prisoners (Attending Court)

The representative from the head office of the Ghana Prisons Service mentioned that during the peak of the COVID-19, around March 2020, there was a collaboration between the Prison Service, the Attorney General and the Judicial Service for the suspension of court attendances by inmates so as to reduce the risk of inmates being

infected during court attendances. This suspension was still in place but limited court attendances were allowed.

Similarly, interactions with the OICs revealed that at the height of the COVID-19, there was a directive by the Chief Justice to all detention facilities not to bring remand prisoners to court any longer due to the outbreak of COVID-19 in some courts. Twelve OICs stated that they had reduced court attendance of the remand prisoners, whereas for 11 OICs, the issues of court attendance were not applicable to them.

Feeding

At the head office of the Ghana Prisons Service, the representative mentioned that the feeding rate was still the same (Ghc1.80 per prisoner per day), though in the past, food supplies were supplemented by donations from religious bodies, NGOs, families, philanthropists, etc. However, with the onset of COVID-19 these donations had reduced because the Prison Service had restricted contact of outsiders with inmates and this affected donations by churches and institutions as they preferred to donate directly to the inmates (personal interactions) but not to donate to the facility for onward submission.

In corroboration, 26 (78.8%) of the OICs indicated that the feeding rate per day per prisoner was GHc1.80 since 2016 and remained the same during the outbreak of COVID-19. However, inmates were fed 3 times daily. The outbreak of COVID-19 affected donations/feeding support from philanthropists, NGOs, individuals. The internally generated funds (IGFs) of some of the prisons dropped thereby affecting the quantity of food provided for inmates. Four (4) prison facilities were affected in this regard. For instance, the OIC at Ghana Prisons Service, Kete Krachi in the Oti region mentioned that "Our IGF went down hence affecting quality and quantity of food served till date".

Health care

According to the representative from the head office of the Ghana Prisons Service, at the height of the COVID-19 pandemic, inmates were reluctant to seek medical care from the infirmaries or hospitals for fear of contracting the virus from hospital staff who go in and out of the facility. Therefore, the outbreak of COVID-19 affected the healthcare seeking behaviour of the inmates.

The Ghana Prison Service ensures that inmates who tested positive for COVID-19 from the police cells were returned for treatment and they were accepted only after fourteen days or more of treatment and evidence of negative test results for COVID-19. The service quarantined inmates from the courts and ensured that they followed a regime of basic sanitary protocols (washing of hands, sanitizing etc.). Specific Prisons were designated to receive these inmates from the courts. Staff who contracted COVID-19 were advised to contact the Ghana Health Service for treatment. They were encouraged to take their annual leave for full treatment.

The majority (20) of the OICs of the prison facilities indicated that the outbreak of COVID-19 did not influence or affect the health care of the inmates. Inmates with underlying conditions were still able to access the infirmaries to receive treatment. At the Ekuase Prison Camp, there was anxiety among the inmates who frequented the hospital with the slightest sickness. Three (3) facilities namely, Yeji Camp, Navrongo Central and Obuasi local prisons indicated that COVID-19 had increased the demand for health care by inmates.

Staff strength

The representative from the head office of the Ghana Prisons Service mentioned that COVID-19 did not affect staff strength. There were instances where staff who tested positive for COVID-19 were advised to self-isolate. They could only resume if they submitted a negative test result. The staff ran a shift system, because the service made deliberate attempts to reduce the number of officers in the yard. Some officers were asked to take their annual leave.

The adoption of a shift system to ease congestion at the workplace reduced the staff strength of seven (7) of the prison facilities as indicated by the OICs. However, at seven (7) of the prison facilities, new recruitment was rather done to augment the efforts of the staff present thereby increasing the staff strength. At one facility, the staff strength remained the same but with the contact hours reduced as a way of preventing the infection of COVID-19.

Capacity building for staff

In 14 of the prison facilities, it was mentioned that capacity building for staff had reduced due to the ban on mass gathering which affected trainings. However, some staff received COVID 19 related sensitization programmes. At four (4) of the prison facilities, the capacity-building programmes for staff had increased.

For instance, the staff of Ankaful Main Camp Prison in the Central region received training on mental health at Ankaful. Also, the staff of Ghana Prison Service, Kenyasi in the Ahafo region received training from NCCE, District Health Directorate, and Prison Headquarters. At the Kumasi Central Prison, Zoom platform was utilised to provide capacity building for staff.

Recreation

COVID-19 had affected recreational activities of inmates in a number of ways. For the majority (25) of the prisons visited, there was a decrease in recreational activities for the inmates. The aim of this restriction was to reduce physical contact among inmates and also in compliance with the government's directive on mass gathering. For two (2) of the prison facilities; the Ekuase Prison Camp and the Tarkwa local prisons, recreational activities were suspended pending the relaxation of the social gathering restrictions. Because of these restrictions, some facilities resorted to watching football matches and playing in-door games such as Oware, Ludo, Draft etc.

Rehabilitation and integration of inmates

Rehabilitation and integration activities at a greater number (15) of the prison facilities were greatly affected by COVID-19. The inception of COVID-19 made interactions with people difficult. Vocational activities were taught based on interest and also for inmates preparing to be released. Some were also done under strict supervision. For those with rehabilitation activities within the premises of the prison facility, their activities were not affected.

According to the representative from the head office of the Ghana Prisons Service, vocational activities were halted at most facilities and this was confirmed from our interactions with the OICs.

3.6.1.1.2 Measures to Mitigate the Impact of COVID-19

Majority (28) of the prison facilities put in place measures to mitigate the impact of COVID-19 on their operations. Some of the measures taken to recover from the impact of COVID-19 included:

- An increase in the farming income generation activities of the facility;
- Strict observance and enforcement of the COVID-19 protocols by officers, inmates and visitors;
- Introduction of a shift system for officers and for inmates learning trades or vocations;

- Vaccination of inmates and staff and insisting on receiving only vaccinated persons from the police cells;
- Provision of hand sanitizers, nose masks, washing buckets and soap for inmates;

  Restricting movement of inmates by cutting off their out of cell time;
- Sensitization of inmates and officers on the COVID-19 protocols;
- Isolation of new inmate for three (3) weeks before integration;
- Reduction in number of visitors and visiting hours;
- Soliciting support to supplement government budget;
- Ban on congregational worships at the facility.

3.6.1.1.3 Impact of COVID-19 on Vulnerable Inmates

The head office of the Ghana Prisons Service mentioned that very few vulnerable inmates were available at both the male and female prisons which made it easier for them to observe the COVID-19 preventive protocols.

Interactions with the OICs and inmates revealed that vulnerable inmates; such as pregnant or expectant women, nursing mothers, the aged, PWDS, PLWAIDs were not affected by the outbreak of COVID-19.

Measures to Protect Vulnerable Inmates

The majority (19 out of 28) prison facilities with vulnerable inmates put in place measures to protect the vulnerable inmates. At the Winneba local prisons, PLWAIDs were tested regularly and sensitized. At the Senior Correctional Centre, the service ensured that the PLWAIDS observed all COVID-19 protocols, and their needs attended to.

> *Inmates living with HIV and other underlying health conditions are separated from the others. There is an isolation facility where new inmates that are brought in are quarantined for 14 days and tested for COVID before joining the other inmates. This is done to prevent infection of inmates and the spread of COVID among inmates including the vulnerable.* [**OIC, Sekondi Prison Service, Western region**].
>
> *We don't have any of the vulnerable in this facility but should we get a PLHIV/AIDS patient, an aged inmate or person with disability,*
>
> *we have aids who will assist them in their day-to-day activities,*
>
> [**OIC, Ekuase Prison Camp, Western region]**.

At the Ankaful Maximum Security Prison, the vulnerable were educated by Planned Parenthood Association of Ghana (PPAG) and Physician assistants. Nurses also attended to them. At the Ejura Camp Prison there were daily follow up and checks on the vulnerable. The Wa Central prison, had reduced physical contact with the over -60- years old inmates. At the Obuasi Local Prisons the vulnerable were excluded from certain activities.

Despite not having any vulnerable person at some of the facilities at the time of visiting, it was mentioned that there were certain policies to protect them.

3.6.1.1.4 Incidence of COVID-19 among Staff and Inmates

According to the Ghana Prisons Service, no case of COVID-19 was reported among inmates. However, visits to the various local prison facilities revealed a total of twelve male officers and one female officer across seven (7) prison facilities infected with COVID-19. Seven (7) inmates were also infected with COVID-19 across three (3) prison facilities. (*See Table 3)*.

Table 3: Prison Facilities and number of COVID-19 cases Recorded

	Frequency of Officers and inmates contracting COVID-19			
Name of Facility	**Male officer**	**Female Officers**	**Male inmates**	**Female Inmates**
Ghana Police Service Bibiani	3		1	-
James Camp Prison	1	1	2	-
Osamkrom Prison Camp	2			
Ejura Camp Prison	1			
Kumasi Central Prison	3			
Koforidua prisons	1		4	-
Duayaw Nkwanta Settlement Camp Prison	1			
Total	**12**	**1**	**7**	**-**

Handling of COVID-19 infections

Both infected inmates and officers were isolated. Staff self-isolated for days and only returned after testing negative. Some inmates were isolated and treated at treatment centres. Infected inmates from the Osamkrom Prison Camp were isolated and sent to the hospital for treatment whereas inmates at the James Camp Prison were isolated, counselled and treated at the Pentecost Retreat centre. There were no records of officer or inmate deaths.

3.6.1.1.5 Measures to Reduce the Incidence of COVID-19

There were a number of measures put in place by the Prison authorities to reduce the incidence of COVID-19 among Officers, inmates and visitors. These included social/physical distancing, hand washing, use of sanitizer, wearing of face mask, checking of body temperature, sensitization, regular testing, and vaccination. Wearing of face mask, washing of hands, and use of sanitizer were the commonly observed preventive measures among staff, inmates, and visitors. With regard to vaccination, most of the officers as well as a good number of inmates were vaccinated as well as checks were placed by some prisons to ensure newest inmates were vaccinated.

Other measures included:

- Isolation for new entrants,
- Introduction of the shift system for officers and moving some of the inmates to empty cells, and
- Attending dining in turns.

Measures to ensure COVID-19 preventive protocols are duly observed

Interactions with OICs and inmates revealed a number of measures including sanctions and incentives to ensure that COVID-19 preventive protocols were duly observed. Officers on duty and yard masters ensured that the face masks were always worn by inmates. Staff who violated the COVID-19 directives were given various forms of punishments including extra duty, whereas inmate offenders were made to work extra, put in isolation, etc. Visitors without nose mask were turned away. For instance, at the Female Prison, Sekondi, and Senior Correctional Centre, Accra, inmates who refused to comply with the wearing of the face mask, were not allowed out of their cells. At the Wa Central Prison, visitors were turned away for not wearing nose mask.

3.6.1.1.6 Stigma and Discrimination

There were no complaints of stigma and discrimination against officers in all the 35 prisons visited. However, at the Gambaga Local Prison, there was a COVID-19 related discrimination complaint against inmates by fellow inmates. A third of the inmate population indicated they would be worried/ashamed about other inmates and officers finding out they had contracted COVID-19. They feared that they would be treated differently by officers and their co-inmates would not get close to them or mingle with them. Also, some feared to get close to an officer (20.8%) or inmate (15.8%) who had recovered from COVID-19.

Avenues to file complaints of stigma and discrimination

According to the respondent from the head office of the Ghana Prisons Service, every complaint in the yard passes through the yard master but if the issue is sensitive, one can request to see the OICs and complain directly to the person. If the case cannot be handled at the facility, it is forwarded to the head office.

Interactions with the OICs and inmates revealed the avenues to file complaints for officers which included the Senior Chief Administration Officer, Senior Chief officer, Officer in Command (OIC), Second in Command (2IC), Counselling Unit of the service, Complaints units, and COVID -19 management team. Avenues for inmates included the Cell leader, Yard Master, OIC, 21C, Chief Warder, Counselling Unit of the service, complaint unit, Senior Chief Officer in Charge of Administration, and Officers on duty.

Handling Issues of Stigma and Discrimination

At the Gambaga Local Prison, the stigmatized person was isolated and further tested to prove that he was not infected. The rest of the prisons did not have any stigma-related issues to handle. It was however mentioned that in the event of stigmatization at the facility, they would handle such through education. Others also stated that stigmatization cases would be handled by the OIC and panel hearings.

3.6.1.1.7 Water and Sanitation

On the basis that Water and Sanitation plays a key role in the prevention and management of the COVID 19 pandemic, the following were assessed.

Source and Regularity of Water Supply

Fourteen of the prison facilities had mechanised bore holes as their main source of water, whereas eight had pipe borne in addition to the mechanised bore holes. Also, five (5) had boreholes or dug wells as their main source of water. All the water sources were potable.

Most (84.8%) of the prisons had a regular (almost always - 5 or more days in a week) source of water supply, whereas for 15.2%, it was irregular (sometimes 3 or less days in a week).

Toilet Facility

Most (97.0%) of the prison facilities had flush toilets for staff, whereas the remaining one (1) used the Traditional Pit latrine. Also, most (93.9%) of the prison facilities had flush/WC toilets for inmates, whereas seven (7) had KVIP/ Traditional pit latrines.

Interviewer's Observation on Condition of Toilet and Washroom

For 23 of the prisons visited, interviewers observed and mentioned that the facilities were neat. Four (4) of the prisons visited did not have good sanitary conditions. At the Sunyani Central prison, the interviewer stated, *what we saw wasn't anything to write home about, it therefore needs attention.*

3.6.1.1.8 Health

Twenty-three of the facilities visited had only infirmaries, whereas four (4) had both infirmaries and first-aid-boxes. Also, four (4) had Hospitals/clinics (*see Figure 12*).

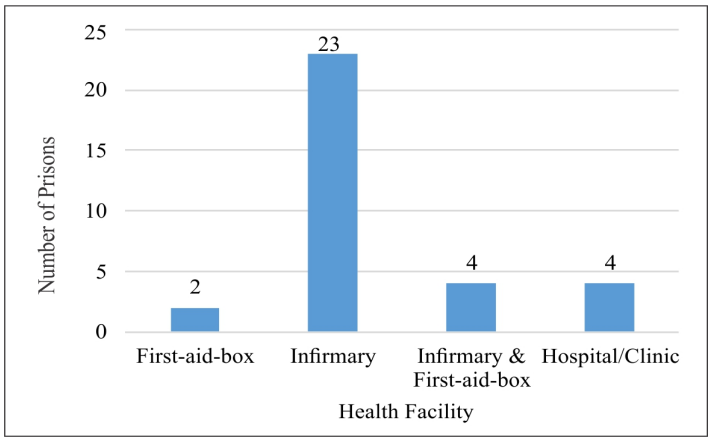

Figure 11: Health Facility available at Prison Facilities

Twenty-seven (27) of the 35 facilities were observed for adequacy of drugs. Ten (10) of the facilities had fairly stocked drugs, thirteen (13) were well stocked, and three (3) poorly stocked. The infirmary at the Bawku local prison was well stocked with a nurse stationed there. At the Sekondi Prison, the infirmary was neat with beds evenly spaced. At the Kumasi Central Prison, there was a clinic with patients on admission and a permanent doctor and a nurse were available at the facility. At the Amamfro Camp Prison, the infirmary had an attendant nurse, a bed for "lie in-patients" (very neat). At the Duayaw Nkwanta Settlement Camp Prison, the infirmary was housed in an old wooden structure. Management had managed to raise a structure up to roofing level but project halted owing to lack of funds to complete.

3.6.1.2 Ghana Police Service

The Commission interacted with the Director General of the Ghana Police Service, the director in charge of DOVVSU, the deputy director of the anti-human trafficking unit of the Ghana Police Service and a Director General representative at the head office of the Ghana Police Service. The Commission also interviewed 95 Regional and District police offices in the sixteen (16) Regions of the country.

Most (77.0%) of the centres visited at the regional and district levels were easily accessible and user-friendly for persons with physical disabilities.

3.6.1.2.1 Impact of COVID-19 on Operations

Arrests and Management of Cells

The Ghana Police Service's head office indicated that COVID-19 impacted on arrests as minimal arrests were made at the inception and peak of the pandemic. The Service was also compelled to grant bail to a number of inmates or transfer persons requiring counselling services to selected counsellors. Police officers were sometimes reluctant to effect arrests because they were not sure of those who had the virus and those who did not have. The Service therefore ensured that all persons who were to be detained were tested. Persons who tested positive were sent to the hospitals for treatment.

The number of arrests decreased in 52 (56.0%) of the police stations between March and December, 2020. Some stations were no longer detaining suspects for minor offences. Also, suspects who tested positive for COVID -19 were either isolated or not accepted into the cells. Furthermore, there were constant and occasional cleaning as well as transfer of suspects to nearby cells to ease congestion.

The Police also collaborated with Ghana Health Service (GHS) to test suspects before they were admitted into the cells.

At the peak of COVID-19, all persons in cells were tested for the virus and the cost of testing was borne by the Ghana Police Service. A major challenge for the Service was how to send people convicted by the court to the Prisons because the Ghana Prisons Service refused to accept any convicted person who was not tested into their facility, which led to overcrowding in some of the police cells.

Working Hours

The Head office of the Ghana Police Service indicated the service adopted shifts or rotation system for staff. However, during the peak of the COVID-19 pandemic, more staff were sent out onto the field to assist with operations.

Some (11) of the police stations adopted shift systems for staff to ease congestion thereby reducing the working hours of staff, whereas for others (15) their working hours increased on account that the station was under staffed. Staff strength for some (2) stations reduced at the inception of COVID-19 as staff were deployed to enforce the COVID-19 preventive protocols. However, for 57 (61.3%) police stations, staff working hours were not affected by COVID-19.

Visits

Thirty-eight of the police stations reduced number of visitors as well as visiting hours in an attempt to avoid or reduce the incidence of COVID-19 among staff and inmates. For three (3) of the police stations, visitors were not allowed at all. Though visiting hours and number of visitors remained the same for majority of 46 police stations, preventive measures were ensured.

Capacity Building for Staff

The head office of the Ghana Police Service indicated that training on COVID-19 by the Ghana Health Service was held for staff to enable them go about their work properly and safely.

3.6.1.2.2 Measures taken to mitigate the impact of COVID-19

At the head office of the Ghana Police, there were directives to guide police officers in their operations. All the police stations instituted measures to mitigate the impact of COVID-19. Some of the measures adopted included:

- Collaborated with the MMDAs, Ghana Health Service to provide education and sensitization for inmates as well as staff;
- Provided veronica buckets, hand sanitizers, soap and PPEs;
- Reduced the number of inmates in the cells;
- Tested suspects, inmates and officers who exhibited COVID-19 symptoms;
- Fumigated and disinfected cells and stations;
- Granted bail to suspects who were arrested for minor crimes;
- Vaccination of staff against COVID-19.

3.6.1.2.3 Incidence of COVID-19

Seventeen police stations recorded COVID-19 infections among staff. One hundred and fifty officers (94 males and 59 females) were infected. Some of these infected officers were supported with money and referred to other hospitals for treatment. Others were also counselled by the police medical team, isolated and treated. All the offices visited recorded no case of COVID-19 related death.

Measures taken to reduce the incidence of COVID-19

Various measures were employed by the stations in order to reduce the incidence of COVID-19 cases among staff, inmates and visitors. The police stations practiced social/physical distancing among staff, compulsory wearing of facemask among staff, inmates, and visitors as well as regular hand washing. Hand sanitizers were unavailable for the inmates in some of the police stations visited, though the majority (78.9%) of the stations were supplied with hand sanitizers for use by staff, inmates and visitors. Thermometer guns were also employed in most (66.7%) of the police stations visited.

Staff, inmates, and visitors were also sensitized on COVID-19 to help reduce its spread. Regular testing of staff and inmates was carried out in 25.0% of the police stations, whereas vaccination of staff against COVID-19 were practiced in 17.9% of the stations. In addition, the majority (62.8%) of the police stations limited staff contact with inmates.

There were also regular check-ups on inmates to ensure adherence to safety protocols and punishments were meted to those who flouted these laws. Officers who flouted the rules were removed from their posts and disciplinary action taken against them. First offenders were verbally cautioned by their District Commanders.

3.6.1.2.4 Stigma and Discrimination

At the time of visit, majority of 89 (95.6%) police stations had not recorded any complaints pertaining to stigma and discrimination.

All the police stations were reported to have confidential avenues to file complaints regarding stigma and discrimination pursuant to C.I. 96 of the Ghana Police Service. They explained that complaints were handled by the station officer and the complaints that were beyond their control were referred to the Commander and then to the Divisional Commander. If the Regional Commander was unable to resolve the complaints, they were then referred to the National level.

3.6.1.2.5 Support Received in Relation to COVID-19

All police stations visited mentioned that they had received various forms of support such as PPEs, sensitization, cash, Veronica buckets, sanitizers and liquid soap from either the MP of the area, District/Municipal assembly, Ghana Police Service (Headquarters), Ghana Health Service, Churches, Banks or CHRAJ.

3.6.1.2.6 Enforcement of COVID-19 Protocols by State Security

In enforcing COVID-19 Protocols in the country, majority (78.6%) of the police stations visited recorded a total of 1,604 (1,083 males and 501 females) arrests.
Seven (7) of the police stations indicated their staff were assaulted while enforcing COVID-19 preventive protocols. Forty-three (30 males and 13 females) officers indicated that they experienced various forms of abuse. Some of these cases were settled in court and the perpetrators prosecuted. Other culprits were cautioned and made to sign a bond upon pleading with opinion leaders.

3.6.2 Places of Informal Detention (Trokosi and Camps for persons accused of witchcraft)

The Commission has over the past years assessed the human rights situation of *trokosis* and persons accused of witchcraft. These practices are in contravention of Chapter 5, specifically Articles 15, 16 (1) (2), 17, 21, 25, 26 and 28 of the 1992 Constitution of the Republic of Ghana which spells out the Fundamental Human Rights and Freedoms of all persons and frowns on all forms of slavery, forced labour and confinement of any form.

On account of the cultural restrictions imposed on them resulting in the curtailment of their human rights and freedoms, CHRAJ assessed the impact of COVID-19 on these places of informal detention.

3.6.2.1 Trokosi

"Trokosi" has its name from a combination of two mutually exclusive Ewe (one of Ghana's major languages) words, *tro* and *kosi. Tro* means deity and *kosi* is a slave which when combined means a slave of deity[32]. Societies that practise *Trokosi* believe that when the deities are wronged by a member of a family or a clan, the repercussions are visited on the family till a member of that family atones for the wrong by relinquishing a girl child or woman preferably a virgin to serve in the slave camp[33].

Three shrines namely Torgbui Kole, Kakli and Tormife all in the Volta Region were visited. The Kakli shrine is located in the South Tongu district. The oversight Priests of these shrines, a female trokosi with the Kakli shrine, as well as three former female trokosis were interviewed. Two of these former trokosis were from the Volta Region and one was from Frankadua in the Asuogyaman District of the Eastern Region.

In all the three shrines visited, there was only one trokosi identified at Kakli shrine; a female under the age of 18 who was admitted in 2021 and had been at the shrine for six months (6) months. One other female was admitted at the Kakli shrine in 2019 but escaped in 2020.

Impact of COVID-19

None of the three shrines had recorded any case of COVID-19. It was mentioned that COVID-19 had not affected the trokosis in anyway. None of the dwellers of the shrine was taken ill of COVID-19.

COVID-19 Preventive Measures

According to the oversight priests of all the three shrines visited, COVID-19 preventive protocols such as social distancing, wearing of face mask, hand washing, and use of sanitizer were being observed by visitors to reduce the incidence of COVID-19.

[32] CHRAJ SOHR (2010)
[33] ibid

The measures put in place at the various shrines to ensure that COVID-19 protocols were duly observed included awareness creation of the need to adhere to the COVID-19 protocols including avoiding shaking hands with one another.

Right to Health

Access to Health Facility

All the three shrines visited had access to a health facility nearby. Residents of Torgbui Kole shrine accessed a CHPS compound nearby, whereas residents of Kakli and Tormife shrines accessed the Naval Base Clinic at Agorta and a district health centre which is a five (5) minute drive from the shrine, respectively.

The shrine relied on the services of the hospital for medical care. The Trokosi at Kakli usually reports to the priest when she falls sick. She expressed that "*I report to the priest who assists me to attend hospital whenever she fell sick*". Her relatives and friends usually bore the cost of her medical treatment.

Water and Sanitation

The main source of water for persons at the Torgbui shrine was pipe borne, those in the Kakli shrine was River/stream/pond/lake/dam, and those at Tormife shrine was a well which were all considered potable. Water from the pipe- borne was not regular but that from the well and the river, lake, ponds was considered regular. All the shrines had access to a toilet facility, public KVIP, and were in good condition.

3.6.2.2 Camps for persons accused of witchcraft

None of the camps (Gnani Tindang, Kpatinga, Kukuo, Leli Dabari and Naba Rufai Healing camp) visited had recorded any case of COVID-19. Interactions with dwellers and caretakers of the camps revealed that COVID-19 safety protocols (including social/physical distancing, wearing of face mask, hand washing, use of sanitizer) were duly followed.

Right to Health

Gnani Tindang, Kpatinga, Kukuo, Leli Dabari, and Naba Rufai Healing Camp residents indicated that they had access to a health care facility (hospital/clinic/CHPs) nearby.

Right to Education

Regarding access to education in five camps visited, more than 789 children had access to kindergarten, primary or secondary education.

Sources of water

Camps for persons accused of witchcraft at the Gnani Tindang, Kpatinga, Leli Dabari, Kukuo as well as the Naba Rufai Healing Camp had access to potable water from a mechanized bore hole, pipe born, river, stream, pond, lake, and dam which provided them with water for about five, three or less days in a week. There has been a steady improvement in the source of water at Kpatinga camp from bore-holes in 2009[34] to pipe- borne water when the Commission visited in November 2021.

Mitigating Measures against incidence and impact of COVID-19

At the time of visit, both caretakers and dwellers of all the Camps visited with the exception of Kukuo confirmed they received COVID-19 related and other support such as PPEs, sensitizations, and cash donations from organizations such as Municipal/District Assembly, Songtaba, UNICEF, ActionAid, MoGCSP (LEAP), Outcast Support Project, and the Roman Measures taken to Ensure Catholic Church.

3.7 Right to Water and Sanitation

On July 28 2010, through Resolution 64/292, the United Nations General Assembly explicitly recognized the human right to water and sanitation and acknowledged that clean drinking water and sanitation are essential to the realisation of all human rights. The WHO recognises access to safe drinking water and sanitation and waste management as well as hygienic conditions as essential for preventing and protecting the health of citizenry during the outbreak of COVID 19[35]. The human right to sanitation entitles everyone in all spheres of life and in all settings, without discrimination, to have physical and affordable access to sanitation that is safe, hygienic, secure, socially and culturally acceptable, and provides privacy and ensures dignity. The research looked at the source of water as well as the types of toilet facility available.

[34] SOHR (2009)
[35] Water, sanitation, hygiene, and waste management for SARS-CoV-2, the virus that causes COVID-19 (who.int).

3.7.1 Source(s) of Water

Senior and Junior High Schools

The main sources of water for the schools visited were, pipe borne, borehole, mechanized borehole, well, rain water and river/streams with the majority (95% JHS and 97.9% SHS) being potable. Also, the majority (86.8% JHS and 90% SHS) of the schools had regular supply to water [36].

Health Institutions

The majority of the hospitals (61.7%) monitored had pipe-borne water as their main source of water followed by mechanized boreholes (29.8%) and the wells (8.5%). The majority of hospitals (87.5%) had regular supply of water, whereas 12.5% had irregular supply of water.[37]

Informal Settlers

Interviews with Informal settlers cited various sources of water; pipe borne 27 (57.4%), dug wells 14 (29.8%), river/stream/pond/lake and dam 3 (6.4%) and borehole 3 (6.4%). A greater proportion 45 (95.7%) mentioned the water is potable, only 2 (4.3%) said otherwise, these two however access their water from the lake. In terms of regularity of water supply; 30 (64%) informal settlers said they had regular water supply, whereas for 17 (36%) it was irregular.

Deprived Communities (Slums)

All the households interacted with at the Deprived Communities (Slums) had a source of water; Pipe borne was the main source of water for many homes 40 (44.0%). Other sources included borehole 19 (20.9%), river/stream/pond/dam 17 (18.7%), and well 12 (13.2%). Most 73 (80.2%) of the respondents indicated that their main source of water was potable. Also, majority 59 (64.8%) had regular supply of water.

3.7.2 Type of Toilet Facility

Senior and Junior High Schools

All Senior High Schools visited (except for Bekwai SDA SHS) had access to a toilet facility. Also 16 JHSs were without a toilet facility. The types of toilet facilities that

[36] Water flow for 5 or more days in a week
[37] Water flow 3 or less days in a week.

were available to schools were flash/Water Closet, Traditional Pit latrine, and Kumasi Ventilated Improved Pit Latrine (KVIP). It was observed that 12 washrooms of Junior High Schools were either unhygienic or not in good condition. At the time of visit, the toilet facility for Adanwomase Senior High School was in poor sanitary condition.

Health Institutions

The majority of patients (93.8%) and health workers (94.9%) used the flush toilet/water closet while others used the Ventilated Improved Pit (KVIP). Apart from five health institutions all the health institutions had clean washrooms.

3.8 Stigma and Discrimination

Stigma is the negative association between a person or group of people who share certain characteristics. It also refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different. In an outbreak, this may mean people are labelled, stereotyped, discriminated against, treated separately, and/or experience loss of status because of a perceived link with a disease[38]. Discrimination can be defined as the difference in treatment on unfair grounds based on sex, race, religion, etc[39]. Stigma can lead to discrimination when the devaluation of the individual is visible through difference in treatment.

The Human Rights Committee in its General Comment 19 on Non-Discrimination explains the term "discrimination" as used in the Covenant on Civil and Political Rights (ICCPR and also based on Articles 2 and 26 of the ICPPR) as any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms

Article 17 of the ICPPR (1 &2) of Ghana's constitution states that "all persons shall be equal before the law. A person shall not be discriminated against on grounds of gender, race, colour, ethnic origin, religion, creed or social or economic status". COVID-19 has disrupted lives and livelihoods across communities and threatens the normal way of life for vulnerable populations. In Ghana, besides the many impacts of COVID-19 on the people and institution; fear, anxiety, uncertainty, rumours and

[38] *WHO &UNICEF Social Stigma associated with COVID-19*
[39] *WHO Stigma and Discrimination*

misinformation about the pandemic is also leading to stigma and discrimination toward health workers, infected people, survivors, and their families[40].

During the field visits, participants' experience of stigma and discrimination were gathered in terms of views and complaints regarding how differently people are treated in terms of social exclusion, restrictions or preference based on grounds of COVID-19 status, religion, sex, race, ethnic background etc.

3.8.1 Hospitals

A total of 34 (23.9%) and 24 (18.2%) of the hospitals received complaints of stigma/discrimination against health workers and patients, respectively.

Of the 34 hospitals, majority of the administrators 32 (94.1%) indicated some of the complaints received against health workers were COVID-19 related. Likewise, 21 (87.5%) out of 24 hospitals indicated complaints received against patients were COVID-19 related.

Nearly half of the patients 120 (48.2%) would be worried/ashamed about other patients finding out that they had contracted COVID-19 for fear of being stigmatized and discriminated against. Others indicated it was a strange disease and might lead to death.

Seventy (28%) of the patients would be worried/ashamed about health workers finding out they have contracted COVID-19 for fear of being neglected, isolated or quarantined. Similarly, 71 (28.4%) of the patients would not be willing to get closer or interact with other patients who had recovered from COVID-19 because they might not be fully recovered and can contract the virus.

Thirty-eight (38) patients representing 15.4% had actually avoided someone (staff/patient) as a result of suspicion of the person contracting COVID-19. The fear of contracting the virus was the main reason for the avoidance.

Avenues to file complaints of stigma and discrimination

For most health centres, there were similar avenues available to file complaints of stigma and discrimination against health workers and patients. Such avenues included reporting to administrators or management, disciplinary committees, rapid

[40] UNDP MTPF document - Addressing COVID-19 Related Stigma and Discrimination

response team, incidence book, grievance form, complaint box, complaint desk, information desk, counselling unit, call or contact numbers, CHRAJ, amongst others.

Complaints made to or through a complaint box, management or administration, and complaint and information desk were deemed confidential by administrators. A significant proportion 147 (59.3%) of the patients were ignorant of avenues available to file complaints of stigma and discrimination. However, when asked whether they knew about the existence of CHRAJ and its functions, 184 (73.9%) responded in the affirmative.

How stigma and discrimination related complaints were handled

Stigma and discrimination- related complaints were primarily handled through investigations, guidance and counselling, sensitization, or referrals to appropriate units or committees (including disciplinary committees) for onward actions.

3.8.2 Schools

Two Senior High Schools; Adidome SHS and Presbyterian SHS had received a total of seven (7) COVID-19 stigma and discrimination related complaints against staff. None of the Junior High Schools visited had received complaints of stigma and discrimination against staff.

Ten (4 JHS and 6 SHS) schools received complaints of stigma and discrimination against students. Of the ten (10) schools, 6 (3 JHS and 3 SHS) schools indicated that some of the complaints were COVID-19 related. With regard to the numbers of complaints, a total of 12 and 15 COVID-19 related complaints were received against students by Junior and Senior High Schools, respectively.

Interactions with students revealed that 60.9% and 24.9% of the Junior and Senior High School students, respectively would be worried/ashamed if other students discovered they had COVID-19. Also, 44.3% and 20.3% of the Junior and Senior High School students respectively would be worried/ashamed about teachers finding they have contracted COVID-19. Furthermore, 24.5% and 11.3% of the Junior and Senior High School students respectively will not be willing to get close to or interact with a student who has recovered from COVID-19. Reasons for this included fear of being discriminated against or shunned by friends/colleagues.

In addition, 21.8% and 7.9% of the Junior and Senior High School students, respectively will not be willing to interact with staff who have recovered from

COVID-19 for similar reasons as in the case of a student who has recovered from the virus. Also, 14.1% and 11.5% of the Junior and Senior High School students respectively have ever avoided someone (teacher/student) as a result of suspicions of the person contracting COVID-19.

Avenues to file complaints of stigma and discrimination

There were both internal and external avenues available to file complaints of stigma and discrimination among Senior and Junior High schools. Internal avenues included lodging complaints with the school counsellor, school chaplain, headmaster, school administrator, and disciplinary committee. External avenues include the CHRAJ, Police, GES, and Department of Social Welfare amongst others. Of these, complaints to Administrators, counsellors, head teachers and CHRAJ were considered confidential avenues. Stigma and discrimination cases were primarily handled through guidance and counselling, investigations and in some cases sanctions applied if proven.

When asked whether they were aware that CHRAJ received complaints of stigma and discrimination, a large majority of 91.4% of Senior High School students answered in the affirmative, whereas in the case of Junior High School Students, they were 44.3%.

3.8.3 Traders

Some of the traders 112 (45.0%) indicated they would be worried to disclose to other traders if they ever contracted COVID-19; they feared being stigmatized/discriminated against. Some were of the view that they would lose their customers upon revealing that they had contracted COVID-19. However, majority 137 (55.0%) would not be worried/ashamed to disclose to their fellow traders if they contracted the disease. They expressed that, COVID-19 is a pandemic and anyone could be a victim. Moreover, it is like any other disease which can be treated. Also, by keeping it to yourself, you put others at risk of contracting it.

Also, seventy-eight (representing 31.3%) of the respondents indicated that they could not get closer to someone who had recovered from COVID-19 for fear of contracting the disease. They expressed the person may not be fully recovered from the disease and could likely infect others. There was also the concern that once you get in touch with a recovered victim of COVID-19, there is the likelihood of being stigmatized. However, majority 171(68.7%) of the traders were ever ready to co-exist or get closer

to a person who had recovered from COVID-19. They were of the view that many individuals were fully recovered and could not infect anyone. Moreover, such individuals rather need our support so there is the need to welcome them while observing the safety protocols.

Avenues to file complaints of stigma and discrimination

The following were avenues for both traders and customers to lodge complaints of stigma and discrimination:

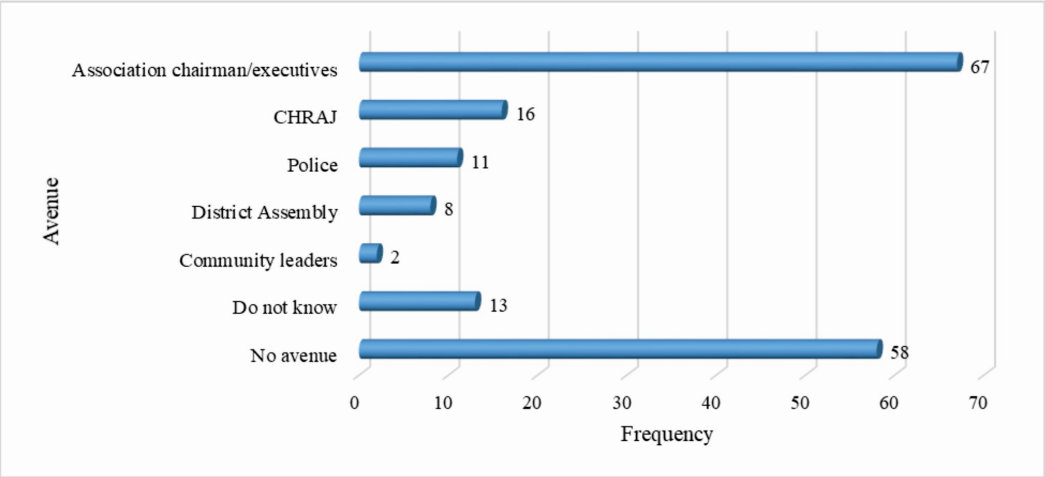

Figure 12: Avenues to lodge Complaints among Traders

3.8.4 Transportation

About 48% of the drivers surveyed indicated they would not disclose to anyone when they contract COVID-19. All the respondents who indicated they would be worried/ashamed of other person's findings out if they had contracted COVID-19 attributed it to fear of stigma and discrimination. They feared that their friends would not get close to them or mingle with them.

However, 178 (51.9%) of the respondents were not worried/ashamed to disclose to their friends. They expressed that COVID-19 is a pandemic and anyone could contract it. Also, it is just like any disease that can be contracted. Furthermore, you disclosing it will help protect others from contracting it.

Also, 105 (30.6%) of the respondents indicated that they could not get closer to a recovered victim of COVID-19 for fear of contracting the disease. Some were unsure whether the person had recovered or if they still had the ability to infect others after

recovering. Others also feared being stigmatized upon coming in contact with someone who had ever contracted the disease.

However, majority 238 (69.4%) of the drivers indicated that they did not have any problem getting closer to recovered victim of COVID-19. Their reasoning was that once a person recovers from the illness, he or she is truly cured and cannot infect anyone else.

The majority of respondents 287 (83.7%) indicated they had never avoided anyone on grounds of suspicion.

Avenues to file complaints of stigma and discrimination

The following were avenues for both drivers and passengers to lodge complaints of stigma and discrimination:

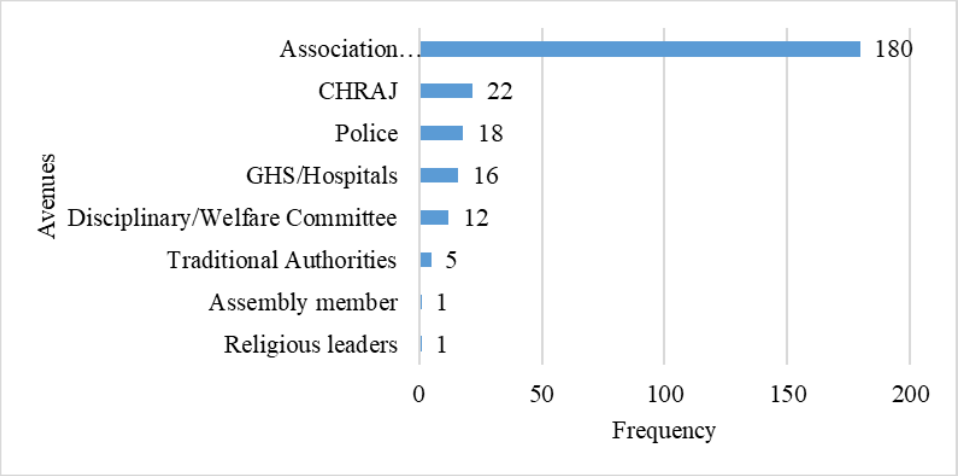

Figure 13: Avenues to File complaints among Drivers

3.8.5 Barbers and Hair Dressers

One hundred and fifty-six (156) barbers and hairdressers, representing 47.0% said they would be worried/ashamed about others finding out they had contracted COVID-19 based on the following reasons:

- Fear of being isolated;
- Fear of losing customers;
- COVID-19 is a deadly virus and can be easily contracted from one person to another;
- Fear of being shunned by the public.

However, 176 (53.0%) said otherwise. They were of the view that everybody was at risk and that the pandemic was curable. One hundred and sixteen (116) (34.9%) said they would have difficulty associating with someone who had recovered from COVID-19 for fear of getting infected. 216 (65.1%) were of the view that there was no need to fear when COVID-19 protocols are being observed, moreover, the person might have been treated and recovered.

Ninety-seven (97) of the respondents representing 30.2% said there existed avenues for filing complaints regarding stigma and discrimination. They mentioned avenues such as: CHRAJ, Police, health centre, assembly man, NCCE, court, social welfare, and chiefs' palace, Ghana Health Service, Municipal Assembly and DOVVSU. Some of the workers also said they would report to their association leaders and also to the owner of the shop. They indicated that all these avenues were confidential.

With the exception of some who mentioned that the police processed such issues to court, the rest could not state how these institutions handled issues pertaining to stigma and discrimination because they had not reported any yet.

3.8.6 CHRAJ Offices

The Commission received a complaint involving a petty trader in the Ashanti region who alleged that she suffered stigma and discrimination from her neighbours because her son contracted COVID 19. This invariably affected her business activity as a petty trader. Similar complaints were filed in the Eastern region.

3.8.7 Hotels/Guest Houses

A significant number 184 (97.9%) of the responses revealed that, there were no incidents of stigma and discrimination among the staff since the inception of the pandemic.

Furthermore, 45 (33.3%) of the responses indicated there were no internal avenues to file complaints pertaining to stigma and discrimination but stated that they could report issues regarding stigma to CHRAJ, Health officials (GHS), Police and the court. About 90 (66.7%) of the respondents stated there existed avenues to file complaints regarding stigma and discrimination. Such complaints could be lodged with the hotel manager, administrator and the front desk officer. Suggestion boxes and telephone calls were also used to file complaints for redress. There were confidential avenues available and these were usually filed with the manager, and

the front desk officer. They usually employed advice, warning and counselling to handle stigma and discrimination-related issues.

3.9 Enforcement of the Imposition of Restrictions Act, 2020 (Act 1012) and Executive Instruments on COVID-19 Safety Protocols

Foregoing discussions have established the general impact of the COVID-19 pandemic and the restrictions imposed as a result of the pandemic on the economic and social and cultural rights of the citizenry. The following section deals specifically with the enforcement of these restrictions imposed by the President of the Republic of Ghana.

3.9.1 Police

In enforcing COVID-19 Protocols in the country, the majority (78.6%) of the police officers interacted with at the selected police stations said they made a number of arrests. A total of 1,604 arrests comprising 1,083 males and 501 females were made in all the police stations visited.

Majority (91.0%) of the police stations which experienced lockdowns in their areas indicated that, there was no case of abuse in the process of enforcing the COVID-19 protocols. Nonetheless, 43 officers (30 males and 13 females) indicated that they experienced various forms of violent behavior by the public during the period of operation. Some of these cases were settled in court and the perpetrators prosecuted whereas others were cautioned, and made to sign a bond. According to them, a number of people did not comply with the COVID-19 protocols during the lockdown period, especially with regard to social distancing.

3.9.2 Health Workers and Patients

Concerning how State Security personnel handled medical staff movement to and from work during enforcement of COVID-19 protocols (especially during the lock down period), the majority of 82 administrators indicated staff were only advised to adhere to the protocols, 25 administrators said staff were asked to produce relevant documents for passage and 3 indicated staff were fined. There were no indications by administrators that their staff were abused. Only one respondent of the Presbyterian Health Centre of Enchi, Aowin in the Western North region, alleged that one male patient was physically abused by State security while on his way to receive treatment.

Interactions with 102 (92.7%) patients revealed that those who had an encounter with State security were only advised to do the needful (including being asked to comply with the COVID-19 protocols), whereas 2 (1.8%) persons were fined and 5 (4.5%) allegedly assaulted physically or verbally (caned or insulted).

3.9.3 Informal Settlers

Seven (7) informal settlers indicated they themselves or their colleagues suffered some form of assault (including being assaulted verbally or caned) by State security during enforcement of the imposition of restrictions. However, none of the seven lodged a complaint about the assault to any institution. Below were some of the experiences:

> *I was caned by a police officer* [**Abinkyi Market, Asafo Kumasi Metro, Ashanti region**]
>
> *I was insulted and asked to go home* [**Container, Asuogyaman, Eastern region**]
>
> *Someone was asked to sweep the street for failing to wear nose mask* [**Railways line, New Juaben South, Eastern region**]

3.9.4 Traders

Seven (7) market association presidents received complaints of assault meted out to traders by security personnel for flouting some of the COVID-19 preventive protocols. For instance, market association president for Lawra Main Market in the Upper West region received a complaint from a trader whose vegetables was scattered for failing to comply with the protocol. Also, a market leader for Kpone Central Market in the Greater Accra region received complaints of several traders being verbally assaulted and beaten in some cases.

Four (4) traders of different markets indicated they were assaulted either by being slapped or having their goods being destroyed by security officials.

3.9.5 Road Transport

Nineteen (19) association chairmen/station masters indicated that they received complaints of abuse by security personnel for flouting COVID-19 protocols. For instance, some drivers alleged to the association chairmen/station masters that they got slapped or caned by security officials for failing to wear face masks, whereas

some were made to sweep the environment; other passengers were disallowed from continuing their journeys.

Twelve (12) drivers indicated they were detained for hours, caned and beaten by security personnel for failing to comply with the COVID-19 protocols.

According to 35 drivers, some passengers were made to clean gutters or the compound, beaten (canned/slapped), fined, verbally abused, dropped from the vehicle or simply cautioned and forced to get mask for not complying with the protocols.

3.9.6 Barbers and Hairdressers

Thirteen (13) barbers and hairdressers indicated they themselves, colleague workers or customers got assaulted by the police for flouting the protocols. Reportedly, some were made to crawl on the floor, clean gutters, caned or arrested by the security.

3.9.7 Deprived Communities (Slums)

Six (6) respondents indicated they either suffered abuse or witnessed one being meted by a police officer while enforcing COVID-19 protocols. However, none of them made a complaint about it to any authority. Some were whipped, made to clean nearby gutters or insulted. A respondent lamented:

> *My son (who is hearing impaired) was assaulted by the police … The police did not show any interest in finding out about the condition of the child. They were only interested in enforcing the rules.*
>
> **[Dumakwai Community – Ashanti region]**

3.9.8 CHRAJ

Following media reports that the COVID 19 Security Task Force went excessively in carrying out their duties and inflicted pain on some citizens who did not follow protocol[41], the CHRAJ issued an advisory to all public bodies, including the COVID 19 Security Task Force, to carry out their mandate with caution, protecting public health and safety, and working within the framework of the Constitution and International Human Rights Instruments.

[41] Here's how people were disciplined for refusing to wear face mask. https://www.ghanaweb.com/GhanaHomePage/NewsArchive/FLASHBACK-Here-s-how-people-were-disciplined-for-refusing-to-wear-face-mask-1159499. General News of Wednesday, 20 January 2021

4.0 Conclusion

This research was conducted on the basis that Ghana as a State party to the Convention on the Economic, Social and Cultural Rights, was required to take a range of intentional, concrete and targeted measures to respond to the COVID-19 pandemic to mitigate the impact of the pandemic, particularly on those who were likely to be most affected. Persons in vulnerable situations such as self-employed workers, those in non-traditional and the informal economy as well as those living in deprived communities (slums) and informal settlements were accorded particular attention by this research. The research therefore assessed the impact of the COVID-19 pandemic on the Economic, Social and Cultural rights of the citizenry particularly persons in vulnerable situations as well as the challenges and human rights violations and abuses that arose from the enforcement of Act 1012 and the Executive Instruments (E.Is) on COVID-19 Safety Protocols.

The empirical evidence of this research established that COVID-19 affected the whole spectrum of Economic Social and Cultural rights. In the area of the right to health for instance, intake of patients in 96.5% of health institutions decreased[42] from March to December 2020. On education, the enforcement of relevant protocols as a result of the pandemic, resulted in the closure of almost all educational facilities in Ghana by late March 2020. Subsequently, 18.1% of schools shifted to distance or online learning, or radio and television, to ensure continuity of education. However, a number of schools, especially those in deprived communities, lacked the necessary infrastructure for distance or online learning. Many low-income homes could not afford the costs associated with online learning. Regarding the right to adequate standard of living, workers in the informal sector and non-traditional businesses recorded substantial reductions or losses in income. Many workers in the informal sector were laid off whilst others had their earnings reduced substantially. Some hotels, particularly in Accra and Kumasi, closed down temporarily during the peak of the pandemic. About 92% of hotels experienced booking cancellations and a marked drop in the number of customers. Seventy-one hotels and five guest houses collapsed because of the pandemic. Though not directly established by this research, women were more likely to be impacted as more women than men worked in service occupations like domestic work, open market and hospitality industries that required face-to- face interaction.

[42] Apart from hospitals and centres designated for the treatment of COVID-19

Generally, the ban on social gatherings impacted cultural rights significantly.

As regards formal detention centres, the President granted amnesty in accordance with Article 72(1) of the 1992 Constitution, to 794 prisoners resulting in a reduction of the prison population. Court attendance and visits were suspended. Recreational, educational activities, vocational workshops were curtailed, and some facilities resorted to indoor games only. Some inmates were granted bail, and some transferred to other facilities to ease congestion. The Ghana Police Service and the Ghana Health Service worked together to ensure that detained persons were tested before they were admitted to a prison facility.

There were also some positive effects of COVID-19 on ESCRs. For instance, concerning health, COVID-19 safety protocols were gradually becoming the new normal, with many institutions making hand sanitizers as well as water and soap for hand washing readily available for use by staff and clients. Also, efforts were committed by the education sector to introduce online and virtual modes of teaching and learning across all levels of education.

In terms of cultural rights, some faith-based organisations such as churches introduced online or virtual means of worship and collection of offerings and were better disciplined in terms of the duration of service.

The lockdown in March 2020 pursuant to Act 1012 and the enforcement of E.I 64, saw a number of individuals arrested for not adhering to the protocols. Also, the report documented some excesses on the part of the security personnel.

On stigma and discrimination, approximately half of the respondents interviewed said they would not want members of the community to know about their COVID-19 status for fear of stigmatisation.

Undoubtedly, the pandemic unearthed gaps that had existed over the years, particularly in Ghana's social infrastructure (health, education, etc.) that required serious attention. Socio-economic interventions such as the construction of 111 medical facilities (Agenda 111), Center for Disease Control were therefore timely and deserved commitment by the government.

The attitudinal awareness by corporate organizations and individuals to maintain hygienic and healthy sanitary conditions, as well as the promotion of simple modest social gatherings such as weddings, funerals etc., were worth sustaining.

On the whole, most respondents were pleased with the various interventions implemented by the Government such as the provision of PPEs, free water and power, hot meals, food items, stimulus package, and others, which facilitated recovery from the negative impact of the pandemic.

APPENDICES

APPENDIX A
STATEMENT BY CHRAJ ON THE STATE OF HUMAN RIGHTS AND CORRUPTION IN GHANA

STATEMENT BY CHRAJ ON THE STATE OF HUMAN RIGHTS AND CORRUPTION IN GHANA AT THE HIGH-LEVEL NATIONAL CONFERENCE TO COMMEMORATE THE IACD AND IHRD PRESENTED BY RICHARD QUAYSON, DEP. COMMISSIONER, CHRAJ

ALISA HOTEL, 10 DECEMBER 2021

1. Introduction

Your Excellency,

The statement we are about to present represent highlights of progress made in advancing fundamental human rights and freedoms and addressing corruption in Ghana. The statement is made up of extracts from research conducted by the Commission on the impact of COVID-19 on the enjoyment of human rights, and reports submitted by the stakeholders who implemented the NACAP. Other sources of information were also consulted.

Protection of Human Rights

Introduction

This year, in keeping with the Commission's mandate to assess the general observance of human rights, the Commission conducted research on the general impact of the COVID-19 pandemic on the Economic, Social and Cultural rights of the citizenry, particularly those in vulnerable situations.

The research was conducted on the basis that, Ghana as a State party to the Convention on the Economic, Social and Cultural Rights, was required to take a range of intentional, concrete and targeted measures to respond to the COVID-19[43]

pandemic to mitigate the impact of the pandemic on those who were likely to be most affected,[44] particularly the vulnerable.

The exercise examined the impact of the pandemic on various formal and informal institutions, persons particularly vulnerable in terms of being self-employed workers, those in non-traditional forms and the informal economy[45] as well as those living in deprived communities (slums) and informal settlements[46].

As of November 21, 2021, Ghana had recorded 130,827 cases of infection, 1,208 deaths and 128,855 recoveries. Greater Accra was the most affected region.[47]

Objectives

The objective is to assess:

- The impact of the COVID-19 pandemic on the Economic, Social and Cultural rights of the citizenry particularly persons in vulnerable situations.
- Human rights violations arising from the enforcement of Act 1012 and the Executive Instruments[48] (E.Is) on COVID-19 Safety Protocols.

Scope and methods

A total of **4,098** respondents were interacted with from **165** districts across the 16 regions of Ghana. Respondents were selected and interviewed using a mixed-method approach.

Findings

The Research established that COVID-19 impacted the whole spectrum of human rights[49].

[44] See Internal Human Rights Treaty Branch (HRTB) toolkit (an OHCHR doc) of treaty law perspectives and jurisprudence in the context of COVID-19. Geneva, May 2020. See also General Comment No. 14 (2000) on the highest attainable standard of health, E/C.12/2000/4, para. 65.
[45] See Committee on Economic, Social and Cultural Rights, General Comment No. 18 (2006) on the right to work, E/C.12/GC/18, paras. 6, 7, 11, 12, 19 and 31.
[46] UNSDG (2020) COVID-19 and Human Rights. We are all in it together. UN Sustainable Development Group (UNSDG)
[47] Statista. Number of new daily coronavirus (COVID-19) cases in Ghana as of November 21, 2021 https://www.statista.com/statistics/1110883/coronavirus-cases-in-ghana/
[48] Imposition of Restrictions Act, 2020 (Act 1012).
[49] See Internal Human Rights Treaty Branch (HRTB) toolkit (an OHCHR doc) of treaty law perspectives and jurisprudence in the context of COVID-19. Geneva, May 2020.

The Right to health

The ICESCR requires State parties to the Convention, to take steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases". From March to December 2020, apart from hospitals and centres designated for the treatment of COVID-19, intake of patients reduced in 96.5% of health institutions. However, intake started improving in 2021.

Right to Education[50]

The Right to Education includes availability and accessibility of functioning educational institutions and programmes in sufficient quantity. The pandemic had severe impact on the right to education.

By late March almost all educational facilities in Ghana had closed. Subsequently, many schools shifted to distance or online learning, or radio and television, to ensure continuity of education. However, a great number of schools, especially those in deprived communities, lacked the necessary infrastructure for distance or online learning. Many low-income homes could not afford the cost associated with the online learning.

Right to adequate standard of living

This considered how the pandemic affected persons and groups in vulnerable situations such as self-employed and workers in non-traditional and the informal economy. These include open market traders, barbers and hairdressers, street venders or hawkers, drivers and station masters in the private road sector, and basic conditions of livelihood of those living in deprived communities and informal settlements.

Majority of workers in the informal sector and in non-traditional businesses recorded substantial reduction or loss in income. The ban on social gatherings impacted them more disproportionately than others. Many workers in the informal sectors were laid off whilst others had their earnings reduced substantially.

According to The Ghana Hotels Association (GHA), some hotels, particularly in Accra and Kumasi, closed down temporarily during the peak of the COVID-19 pandemic. About 92% of hotels experienced booking cancellations and a marked

[50] Article 13 of the Covenant

drop in the number of customers. Seventy-one hotels and five guest houses collapsed because of the pandemic.

The pandemic also extended the existing inequalities, and disproportionately affected women and persons in low-income jobs. For example, more women than men work in service occupations including domestic work, restaurant services, open market, and hospitality industries that required face –to- face interaction were hard hit by the layoffs.

Places of Formal Detention (Prisons and Police cells)

Prisoners and detainees were of particular interest given the rate at which such infectious diseases could spread in such closed settings.

In the wake of the pandemic, and in accordance with Article 72(1) of the 1992 Constitution, the President granted amnesty to 794 prisoners[51]resulting in a reduction of the prison population.

Court attendances as well as visits were suspended. Recreational, educational activities, vocational workshops were curtailed, and some facilities resorted to in-door games only. Some inmates were granted bail, and some transferred to other facilities to ease congestion.

The Ghana Police Service and the Ghana Health Service worked together to ensure that detained persons were tested before they were admitted to a prison facility.

The records show that no inmate contracted COVID-19.

Stigma and Discrimination

For fear of stigmatisation, approximately half of the respondents said they would not want members of the community to know about their COVID-19 status.

Enforcement of Act 1012 and Executive Instruments on COVID-19 Safety Protocols.

Pursuant to Act 1012, measures were taken to contain the spread of COVID-19, including lockdown in March 2020. The measures introduced were considered timely given the public health risk that the pandemic poses. However, the implementation

[51] President grants Amnesty to 794 prisoners – Business Ghana

of the law saw some excesses on the part of the security personnel. A total of 1,604 individuals were arrested for not adhering to the COVID-19 safety protocols.

Some of the respondents claimed they were victims of human right violations, while others claimed they witnessed violations by security personnel who were enforcing the COVID-19 safety protocols, including flogging, beating and insults.

Mitigating Measures by the State

Most of the respondents said the Government's interventions helped them to recover from the negative impact of the pandemic. The Government interventions include provision of PPEs, free water and power, hot meals, food items, stimulus package, and others.

Conclusion

The COVID-19 pandemic, and the measures put in place to curtail the spread of the pandemic, affected different rights enshrined in the national constitution and international human rights instruments. Those particularly affected include the rights to health, education, work**,** adequate shelter, and food; freedom of movement, religion and assembly.

On the other hand, there is empirical evidence to show that our collective response to the pandemic produced many positives.

Before the pandemic, majority of schools in Ghana only employed the face-to-face method of instruction. With the emergence of the pandemic, innovatively, online modes of teaching and learning were introduced by some schools. Relatedly, the introduction of virtual trainings and meetings for public and private institutions, and the growing acquaintance with video conferencing software, is gradually becoming the norm.

The pandemic has unearthed gaps that existed particularly in Ghana's social infrastructure (health, education, etc.) that must be addressed. Long term socio-economic interventions such as the construction of 111 medical facilities (Agenda 111), Center for Disease Control and many more are welcome since they will help reduce inequalities.

The attitudinal awareness by corporate organizations and individuals to maintain hygienic and healthy sanitary conditions, as well as the promotion of simple modest social gatherings such as weddings, funerals etc., are worth sustaining.

The efforts by the Criminal Justice System to reduce custodial sentences for minor offences and the claim that no inmate in adult prisons contracted the virus is commendable.

On this international Human Rights Day, as we reflect on the theme "Equality: Reducing Inequality, Advancing Human Rights", may we concretely and intentionally, seek to bridge the gaps unearthed by the pandemic in the promotion of the fundamental human rights for all. May we seek to reduce inequality and advance Economic, Social, and Cultural rights of all persons, particularly those in vulnerable situations, so as to ensure that no one is left behind.

Dated at the CHRAJ, this 10th Day of December 2021

APPENDIX B

GENERAL GUIDELINES

- Print questions to take along during field work, carry a note pad to record responses and additional notes;
- Checklist should NOT be given to officers of the institution to complete (a copy of the segment on statistical data could be given to respondents to complete and returned a day or two after the interview). Officers should follow up diligently on this;
- If it becomes necessary to use a recorder, seek consent. Employ short hand where necessary and later expand notes;
- Be familiar with concepts such as stigma and discrimination as employed by the tool;
- Seek consent before taking pictures. Do not target faces but scenes that will strongly complement your responses;
- In open ended questions, record exactly the responses of the respondent, do not add your impressions or interpretations;
- If a question is not applicable, don't merely skip, state it is not applicable so we do not categorize it as an oversight;
- State in full all acronyms;
- CHRAJ is not a welfare institution-NO promises should be made. Just explain clearly the objectives of the exercise and the three (3) pronged mandates of the Commission;
- Transfer responses to online google forms as soon as your full set of responses are ready.

APPENDIX C

SAMPLE CHECKLISTS

COMMISSION ON HUMAN RIGHTS & ADMINISTRATIVE JUSTICE (CHRAJ) IMPACT OF COVID-19 ON ESC RIGHTS OF THE GHANAIAN CITIZENRY AS PART OF THE OBSERVANCE OF THE STATE OF HUMAN RIGHTS IN 2021

PUBLIC AND PRIVATE HOSPITALS

To be administered to the person in charge (Administrator)

Checklist should NOT be given to officers of the institution to complete

CHRAJ Regional / District office:

_____

Name of CHRAJ monitoring officer (s):

_____

Date of interview: _____

A. Background Information of Institution

Name of institution:

_____

2. Region & district of institution:

_____

1. Mailing Address of institution:……..
4. Physical location/GPS address of institution:……..
5. Phone numbers of institution:……
6. Email address of institution:……...
7. Is this institution accessible to persons with physical disability?
   - **Yes**
   - **No**

B. Quality of Facility, Services & Personnel[52]

1. What is the staff strength?

Male_____ Female_____

2. How many people access health care from the hospital per day on the average?

Patients	**Male**	**Female**
Number of Outpatients		
Number on Admission		

3. What is doctor to patient ratio?.....
4. What is the nurse-to-patient ratio?.....
5. a) Does this institution have an ambulance service?
   - Yes
   - No

b) If yes to 5(a),

Ambulance	**No.**
No. functional	
No. non-functional	

c) Is the number of ambulance(s) adequate? ……

d) If no to 5(a), how are patients conveyed to other facilities?.....

[52] International Human Rights Instruments, Section 1, General Comment 14.12d

6. a) Does this institution have adequate facilities to provide patients consultation, examination & treatment?

Area	Yes	No
Consultation		
Examination		
Treatment		

b) If no, please explain:……

C. Availability of Drugs

1. a) Are all essential drugs[53] available at this institution?
   - □ Yes
   - □ No

   i. If no, please list essential drugs needed:…….

   b) Are these drugs covered under NHIS?
   - □ Yes
   - □ No
   - □ Not all drugs

   c) Did COVID-19 affect availability of essential drugs?
   - □ Yes
   - □ No

   d) If yes to (c) How did COVID-19 affect it?.....

   e) What measures have you taken to address shortage of essential drugs?

_____

D. Water and Sanitation

1. a) What is the **main** source of water?
   - □ Pipe borne
   - □ Well
   - □ River/stream/pond/lake/dam
   - □ Rain water
   - □ Other (please specify) _____

   b) Is this water potable?
   - □ Yes
   - □ No

[53] According to WHO, essential medicines are the medicines that satisfy the priority health care needs of the population

c) How regular is the water supply?

- Almost always – 5 or more days in a week
- Sometimes – 3 or less days in a week

3. What type of toilet facility is available for Staff? (Please tick as many as apply)

- Flush/WC
- Ventilated Improved Pit Latrine (KVIP[54])
- Traditional Pit Latrine
- No facility
- Other (please specify)

_____

4. What type of toilet facility is available for patients? Please tick where applicable

- Flush/WC
- Ventilated improved pit latrine (KVIP)
- Traditional pit latrine
- No facility
- Other (please specify)

_____

5. What is the number of toilet[55]/washroom facilities for staff and patients?

Gender	Staff	Patients
Male		
Female		

Interviewer's observation on toilet/washroom facilities (Take pictures if possible; seek permission before taking them)

_____

E. Impact of COVID -19 on Service Delivery

1. a) How did the COVID -19 affect the following areas from March to December, 2020? **Kindly explain**

[54] Ventilated improved pit latrines, commonly known as VIP latrines, are an improvement to overcome the disadvantages of the simple pit latrines. The main problems associated with traditional simple pit latrines, i.e. fly and mosquito nuisance and unpleasant odors are effectively minimized by the action of a vent pipe, fly screen and a squatting cover in the VIP latrines

[55] Number of toilet seats

Areas	Response (increase/decrease, ability to meet demand)
Intake of patients	
Number of recorded teenage pregnancies	
Management of units/wards	
Working hours	
Visits (Number of visitors and visiting hours)	
Staff strength	
Salary/allowances of workers	
Medical supplies	
Others (please specify)	

b) What is the effect of COVID-19 pandemic on the following areas from January, 2021 till date? **Kindly explain**

Areas	Response
Intake of patients	
Number of recorded teenage pregnancies	
Management of units/wards	
Working hours	
Visits (Number of visitors and visiting hours)	
Staff strength	
Salary/allowances of workers	
Medical supplies	
Others (please specify)	

2.a) Have there been measures taken by the hospital administration to mitigate the impact of COVID -19 in these areas? (**Policies, Reliefs-stimulus packages**)

- Yes
- No

b) If yes, specify:…….

3.a) Have there been measures taken by the State to mitigate the impact of COVID -19 in these areas? (**Policies, Reliefs-stimulus packages**)

- Yes
- No

b. If yes, specify _____

4. a) Does your facility have policy on paid extended sick leave for staff?

- Yes
- No

b) If yes, does it cover those who contracts COVID-19?

- Yes
- No

d) If yes, kindly explain: _____

5.a) Does your facility have policy on child care for staff?

- Yes
- No

b) If yes, kindly explain:…….

6. How does your facility handle suspected COVID-19 cases? (Tick as many as apply)

Measures	**Explanation**
Testing of suspected patients	
Referral of covid-19 confirmed cases	
Availability of special wards and units for COVID-19 related cases	
Availability of special equipment, including ventilators, for COVID-19 patients who need them	
Separation of patients with COVID-19 from patients with other infectious diseases	
Quarantine of persons exposed to COVID-19	
None of the above	
Other (please specify) ……	

7. a) Does your Centre provide psychological counselling for persons with the COVID-19 to manage stress, fear, anxiety and trauma?

- Yes
- No

b) If yes to 5 (a), who provides the counselling?

_____

8. How did COVID-19 affect the health care needs of the following group of persons?

Vulnerable Group	**Explain**
Children	
Pregnant or expectant women	
Nursing mothers	
The aged population (60 and above)	
Persons with Disability (PWDs)	
Persons living with HIV/AIDs	
Persons with underlying health Conditions	

9. a) Does your facility have special measures in place to protect these vulnerable patients who access your services?

- Yes
- No

b) If yes, kindly describe the measures:

Vulnerable Group	**Explain**
Children	
Pregnant or expectant women	
Nursing mothers	
The aged population (60 and above)	
Persons with Disability (PWDs)	
Persons living with HIV/AIDs	
Persons with underlying health Conditions	

10. What measures have the hospital administration taken to reduce the incidence of COVID-19 cases among **staff, patients, and visitors** since its inception? (**Please tick as many as apply)**

Measures	**Staff**	**Patients**	**Visitors**
Social/physical distancing			
Wearing of face masks			
Hand washing			
Use of sanitizer			
Checking of Temperature			
Sensitization			

Regular testing			
Vaccination			
Limiting staff's contact with patients			
Others (Specify)_____			

11. What measures (including sanctions/incentives) has the hospital administration put in place to ensure protocols are duly observed?

_____

Interviewer's observation on the availability of water for hand washing, social distancing, sanitizer at vantage points, and the wearing of facial masks and comments below

(Take pictures if possible; seek permission before taking them)

_____

F. Incidence of COVID-19

1. a) Did you record any case of COVID-19 infection among?

i. Health workers □ Yes □ No

ii. Patients □ Yes □ No

b) If yes to (i) and (ii), kindly indicate how many.

No.	**Male**	**Female**
Health workers		
Patients		

c) If yes to (i) and/or (ii), how was it handle: _____

d) Who bore the cost of treatment?

Group	**Bearer of cost**
Health workers	
Patients	

2. a) Did you record COVID-19 related deaths at your centre?

i. Health workers □ Yes □ No

ii. Patients □ Yes □ No

iii. New born Infants[56] □ Yes □ No

b) If yes to (i), (ii) and (iii) kindly indicate how many.

No.	Male	Female
Workers		
Patients		
Infants		

G. Impact of COVID-19 on the Right to Physical & Mental Health for Persons with Disabilities[57]

1. Does the hospital render services to these group of people?

Group	Yes	No
Persons with physical disability		
Persons with intellectual, sensory or mental disability		

2. Did COVID-19 affect accessibility of health care to the following group of persons?

Group	Yes	No
Persons with physical disability		
Persons with intellectual, sensory or mental disability		

3. If yes to (2), how did COVID-19 affect accessibility of health care:

Group	Explanation
Persons with physical disability	
Persons with intellectual, sensory or mental disability	

4. What measures has your facility put in place to mitigate the effects thereof?

_____

H. Impact of COVID-19 on the Right to Maternal Health[58]

[56] The World Health Organization (WHO) defines a newborn infant, or neonate, as a child that's under 28 days old

57 International Human Rights Instruments, Section I, General Comment 5.34

[58] International Human Rights Instruments, Section I, General Comment 14.14

1. a) Does the hospital have facilities for the following services[59]?

Service	Yes	No
Prenatal Care		
Neonatal Care		
Postnatal Care		

b) If yes to 1(a), which of the services was affected by COVID-19?.....

c) If yes to (b), how did COIVID 19 affect the service?.....

d) What measures did your facility put in place to mitigate the effects thereof?.....

I. Impact of COVID-19 National Health Insurance Scheme

1. Is your facility an accredited NHIS service provider?
   - Yes
   - No
2. a) Did COVIDI 19 affect NHIS service?
   - Yes
   - No
   - Do not know

   b) If yes to (a), how did COVID-19 affect the service?.....

3. a) Does NHIS cover the treatment for COVID-19 patients?
   - Fully covers
   - Partially covers
   - No

b) If NHIS covers partially, kindly explain aspects it covers:

_____

J. Stigma & Discrimination[60]

1. Have you received complaints of stigma/discrimination against health workers?
   - Yes
   - No

[59] International Human Rights Instruments, Section I, General Comment 14.14; International Human Rights Instruments, Section I, General Comment 14.21

[60] Stigma: Attitudes and beliefs based on prejudices, stereotypes usually on grounds of religion, sex, race, ethnic background etc.
Discrimination: Visible difference in treatment of others (such as being afraid to physically associate eat, sit by, etc) usually based on prejudices, stereotypes on grounds of religion, sex, race, ethnic background etc.

2. a) If yes to (1), are some of these complaints COVID-19 related?

- Yes
- No

b) If yes to 2(a), how many?

- Male_____
- Female_____

3. What were the sources of stigma/discrimination? (Tick as many as apply)

- Fellow staff
- Patients
- Administrative staff
- Others (please specify) _____

4. Have you received complaints of stigma/discrimination against patients?

- Yes
- No

5. a) If yes to (4), are some of these complaints COVID-19 related?

- Yes
- No

b) If yes to 5(a), how many?

Male_____

Female_____

6. What were the sources of stigma/discrimination? (Tick as many as apply)

- Fellow staff
- Patients
- Administrative staff
- Others (please specify) _____

7. a) What avenues are available to file complaints of stigma and discrimination for:

i. Health workers _____

ii. Patients_____

b) Which of these avenues is/are confidential? :_____

8. How were complaints of stigma handled?.....

K. Support Received in Relation to COVID-19

1. What form of support have you received since the inception of COVID-19? (Tick as many as apply)

Type of support	Name of organisation(s)
□ PPEs	
□ Ventilators	
□ Sensitizations	
□ Cash	
□ Others (please specify) _____	

2. What is the level of State support to health care delivery in these times of COVID-19 pandemic as compared to previous years when COVID-19 was non-existent?

Type of support	Remarks (Excellent / Satisfactory / Poor)	Kindly Explain
□ PPEs		
□ Ventilators		
□ Sensitizations		
□ Cash		
□ Others (please specify) _____		

L. Enforcement of COVID-19 Protocols by State Security

1. a) How did State security personnel handle staff movement to and from work during the period of lockdown and/or enforcement of COVID-19 protocols?
   - □ Advised to do adhere to COVID-19 protocols
   - □ Insisted staff produce relevant document for passage
   - □ Fined
   - □ Abused
   - □ Nothing
   - □ Others (please specify) _____

b) If abused, kindly indicate the form (verbal assault, physical assault) and explain:

_____

_____

2. a) Did any of your patients' report having been physically abused (beaten, slapped, etc) by State security whiles on his way to receive treatment during the period of lockdown and/or enforcement of COVID-19 protocols?

   Yes

   No

   b) If yes, how many?

   Male_____

   Female_____

2. a) Did you treat any patient who was physically abused (beaten) by security personnel as a result of enforcement of COVID-19 protocols?

   Yes

   No

   b) If yes, how many?

   Male_____

   Female_____

M. Additional Comments, Observations & Recommendations

_____

COMMISSION ON HUMAN RIGHTS & ADMINISTRATIVE JUSTICE (CHRAJ) IMPACT OF COVID-19 ON ESC RIGHTS OF THE GHANAIAN CITIZENRY AS PART OF THE OBSERVANCE OF THE STATE OF HUMAN RIGHTS IN 2021

PATIENTS/CLIENTS – General Hospital
To be administered to Patients/Clients

Checklist should NOT be given to patients/Clients to complete

CHRAJ Regional / District office: _____

Name of CHRAJ monitoring officer(s): _____

Date of interview_____

A. Background Information of Institution

1. Name of institution:…….

2. Region & district of institution:…….

3. Category of Patients
   - Pregnant women
   - Nursing mother
   - Aged (60+)

- Persons with Disability (Physical/ Intellectual, Sensory & Mental/ Persons with Albinism)
- Any other Patient

4. Is this institution accessible to persons with physical disability?
   - **Yes**
   - **No**

B. Accessibility to Healthcare[61]

1. Where do you live?
2. How do you get to this facility?
   - Walking
   - Bicycle
   - Motorcycle
   - Automobile

3. How long does it take you to get to this institution?
   - 0 minutes – 20 minutes
   - 20 minutes – 40 minutes
   - 40 minutes – 60 minutes
   - 60 minutes +

4.a) Is this the closest facility to your residence?
- Yes
- No

b.) If no, why do you access health care at this facility?

C. Availability of Services[62]

1. How long did you have to wait before you were seen today?

   - 0 minutes – 30 minutes
   - 30 minutes – 1 hour
   - 1 hour – 2 hours
   - 2 hours – 3 hours
   - 3 hours – 4 hours
   - 4 hours – 5 hours
   - 5 hours – 6 hours
   - 6 hours +

[61] International Human Rights Instruments, Section I, General Comment 14.12b, The Ghana Health Services Patient Charter, Right 1

[62] International Human Rights Instruments, Section I, General Comment 14.12a

2. Did you receive the services you sought for today?

- Yes
- No

3. Did the hospital disclose the full details of your health condition to you?

- Yes
- No

4. Are you satisfied with services provided?

- Yes
- No

5. What challenges do you face in terms of accessing health care?.....

This section is to be administered to persons in vulnerable situation (Pregnant women, Nursing mothers, aged (60+), PWDs, persons with underlying health conditions)

6. a) Are there special measures in place to protect persons in vulnerable situations?

- Yes
- No

b) If yes, kindly explain: …….

D. Affordability

1. a) Are you registered under the NHIS?

- Yes
- No,

b) If no to 1(a), kindly indicate why:……

c) If yes to 1(a), is your subscription active?

- Yes
- No

e) If no, kindly indicate why NHIS subscription has not been renewed?.....

e). If yes to 1(a), do you access health care under the NHIS?

- Yes
- No,

f) If no, kindly indicate why

E. Stigma & Discrimination[63]

1. Please tick as applicable;

No	Items	Yes	No	Explanation
a	Will you be worried / ashamed about other patientgs finding out you have contracted COVID-19?			
b	Will you be worried/ashamed about health worker finding out you have contracted COVID-19?			
c	Will you have problem getting closer or interacting with other patients who has recovered from COVID-19?			
d	Have you avoided anyone (staff / patient) as a result of suspicion of the persons contracting COVID-19?			

2. a) Do you know of any avenues to file complaints of stigma and discrimination?

- Yes
- No

b) If yes, kindly indicate

_____

3a. Have you heard of the CHRAJ?

Yes No

b) If yes, what do you know about the CHRAJ?.....

4. Are you aware that CHRAJ receives complaints of persons who are shunned or treated differently by others?
   - Yes
   - No

[63] Stigma: Attitudes and beliefs based on prejudices, stereotypes usually on grounds of religion, sex, race, ethnic background etc.
Discrimination: Visible difference in treatment of others (such as being afraid to physically associate eat, sit by, etc) usually based on prejudices, stereotypes on grounds of religion, sex, race, ethnic background etc.

F. Complaints[64]

1. Are you aware of your right to submit a suggestion or complaint at this institution?

- Yes
- No

2. If you had a suggestion or complaint, how would you go about submitting it?.....

G. Enforcement of COVID-19 Protocols by State Security

1. a) How did state security personnel handle you during the period of lockdown and/or enforcement of COVID-19 protocols?

- Advised to do the needful (including complying with COVID-19 protocols)
- Fined
- Abuse
- Nothing
- Others (please specify) _____

b) If abused, kindly indicate the form (verbal assault, physical assault) and explain:……

H. Additional Comments, Recommendations & Observations

_____

[64] The Ghana Health Services Patient's Charter, Right 10

COMMISSION ON HUMAN RIGHTS & ADMINISTRATIVE JUSTICE (CHRAJ) IMPACT OF COVID-19 ON ESC RIGHTS OF THE GHANAIAN CITIZENRY AS PART OF THE OBSERVANCE OF THE STATE OF HUMAN RIGHTS IN 2021

JHS/SHS SCHOOLS – Head Master/Mistress
To be administered to school HEADS in the regions.

Checklist should NOT be given to officers of the institution to complete

CHRAJ Regional / District office: _____

Name of CHRAJ monitoring officer(s):

_____

Date of interview: _____

A. Background Information of Institution

1. Name of institution: ……
2. Region & district of institution:…….
3. Mailing address of institution:……..

4. Physical location/GPS Address of institution:……

5. Phone number(s) of institution:……..……

6. Email address of institution:……..

7. What level of institution is this?

   - Junior High School
   - Senior High School

8. Category of school

   - Day school
   - Boarding School
   - Day and Boarding School

9. Is this institution accessible to persons with physical disability?

   - **Yes**
   - **No**

B. Statistics

1. Please provide total population disaggregated by sex;

Class	**Male**	**Female**
JHS / SHS 1		
JHS / SHS 2		
JHS / SHS 3		
Total		

C. Availability[65]

1. How many communities does this institution serve? (***Only JHS***)
   - 1
   - 2
   - 3
   - 4
   - 5 or more

[65] International Human Rights Instruments, Section I, General Comment 13.6a

D. Impact of COVID-19 on teaching/learning

1. a) Please indicate the methods of teaching;

	Methods (**Tick as many as apply**)
Before COVID-19	□ Face to face □ Online □ Others (please specify)_____
During COVID-19	□ Face to face □ Online □ Others (please specify)_____

b) If online, what have been the challenges in the following areas? (**Tick as many as apply**)

Challenge	**Explanation**
□ Computers for teachers	
□ Computers for pupils	
□ Internet connectivity	
□ Internet data/bundle	
□ Level of participation	
□ Others (please specify) _____	

2. How did COVID-19 affect the following areas since its inception?

Area	**Explanation**
Enrolment	
Attendance	
Teaching	
Learning	
Class size	
Teaching Hours	
Teaching & Learning Materials	
Staff strength	
Capacity building of staff	
Revenue[66]	
Others (please specify) _____	

[66] Private school

3a). Has the State put in measures to mitigate the impact of COVID-19? (**Policies, reliefs-stimulus packages**)

- Yes
- No

b. If yes, specify:…….

4.a) Has the school administration put in place measures to mitigate the impact of COVID-19? (**Policies, reliefs-stimulus packages**)

- Yes
- No

b) If yes, specify:…….

E. Incidence of COVID-19

1.) Did you record any case of COVID-19 infection among?

a. Staff □ Yes □ No
b. Student □ Yes □ No

c) If yes to (a) and (b), kindly indicate how many.

No.	Male	Female
Staff		
Student		

d) If yes to 1(a), how was it handled?.....

2. Did you record COVID-19 related deaths in your school?

a. Staff □ Yes □ No
b. Student □ Yes □ No

c) If yes to (a) and (b) kindly indicate how many.

No.	Male	Female
Staff		
Student		

3. What measures has the school administration put in place to reduce the incidence of COVID-19 cases among **staff, students, and visitors**? (**Please tick as many as apply)**

Measures	Staff	Students	Visitors
Social/physical distancing			
Wearing of face masks			
Hand washing			

Use of sanitizer			
Checking of Temperature			
Vaccination			
Sensitization			
Others (Specify)_____			

4. What measures (including sanctions/incentives) has the school administration put in place to ensure that the COVID-19 protocols are duly observed?

…….....

*Interviewer's observation on the availability of water for hand washing, social distancing, sanitizer at vantage points, and the wearing of facial masks and comments below (**Take pictures if possible; seek permission before taking them**)*

_____

F. Impact of COVID-19 on Right to Education for Persons with Disability[67]

1. a) Are there students with disabilities at this school?

- Yes
- No

b) If yes, how many have;

Type of disability	**No. of students**
Physical	
Intellectual (i.e. learning or social)	
Sensory (i.e. blindness or deafness)	
Mental (i.e. down syndrome or autism)	

2. a) Did COVID-19 affect persons with disabilities?

- Yes
- No

b) If yes to 2(a), how did COVID-19 affect these group of students?

Type of disability	**No. of students**
Physical	
Intellectual	

[67] International Human Rights Instruments, Section I, General Comment 5.35; International Human Rights Instruments, Section I, General Comment 13.6b

(i.e. learning or social)	
Sensory (i.e. blindness or deafness)	
Mental (i.e. down syndrome or autism)	

2. What measures have the school administration put in place to mitigate the effects of COVID-19 on students with disabilities?

_____

4a) Has the school administration put in place special instructions or services in place to assist students with intellectual, sensory or mental disabilities to follow the COVID-19 protocols?

- Yes
- No

b) If yes, please explain what services are in place

_____

G. Stigma & Discrimination[68]

1. Have you received complaints of stigma/discrimination against staff?

- Yes
- No

2. a) If yes to 1(a), are some of these complaints COVID-19 related?

- Yes
- No

b) If yes to 1(a), how many?

Male_____

Female_____

3. Have you received complaints of stigma/discrimination against students?

- Yes
- No

[68] Stigma: Attitudes and beliefs based on prejudices, stereotypes usually on grounds of religion, sex, race, ethnic background etc.
Discrimination: Visible difference in treatment of others (such as being afraid to physically associate eat, sit by, etc) usually based on prejudices, stereotypes on grounds of religion, sex, race, ethnic background etc.

4. a) If yes to (3), are some of these complaints COVID-19 related?

- ☐ Yes
- ☐ No

b) If yes to 4(a), how many?
Male_____
Female_____
5. What were the sources of stigma/discrimination? (Tick as many as apply)

- ☐ Fellow teachers
- ☐ Students
- ☐ Others (please specify)_____

6a) What avenues are available to file complaints of stigma and discrimination for:

i. Staff _____

ii. Students_____

b) How many of these avenue(s) is/are confidential?.....

c) How were issues of stigma and discrimination handled?.....

H. Support Received

1. What form of support have you received since the inception of COVID-19? (Tick as many as apply)

Type of support	**Name of organisation(s)**
☐ PPEs	
☐ Sensitizations	
☐ Cash	
☐ Others (please specify)_____	

I. Water & Sanitation[69]

1. a) What is the **main** source of water?

- ☐ Pipe borne
- ☐ Well
- ☐ River/stream/pond/lake/dam
- ☐ Rain water
- ☐ Other (please specify) _____

[69] International Human Rights Instruments, Section I, General Comment 14.4

b) Is this water potable?

- Yes
- No

c) How regular is the water supply?

- Almost always – 5 or more days in a week
- Sometimes – 3 or less days in a week

2. What type of toilet facility is available for Staff? (Please tick as many as apply)

- Flush/WC
- Ventilated Improved Pit Latrine (KVIP[70])
- Traditional Pit Latrine
- No facility
- Other (please specify)_____

3. What type of toilet facility is available for patients? Please tick where applicable

- Flush/WC
- Ventilated improved pit latrine (KVIP)
- Traditional pit latrine
- No facility
- Other (please specify)_____

4. What is the number of toilet[71]/washroom facilities for staff and students?

Gender	**Staff**	**Students**
Male		
Female		

Interview's observation on toilet/washroom facilities (Take pictures if possible; seek permission before taking them)

[70] Ventilated improved pit latrines, commonly known as VIP latrines, are an improvement to overcome the disadvantages of the simple pit latrines. The main problems associated with traditional simple pit latrines, i.e. fly and mosquito nuisance and unpleasant odors are effectively minimized by the action of a vent pipe, fly screen and a squatting cover in the VIP latrines.

[71] Number of toilet seats

J. Health

1. a) Does this school have a first aid box?
   - ☐ Yes
   - ☐ No

   b) If yes, how well stocked is it[72]?
   - ☐ Well-stocked
   - ☐ Fairly-stocked
   - ☐ Poorly-stocked

2. a) Does this institution have a sick bay/infirmary?
   - ☐ Yes
   - ☐ No

   b) Does this institution have a regular nurse or health assistant?
   - ☐ Yes
   - ☐ No

3. How does the school handle suspected cases of COVID-19?.....

K. Boarding / Dormitory Facility

1. What is the Expected/Current capacity of the facility?

Facility	**Expected**		**Current**	
	Male	**Female**	**Male**	**Female**
Male Dormitory				
Female Dormitory				

2. a) Did COVID-19 affect accommodation of students?

   - ☐ Yes
   - ☐ No

b) If yes to 2(a), kindly explain:……..

c) If yes to 2(a), what measures did the school administration put in place to mitigate these challenges?.....

3. a) How many times are students fed in a day?.....

[72] https://www.redcross.org/get-help/how-to-prepare-for-emergencies/anatomy-of-a-first-aid-kit.html. Al kits for a family should contain absorbent compress dressing, adhesive bandages, adhesive cloth type, antibiotic ointment packages, antiseptic wipe packets, packets of aspirin, emergency blanket, breathing barrier, instant cold press, pair of non latex gloves, hydrocortisone ointment packets, gauze roll bandage, roller bandage, sterile gauze pads, sterile gauze pads, oral thermometer, triangular bandage, tweezer, emergency first aid guide

b) Is the food adequate?.....

- Yes
- No

d) What is the quality of the food?.....

4. a) What measures have the school administration taken to reduce the incidence of COVID-19 cases among **students and visitors**? (**Please tick as many as apply)**

Measures	**Students**	**Visitors**
Social/physical distancing		
Wearing of face masks		
Hand washing		
Use of sanitizer		
Checking of Temperature		
Vaccination		
Sensitization		
Others (Specify)_____		

b) What measures (including sanctions/incentives) has the school administration put in place to ensure that the COVID-19 protocols are duly observed?

_____

_____

*Interviewer's observation on the availability of water for hand washing, social distancing, sanitizer at vantage points, and the wearing of facial masks and comments below (**Take pictures if possible; seek permission before taking them**)*

_____

L. Additional Comments, Observations & Recommendations

_____

COMMISSION ON HUMAN RIGHTS & ADMINISTRATIVE JUSTICE (CHRAJ) IMPACT OF COVID-19 ON ESC RIGHTS OF THE GHANAIAN CITIZENRY AS PART OF THE OBSERVANCE OF THE STATE OF HUMAN RIGHTS IN 2021

DETENTION FACILITIES-Officer in Charge (OIC)

To be administered to the Officer- In -Charge, **detention facility**

Checklist should NOT be given to officers of the institution to complete

CHRAJ Regional/District office: _____

Name of CHRAJ monitoring officer(s):……

Date of interview: _____

A. Background Information of Institution

1. Name of institution:_____
2. Region & district of institution:……..
3. Mailing address of institution:……
4. Physical location/GPS Address of institution:…….……
5. Phone number(s) of institution:……..
6. Email address of institution:……

7. Is this institution accessible to persons with physical disability?

- **Yes**
- **No**

B. Statistics

Provide data on the following:

B. Capacity of facility

1. a Type of facility: (Tick as apply)

- Maximum Security
- Prison Camp
- Infectious Diseases
- Senior Correctional centre

b. Provide data on the above selected facility[73].

Name of facility:					
	Current Capacity			**Operational Capacity**	
Capacity	Male	Female		Male	Female
Lifers					
Convicts					
Remands					
Others specify_____					
Total					

[73] Paragraph 10 of the European committee for the prevention of torture and inhumane or degrading treatment or punishment (CPT); the minimum standard of living space should exclude the sanitary facilities within a cell. Consequently, a single- occupancy cell should measure $6m^2$ plus the space required for a sanitary annexe (usaully1 m^2 to 2 m^2) Equally the space taken up by the sanitary annexe should be excluded from the calculation of $4m^2$ per person in multiple occupancy cells. Further, in any cell, accommodating more than one prisoner, the sanitary annexe should be fully partitioned.

bi) Provide data on the number of detainees for the following vulnerable groups

Vulnerable detainees	**Number**
Pregnant or expectant women	
Nursing Mothers	
The Aged(60+)	
Persons with disability	
Persons living with HIV/AIDS	

c) Provide data on the ages of detainees

Age range of Inmates	Male	Female
Under 18		
19-30		
31-40		
41-50		
51-60		
60+		

C. OPCAT

1. What are your views about the OPCAT?

D. Impact of COVID-19

1. a) How did the COVID-19 affect the following areas from March 2020? **Kindly explain**

Areas	**Response (increase / decrease, ability to meet demand)**
Number of convicts in a cell	
Number of remand prisoners in a cell	
Working hours	

Visits (Number of visitors and visiting hours)	
Out of cell time for inmates	
Remand prisoners (attending court)	
Feeding	
Health care	
Staff strength	
Capacity building for staff	
Recreation	
Rehabilitation and integration of inmates	
Others (please specify) _____	

2. a) Has the Prison taken measures to recover from the impact of COVID-19?

   - Yes
   - No

   b) If yes,

kindly specify: _____

3. a) How did the pandemic affect vulnerable inmates?

Inmates	**Response**
Pregnant or expectant women	
Nursing mothers	
The aged population (60 and above)	
Persons with Disability (PWDs)	
Persons living with HIV/AIDs	

   b) Have there been measures to protect these vulnerable inmates?

   - Yes
   - No

   If yes, kindly specify? …….

4. a) What measures have the prison taken to reduce the incidence of COVID-19 cases among **Officers, inmates, and visitors**? (**Please tick as many as apply)**

Measures	**Officers**	**Inmates**	**Visitors**
Social/physical distancing			
Wearing of face masks			
Hand washing			
Use of sanitizer			
Sensitization			
Regular testing			
Vaccination			
Others (Specify)_____			

5. What measures (including sanctions/incentives) has the prison put in place to ensure

Covid-19 protocols are duly observed?.....

_____

E. Incidence of COVID-19

1a. Did any officer contract COVID-19?

- Yes
- No

b. If Yes to 1(a) how many?

- Male_____
- Female_____

2. a) Did any inmate contract COVID-19?

- Yes
- No

b) If yes to 2(a), how many contracted?

- Male_____
- Female_____

c) If yes to 1(a), how was it handled? (***Isolation, feeding, health care, among others)***

_____

_____

2.a) How many deaths were recorded as a result of COVID-19?

- Officers_____
- Inmates _____

b) How were the bodies handled?.....

c) Do the families usually have access to their bodies?.....

d) In the event that family contact cannot be established:

- How are they buried?:_____
- What funeral arrangements are done for such people?:_____

F. Stigma & Discrimination[74]

1. Have you received complaints of stigma /discrimination against officers?

- Yes
- No

2. a) If yes to (1), are some of these complaints COVID-19 related?

- Yes
- No

b) If yes to 1(a), how many?

- Male_____
- Female_____

3. Have you received complaints of stigma/discrimination against inmates?

- Yes
- No

4. a) If yes to (3), are some of these complaints COVID-19 related?

- Yes
- No

[74] Stigma: Attitudes and beliefs based on prejudices, stereotypes usually on grounds of religion, sex, race, ethnic background etc.
Discrimination: Visible difference in treatment of others (such as being afraid to physically associate eat, sit by, etc) usually based on prejudices, stereotypes on grounds of religion, sex, race, ethnic background etc.

b) If yes to 4(a), how many?

Male_____
Female_____

5. What were the sources of stigma/discrimination? (Tick as many as apply)

- Fellow officers
- Inmates
- Others (please specify)_____

6a. What avenues are available to file complaints of stigma and discrimination for:
Officers_____

Inmates_____

b) How many of these avenues is/are confidential? _____

c). How were issues of stigma handled?.....

G. Water and Sanitation

1. a) What is the **main** source of water?

- Pipe borne
- Well
- River/stream/pond/lake/dam
- Rain water
- Other (please specify) _____

b) Is this water potable?

- Yes
- No

2. How regular is the water supply?

- Almost always – 5 or more days in a week
- Sometimes – 3 or less days in a week

3. What type of toilet facility is available for Staff? (Please tick as many as apply)

- Flush / WC
- Ventilated Improved Pit Latrine (KVIP[75])
- Traditional Pit Latrine
- No facility
- Other (please specify)_____

[75] Ventilated improved pit latrines, commonly known as VIP latrines, are an improvement to overcome the disadvantages of the simple pit latrines. The main problems associated with traditional simple pit latrines, i.e. fly and mosquito nuisance and unpleasant odors are effectively minimized by the action of a vent pipe, fly screen and a squatting cover in the VIP latrines.

4. What type of toilet facility is available for inmates? Please tick where applicable

- ☐ Flush/WC
- ☐ Ventilated improved pit latrine (KVIP)
- ☐ Traditional pit latrine
- ☐ No facility
- ☐ Other (please specify)_____

5. What is the number of toilet[76]/washroom facilities for officers and inmates?

Gender	**Staff**	**Inmates**
Male		
Female		

Interviewer's observation on toilet/washroom facilities (Take pictures if possible; seek permission before taking them)

_____

H. Health

1. Which of the following is/available to your facility?

- ☐ First-aid box
- ☐ Infirmary
- ☐ Hospital or clinic
- ☐ Other (please specify) _____

Interviewer to inspect first aid box and infirmary for adequacy of drugs

_____

I. Torture

1a. How do you address allegations of torture

b. If yes, what measures were taken

c). How do you address inter-inmate violence? –

[76] Number of toilet seats

J. Bedding

1.a) Considering the nature of overcrowding how do inmates manage to get a bed or space to sleep?

b) Are you aware of the situation where inmates trade bed / bed space amongst themselves?

Item	**Yes**	**No**
Bed		
Bed Space		

c) What is your view about inmates trading beds and bed space to other inmates?

d) If yes, explain:…….

K. Juveniles

1. Do you still encounter the incarceration of Juveniles in adult prisons?

- Yes
- No

2. If yes to (1), why is this the case and how do you address such situations?.....

L. Feeding

1. What is being done to increase the feeding rate?.....

2. What challenges are you facing in your pursuit?.....

M. Additional Comments, Observations, Innovations & Recommendations

_____

COMMISSION ON HUMAN RIGHTS & ADMINISTRATIVE JUSTICE (CHRAJ) IMPACT OF COVID-19 ON ESC RIGHTS OF THE GHANAIAN CITIZENRY AS PART OF THE OBSERVANCE OF THE STATE OF HUMAN RIGHTS IN 2021

DEPRIVED COMMUNITIES (SLUMS)[77]
To be administered to persons living in Slums

CHRAJ Regional/District office: _____
Name of CHRAJ monitoring officer(s): _____
Date of interview: _____

A. Background Information

1. Name of Community:……..
2. Region & district of the Community:……
3. Physical location of Community:……..

[77] According to UN-HABITAT, Sub-Saharan Africa's slums are the most deprived; over 80 per cent of the region's slum households have one or two shelter deprivations, but almost half suffer from at least two shelter deprivations. Approximately one-fifth of slum households live in extremely poor conditions, lacking more than three basic shelter needs. Generally, the lack of sanitation and water in the region's slums is compounded by insufficient living space for families and inadequate, makeshift housing. SOWCR 5.pdf (unhabitat.org)

4. Is this community accessible to persons with physical disability?

- **Yes**
- **No**

B. Household Demographics[78]

1. Sex of respondent:
   - Male
   - Female
2. Age of respondent:
   - Less than 18 years _____
   - 18 years – 30 years _____
   - 31 years – 40 years _____
   - 41 years – 50 years _____
   - 51 years – 60 years _____
   - 60+ years _____

3. What work do you do?_____
4. How much do you make/earn in a month on the average?
   - Less than GHc500.00
   - GHc 500.00 – GHC 1000.00
   - GHc 1001.00 – GHc 1500.00
   - GHc 15001 – GHc 2000.00
   - Above GHc 2000.00

5. How many people are in a household?
   Males: _____
   Females: _____

6. Age composition of household members:
   - Less than 18 years
   - 18 years – 30 years
   - 31 years – 40 years
   - 41 years – 50 years
   - 51 years – 60 years
   - 60+ years

[78] Universal Declaration of Human Rights, Article 25; African Charter on Human Rights, Article 24

7. Is anyone in this groups in your household[79]…

Vulnerable Groups	Tick as applicable	Number
Physically challenged		
Mentally challenged		
HIV/AIDS positive		
Pregnant		
Children		
Elderly (60+ years)		
Terminally ill[80]		
Other (please specify		

C. Affordability[81]

1. a) Do you rent or own this house?
   - Rent
   - Own

b) If you rent this house, how much do you pay in rent a month?

_____

D. Availability[82] & Habitability[83]

1. What type of house do you live in?
   - Hut
   - Wooden Kiosk
   - Thatched
   - Steel Container
   - Sancrete block

[79] International Human Rights Instruments, Section I, General Comment 4.8e;
[80] A terminal illness is a disease or condition which can't be cured and is likely to lead to someone's death. It's sometimes called a life-limiting illness.
[81] International Human Rights Instruments, Section I, General Comment 4.8c
[82] Universal Declaration of Human Rights, Article 25; International Human Rights Instruments, Section I, General Comment 4.7; International Human Rights Instruments, Section I, General Comment 4.8a
[83] International Human Rights Instruments, Section I, General Comment 4.8d

- ☐ Other (please specify) _____.

2. What is the roof of your house made of[84]?
   - ☐ Natural materials
   - ☐ Tiled or concrete
   - ☐ Corrugated/Zinc roofing
   - ☐ Other (please specify) _____

3. a) Is your roof sufficient in protecting your house from the elements (i.e. wind, rain, fire)?
   - ☐ Yes
   - ☐ No

b) If no, please explain:

_____

_____

4. a) What is your main source of water?
   - ☐ Pipe borne
   - ☐ Well
   - ☐ River/stream/pond/lake/dam
   - ☐ Rainwater
   - ☐ Other (please specify) _____

   b) Is this water potable?
   - ☐ Yes
   - ☐ No

   c) How regular is the water supply?
   - ☐ Almost always – 5 or more days in a week
   - ☐ Sometimes – 3 or less days in a week

5. What type of toilet facility is available for you and your household[85]?
   - ☐ Own flush
   - ☐ Shared flush
   - ☐ Ventilated improved pit latrine (KVIP[86])

[84] International Human Rights Instruments, Section I, General Comment 4.8d
[85] International Human Rights Instruments, General Comment 14.4
[86] Ventilated improved pit latrines, commonly known as VIP latrines, are an improvement to overcome the disadvantages of the simple pit latrines. The main problems associated with traditional simple pit latrines, i.e. fly

- Traditional pit latrine
- No facility
- Other (please specify) _____

6. What is the number of toilet[87]/washroom facilities for household?

Gender	Number
Male	
Female	

Interviewer's observation on toilet/washroom facilities (Take pictures if possible; seek permission before taking them)

_____

_____

E. Availability and Accessibility to Healthcare[88]

1. Do you have a health facility close to where you live?
   - Yes
   - No
2. How long does it take you to reach the nearest healthcare facility?
   - 0 minutes – 15 minutes
   - 15 minutes – 30 minutes
   - 30 minutes – 45 minutes
   - 45 minutes – 60 minutes
   - 60+ minutes

3a) Is seeking professional medical care & treatment within your financial means?
   - Yes
   - No

b) If No, why?

_____

_____

a) Are you registered with the National Health Insurance Scheme?
   - Yes
   - No

and mosquito nuisance and unpleasant odours are effectively minimized by the action of a vent pipe, fly screen and a squatting cover in the VIP latrines.

[87] Number of toilet seats

[88] International Human Rights Instruments, Section I, General Comment 14.12b, The Ghana Health Services Patient Charter, Right 1

b. If no, why?

_____

_____

c If yes to 4(a), is your subscription active?

- Yes
- No

d) If no, kindly indicate why NHIS subscription has not been renewed?

_____

_____

4. Which of the following are common ailments among you and your colleagues?
   - Diarrhoea
   - Malaria
   - Cholera
   - Typhoid fever
   - COVID-19
   - Other (please specify) _____

F. Impact of COVID-19

1. How has COVID-19 affected you and/or colleagues in the following areas:

Areas	**Explain**
Accommodation	
Movement	
Accessing healthcare	
Feeding	
Work	
Using toilet facilities	
Social Gatherings (Parties, weddings, etc)	
Religious Gathering	
Funerals	
Sporting events	
Other specify_____	

2. How has COVID-19 affected the following vulnerable persons among you?

Vulnerable Groups	**Response**
Physically challenged	
Mentally challenged	
HIV/AIDS positive	
Pregnant women	
Children	
Elderly (60+ years)	
Terminally ill[89]	
Other (please specify	

3. a) What measures have the State taken to mitigate these effects of COVID-19? (**Policies, reliefs/stimulus packages**)

_____

_____

G. Support Received

1a) Did you or any of your colleagues have the opportunity to benefit from government's free:

- Cooked meals
- Uncooked/Dry meals
- Others (specify)_____

b) If cooked meals, what were you usually served? _____

c) How many times in a day were you served these cooked meals?

- One time
- Two times
- Three times
- Four or more times

[89] A terminal illness is a disease or condition which can't be cured and is likely to lead to someone's death. It's sometimes called a life-limiting illness.

d) Was it the food enough/adequate for the day?

- Yes
- No

e) If no, explain

_____

f) If Uncooked/Dry meals, what were you usually served?

_____

g) How many times in a week were you served these uncooked meals?

- One time
- Two times
- Three times
- Four or more times

h) Was it enough/adequate for the week?

- Yes
- No

If no, explain

_____

2. a) Which of the two forms of provision did you prefer?

- Cooked meals
- Uncooked/Dry meals

b) Explain your answer_____

H. Abuse Meted against Individuals while Enforcing COVID -19 protocols

1. a) Did you or any of your colleagues suffer any form(s) of assault (slapped, whipped, insulted, etc) as a result of the imposition of restrictions by the President?

- Yes
- No

b) If Yes to 1(a), kindly explain what happened

_____

_____

_____

2a) If you were assaulted, did you report to any institution?

- Yes
- No

b) If yes to 2(a), which institution did you report to?

_____

c) What was the outcome? Kindly Explain

_____

_____

I. Other Support Received

1. What kind of support have you received since the inception of COVID -19? (Name the institutions that provided the support and what they supported with)

Organization	**Support provided**

J. Additional Comments, Observations & Recommendations

_____

APPENDIX D

NUMBER OF RESPONDENTS TARGETED PER INSTITUTION/GROUP PER DISTRICT

Table 4: Number of respondents targeted per institution/group per district

Schedule	Target Institution/ Facility	Respondents
1	2 JHS	1 Head teacher-each Pupils- (2) each
2	2 SHS	1 Head teacher-each Teachers - (2) each Pupils- (2) each
3	2 Hospital	Administrator Doctors (2) Nurses (2) Patients (2)
4	1 Hotel / Guest House	Administrator -guided interviews Employees (2)
	1 Hair Saloon 1 Barbering Shop	Owner / Operator-guided interviews Employees (2)
	2 Trotro/ Taxi stations	Chairman / Station Master each 2 Drivers each
5	All Prisons (Male and Female) Correctional Centres for Juveniles and Young Offenders (JCCs and SCCs)	Officer in Charge-guided interviews FGD (5 male and female inmates selected by CHRAJ staff)
6	1 Market	1 Market Leader / Queen-guided interviews 2 Traders (market women, male traders)- guided interviews
	Metropolitan/Municipal/District Assembly	1- Coordinating Director-Guided Interviews
	Ghana Police Service	1-Regional/District Commander-

		guided interviews
	Commission's District and Regional offices	1-Regional/district Commander - guided interviews
	1 Deprived Community (Slums)	4 persons
	1 Informal Settlment (Homeless)	2 persons

Table 5: Targeted respondents for Camps for persons accused for witchcraft

Schedule	Target Institution/ Facility	Respondents
1A	Gnaani Witch Camp (Yendi Municipality)	-Settlement / traditional / religious caretaker -Witch Camp dwellers-focus group (2) comprising 4 persons each
1A	Kukuo Witch Camp (Bimbilla District)	- Settlement / traditional / religious caretaker -Witch Camp dwellers-focus group (2) comprising 4 persons each
1A	Gambaga Witch Camp	- Settlement / traditional / religious caretaker -Witch Camp dwellers-focus group (2) comprising 4 persons each
1A	Kpantinga Witch Camp (Gushegu District)	- Settlement /traditional / religious caretaker -Witch Camp dwellers-focus group (2) comprising 4 persons each
1A	Leli-Dabogni Witch Camp (Gushegu District)	- Settlement /traditional / religious caretaker -Witch Camp dwellers-focus group (2) comprising 4 persons each

Table 6:Targeted respondents for shrines (trokosi)

Schedule	Target Institution/ Facility	Respondents
1B	1. Afife – Torgbui Nyigbla Shrine- (Ketu North)	- Oversight priest of trokosi shrine - Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)
1B	1. Ablortsivia Shrine 2. Afegame Shrine 3. Atsifodi Shrine (Ketu South)	- Oversight priest of trokosi shrine - Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)
1B	1. Dalive-Kakpli Shrine 2. Agave Afedome – Adzemu Shrine (South Tongu)	- Oversight priest of trokosi shrine -Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)[90]
1B	1. Mafi Kpogadzi – Togbe Ngorgbe Shrine (Central Tongu)	- Oversight priest of trokosi shrine - Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)
1B	1. Weme (Akatsi-South)	- Oversight priest of trokosi shrine - Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)
1B	1. Ave-Dakpa - Trohove Shrine 2. Ave-Adido Trohove Shrine (Akatsi North)	- Oversight priest of trokosi shrine - Shrine dwellers-focus group (2) comprising 2 persons each -Former trokosi-(2)
1B	Baptist Vocational Training Institute - Frankadua	-Former trokosi-(2) – guided interviews to be executed by Akosombo District Director

APPENDIX E

NUMBER OF RESPONDENT PER INSTITUTION/GROUP

Table 7: Number of respondents interacted with

Institution / Group	Number of Respondents	Percent
General Hospital (Administrator)	155	3.7
General Hospital (Health Workers)	414	10.2
General Hospital (Patients)	251	6.2
JHS/SHS (Head Teachers)	335	8.3
JHS/SHS (Teachers)	574	14.2
JHS/SHS (students)	579	14.3
MMDAs	102	2.5
Traders	258	6.2
Transport Stations	344	8.6
Deprived Communities (Slums)	93	2.3
Informal Settlers	50	1.2
Barbers and Hairdressers	337	8.3
CHRAJ Regional/District Offices	102	2.5
Detention Facilities (OIC)	33	0.8
Detention Facilities (Inmates)	120	3.0
Trokosi (Priest of Shrine)	3	0.1
Trokosi (Former Trokosi)	3	0.1
Trokosi (Current Trokosis)	1	0.0
Hotels/Guest Houses	195	4.7
District Police Stations	95	2.4
Witch Camps (Caretaker)	5	0.1
Witch Camps (Dwellers)	8	0.2
Institutions	7	

APPENDIX F

DISTRICTS PER REGION VISITED

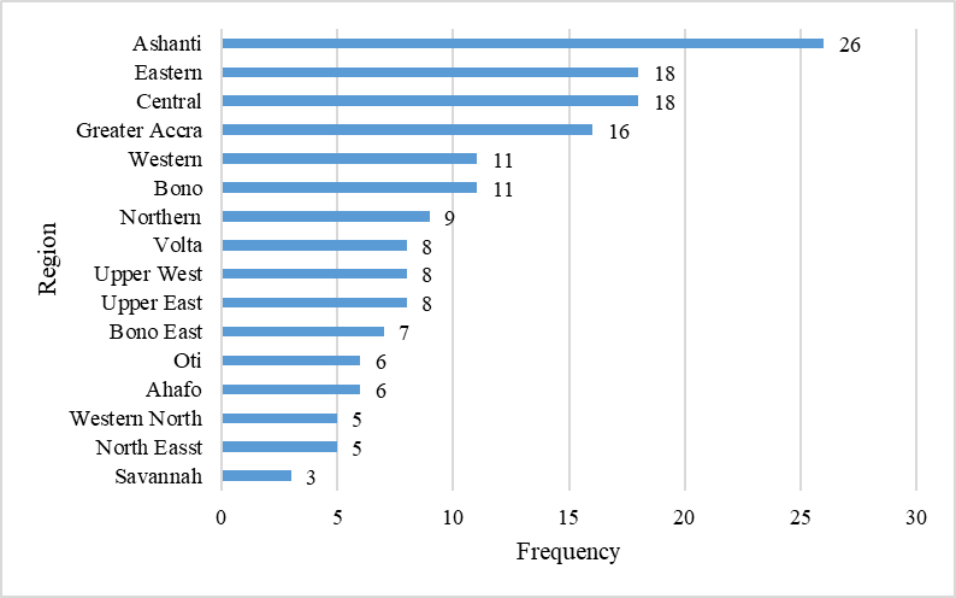

Figure 14: Number of Districts Per Region

Table 8: Districts Per Region Visited

AHAFO	ASHANTI	BONO	BONO EAST	CENTRAL
Astutifi North	Adansi South	Berekum East	Atebubu - Amanten Municipal Assembly	Abura Asebu Kwamankese
Asunafo North Municipal Assembly	Ahafo Ano North Municipal Assembly	Berekum municipal Assembly	Kintampo Municipal Assembly	Agona West Municipal Assembly
Asutifi South	Adansi South District	Berekum West District Assembly	Kintampo North	Ajumako Enyan Essiam District
Tano District-Bechem	Ahafo Ano North Municipal Assembly	Dormaa Municipal	Nkoranza Municipal	Asikuma Odoben Brakwa District
Tano North Municipal	Ahafo Ano South West	Dormaa Central Municipal	Nkoranza South Municipal	Assin Foso Municipal Assembly
Tano South Municipal	Amansie West District	Dormaa East District	Sene West District Assembly	Atti Morkwa District
	Asante Akim Central	Jaman South Municipal	Techiman Municipal	Awutu Senya East
	Ashanti Akim South Municipal	Sunyani Municipal Assembly		Breman Asikuma Odenkwa
	Asokwa Municipal	Sunyani West District Assembly		Cape Coast Metropolis
	Atwima Nwabiagya	Tain District Assembly		Cape Coast South
	Bantama North	Wenchi Municipal		Effutu Mumicipal
	Bantama Sub-Metro			Gomoa Central

	Bekwai Municipal			Gomoa West
	Bosomtwe District Assembly			Komenda / Edina / Eguafo / Abirem Municipal
	Ejura Sekyedumase			Mfantseman Municipal Assembly
	Kumasi Metropolis			Twifo Atti Morkwa District
	Kwabre East Municipal			Twifo Hemang Lower Denkyira District
	Mampong Municipal			Upper Denkyira East Municipal
	Manhyia South			
	Amansie West District		**NORTH EAST**	**SAVANNAH**
	Obuasi Municipal Assembly		Builsa South	BOLE DISTRICT ASSEMBLY
	Offinso Municipal		Bunkprugu Nakpnduri District	East Gonja Municipal Assembly
	Offinso South		East Mamprusi Municipality	West Gonja Municipal Assembly
	Sekyere Central		Mamprugu Moagduri District	
	Sekyere East		WEST MAMPRUSI	
	Sekyere South			

EASTERN	GREATER ACCRA	NORTHERN	WESTERN	WESTERN NORTH
Abuakwa North	Ada East District Assembly	Gushegu Municipal Assembly	Ahanta West	Aowin Municipality
Abuakwa South	Accra Metropolitan Assembly	Nanumba North Municipal Assembly	Effia-Kwesimintsim Municipal Assembly	Bibiani/ Anhwiaso/ Bekwai municipal Assembly
Akuapem North Municipal	Ayawaso East	Saboba District Assembly	Ellembele District Assembly	Juaboso District Assembly
Asuogyaman District Assembly	Ayawaso North	Sagnarigu Municipal Assembly	Jomoro Municipal Assembly	Sefwi Juaboso District
Birim Central Municipal	Ayawaso West District	Savelugu Municipal Assembly	Nzema East Municipal Assembly	Sefwi Wiawso Municipal Assembly
Birim North District Assembly	Dangme East District Office	Tamale Metropolis	Sekondi-Takoradi Metropolitan Assembly	
Fanteakwa North District	Ga Central Municipal	Tolon District Assembly	Shama District Assembly	
Kawhu West	Ga North	Yendi Municipal	Tarkwa Nsuaem Municipal	
Kwaebibirem Municipal Assembly	Ga South	Zabzugu District Assembly	Wasa Amenfi West District	
Kwahu Afram Plains North	Ga West		Wassa Amenfi Central District	

Kwahu West Municipal Assembly	Korley Klottey Municipal Assembly		Wassa East	
Lower Manya Krobo Municipal	Kpone - Katamanso Municipal Assembly			
New Abirem	Shai Osudoku District Assembly			
New Juaben North	Tema Metropolitan Assembly			
New Juaben South	Tema West Municipal Assembly			
Nsawam/ Adoagyiri	Weija-Gbawe			
Suhum Municipal Assembly				
West Akim Municipal Assembly				
OTI	**UPPER EAST**	**UPPER WEST**	**VOLTA**	
Biakoye District	Bawku Municipal Assembly	Daffiama-Bussie-Issa District	Adidome	
Jasikan District	BAWKU WEST DISTRICT	Jirapa Municipal	Akatsi South	
Kadjebi District Assembly	Bolga municipal	Lambussie District	Central Tongu	

Karachi East Municipal Assembly	Bolgatanga Municipality	Lawra municipal assembly	Ho Municipal	
Krachi West	Bongo District Assembly	Nadowli/kaleo district assembly	Hohoe Municipal	
Nkwanta South	Builsa North	Nandom Municipal Assembly	Keta Municipal	
	Kassena - Nankana	Sissala East Municipal Assembly	Kpando Municipal	
	Pusiga District	Wa Municipal Assembly	South Tongu District	

[i] See Internal Human Rights Treaty Branch (HRTB) toolkit (an OHCHR doc) of treaty law perspectives and jurisprudence in the context of COVID-19. Geneva, May 2020. See also General Comment No. 14 (2000) on the highest attainable standard of health, E/C.12/2000/4, para. 65.

[ii] The State, acting through the President, may derogate from its human rights obligations in exceptional circumstances, particularly during armed conflicts, natural disasters or other public emergencies that threaten the life of a nation. It is required that the state of emergency is declared officially and that the derogation is lifted as soon as the situation permits.

Subsequent to the enactment of the Imposition of Restrictions Act, the President imposed certain restrictions on fundamental rights by means of a number of Executive Instruments, which came into force on March 23, 2020. The Executive Instrument Number one (1), imposed a suspension of all public gatherings including religious gatherings, conferences, workshops, funerals, festivals, political rallies, sporting events, private social gatherings, nights clubs and events centres. A number of industries were exempted from these restrictions, namely persons working; in service provision, manufacturing or industrial workplaces, supermarkets, shopping malls and markets, security services and essential services (as defined by the Instrument). Exempted industries were required to observe social distancing and hygienic procedures. However, restrictions were imposed on foreign travel, and all of Ghana's borders closed for two weeks.

Other measures led to the promulgation of the Declaration of Public Health Emergency Coronavirus Disease (COVID-19) Pandemic Instrument, 2020, which came into force on 23 March 2020. The Declaration mandated that all persons who exhibited symptoms be tested for COVID-19 and all persons entering the country to be tested and undergo 14 days quarantine. It authorised the health authorities to subject anyone who was unable to self-quarantine to mandatory quarantine and made provision for social distancing and hygienic procedures.

The government also issued the Electronic Communications System-Instrument, 2020 (EI 63) which required mobile telecom network operators to put their networks 'at the disposal of the State for the mass dissemination of information to the public in case of an emergency, including a public health emergency' and to cooperate with the National Communications Authority to provide information to State agencies in times of emergencies. This was adopted ostensibly to facilitate contact tracing.

Further, the government also passed the Novel Coronavirus Covid-19 National Trust Fund Act 2020 (Act 1013), to mobilise resources to complement the efforts of the government in responding to the pandemic.

This was followed by the Imposition of Restrictions Coronavirus Disease (COVID-19) Pandemic (No. 2) Instrument, 2020, which among others imposed 14 days lockdown in the major urban centres of Greater Accra and Kumasi Metropolitan areas, including suspension of intercity movements for both private and commercial purposes. Operators of intra-city transport were also required to reduce loading capacity to enable social distancing and ensure hygienic procedures are followed. Persons exempted from these restrictions included members of the executive (both national and local), legislature and judiciary, and other persons providing essential services such as members of the media, road and railway construction workers, farmers and fisher folk, staff of electricity, water and telecommunication service providers, the staff of fuel stations, banks and ancillary financial institutions, licensed private security personnel, staff of pharmaceutical, food and beverage companies and environmental and sanitation workers.

The Executive Instrument Number two (2) required all persons who tested positive for COVID-19 to provide health authorities with information relating to all persons they had been in contact with.

On April 3, 2020, the government issued Imposition of Restrictions (Coronavirus Disease (COVID-19) Pandemic) (No. 3) Instrument, 2020, which extended the closure of the borders for another 14 days, except 'the transportation of goods, supplies and cargo into Ghana'. Imposition of Restrictions (Coronavirus Disease (COVID-19) Pandemic) (No. 4) Instrument, 2020 followed on April 11, 2020, extending the restrictions on public gathering imposed by Executive Instrument (No. 1) for another 14 days, and the lockdown imposed by Executive Instrument (No. 2) for a further 7 days. The Closure of the borders was extended for a further two weeks via Imposition of Restrictions (Coronavirus Disease (COVID-19) Pandemic) (No. 5) Instrument, 2020, which commenced on April 17, 2020.