GHANA HIV / AIDS STRATEGIC FRAMEWORK

2001 - 2005

GHANA AIDS COMMISSION

PREFACE

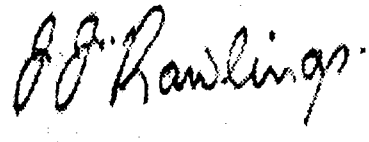
The National HIV/AIDS Strategic Framework for Ghana has been formulated in recognition of the developmental relevance of the disease. It is an issue that requires a holistic, multi-sectoral and multi-disciplinary response to confront it and bring it under control. Ghana, by this document and the bold initiatives therein outlined, has joined the global community in a united effort to combat the epidemic.

Over the years, the incidence of HIV/AIDS has increased steadily and has almost reached epidemic proportions in the country. The very fact that victims of HIV are mainly in the productive ages of 25-49 years, poses a major challenge to Ghanaís developmental efforts. We, therefore, have to take urgent and pragmatic steps to confront the epidemic.

This Framework provides broad guidelines for sector Ministries, Departments, Agencies, District Assemblies, the Private Sector, Non-Governmental Organisations and civil society at large, to evolve such specific HIV/AIDS strategic plans and activities as may be determined by their peculiar needs and circumstances .

The implementation of these strategic plans would require not only enormous human and financial resources but also individual and collective will and commitment. It is, therefore, my fervent hope and desire that all sectors - public, private, non-governmental, and donor agencies - will act in concert to ensure that we meet the targets set in this Framework.

I wish to acknowledge the leadership role played in this effort ,by the National Population Council (NPC) and the contributions from the Ministry of Health (MOH), National Development Planning Commission (NDPC), Ministry of Employment and Social Welfare (MESW), Ghana Social Marketing Foundation (GSMF), International Federation of Women Lawyers (FIDA), J. S. A Consultants Ltd., and the Centre for the Development of People (CEDEP), as well as all others who in diverse ways have contributed to the development of the Framework. Finally, let me thank the UNAIDS and DFID for their financial assistance.



H.E. Flt Lt. J.J. Rawlings
President of the Republic of Ghana

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LIST OF ACRONYMS

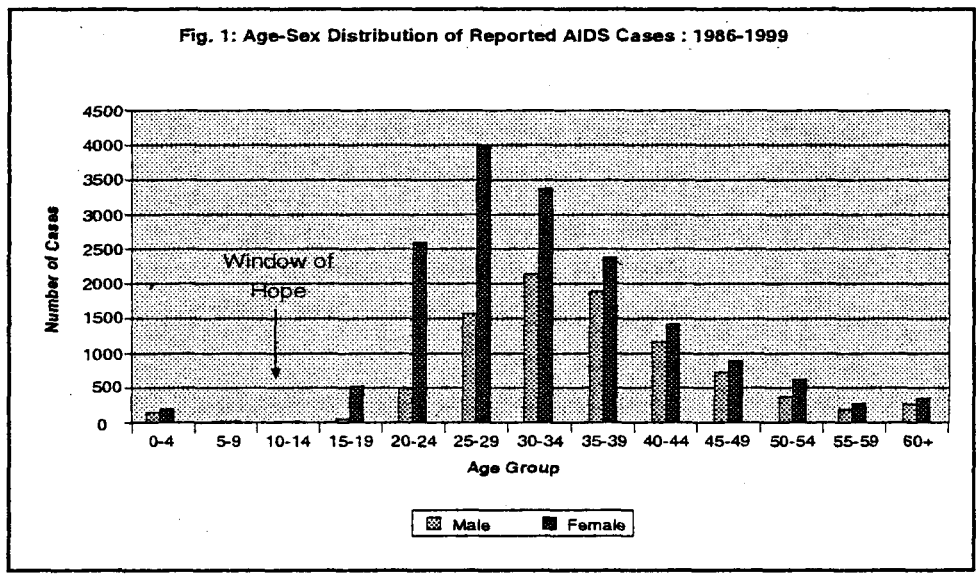
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organisations
CEDEP	Centre for the Development of People
CHAG	Christian Health Association of Ghana
CHRAJ	Commission for Human Rights and Administrative Justice
CSW	Commercial Sex Workers
DA	District Assemblies
DHMT	District Health Management Team
DRI	District Response Initiative
FBO	Faith-Based Organisations
FIDA	International Federation of Women Lawyers
GAC	Ghana AIDS Commission
GBA	Ghana Bar Association
GDP	Gross Domestic Product
GEA	Ghana Employers Association
GES	Ghana Education Service
GHS	Ghana Health Service
GJA	Ghana Journalists Association
GNAT	Ghana National Association of Teachers
GPRTU	Ghana Private Road Transport Union
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
HIV	Human Immune-Deficiency Virus
IE&C	Information, Education and Communication
IRS	Internal Revenue Service
JSS	Junior Secondary School
KVIP	Kumasi Ventilated Improved Pit-latrine
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MESW	Ministry of Employment and Social Welfare
MLGRD	Ministry of Local Government and Rural Development
MOC	Ministry of Communication
MOD	Ministry of Defence
MOE	Ministry of Education
MOF	Ministry of Finance
MOFA	Ministry of Food and Agriculture
MOH	Ministry of Health
MOJ	Ministry of Justice

MOYS	Ministry of Youth and Sports
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NBTS	National Blood Transfusion Service
NBSSI	National Board for Small Scale Industries
NCCE	National Commission on Civic Education
NCWD	National Commission for Women and Development
NDPC	National Development Planning Commission
NFED	Non-Formal Education Division
NGO	Non Governmental Organisation
NPC	National Population Council
OPD	Out-Patient Department
OVI	Objectively-Verifiable Indicators
PEP	Post Exposure Prophylaxis
PIP	Population Impact Project
PLWHA	People Living With HIV/AIDS
PTA	Parent Teacher Association
PR	Public Relations
RCC	Regional Coordinating Council
RHMT	Regional Health Management Team
SP	Strategic Plan
SSNIT	Social Security and National Insurance Trust
SSS	Senior Secondary School
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendants
TRP	Technical Resource Pool
TUC	Trades Union Congress
UNAIDS	United Nations Program on AIDS
VCT	Voluntary Counselling and Testing
WAJU	Women and Juvenile Unit of the Ghana Police Service
TFR	Total Fertility Rate

INTRODUCTION

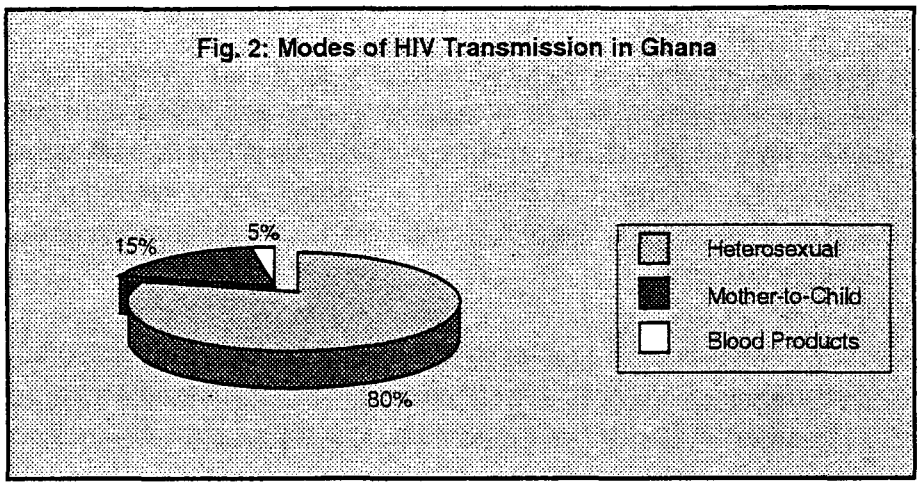
1.1 Background

The first 42 cases of Human Immune-Deficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) in Ghana were recorded in 1986, mainly among women who had travelled outside the country. By the end of December 1999, a cumulative total of 37,298 cases had been recorded. Nearly 90% of the cumulative AIDS cases from 1986-1999 are between 15-49 years of age, with 63% of all reported HIV/AIDS cases being females. The female-to-male HIV/AIDS infection ratio is, however, gradually attaining parity, changing from 6:1 in 1987 to approximately 2:1 in 1998. The peak ages for infection are 25-29 years for females and 30-34 years for males (See Fig 1).



The national prevalence rate of HIV has risen from 2.6% in 1994 to 4.6% according to the 1998 sentinel surveillance report. HIV Sero-prevalence among Sexually-Transmitted Disease (STD) patients and blood donors is recorded to be 17% and 4%, respectively. Among Commercial Sex Workers (CSW) in Accra and Kumasi, it has been found that 75.8% and 82%, respectively, are HIV positive. The National AIDS Control Programme (NACP) projects the average national prevalence rate to increase to 6.4% by 2004, 8.2% by 2009 and 9.5% by the year 2014 if the current trend continues.

Heterosexual transmission of HIV accounts for 75-80% of all HIV/AIDS infection. Vertical transmission (from mother to child) accounts for 15% while transmission through blood and blood products accounts for 5%. (See Fig. 2). HIV I and II are both present. The former is the most commonly found, with the subtypes A and D identified as the most predominant.



1.1.1 The Demographic Factor

Ghana's population is estimated at 18,412,529 with a growth rate of 2.5% according to preliminary results of the 2000 Population and Housing Census. Life expectancy currently stands at 57 years. The current level of HIV/AIDS transmission , however, can drastically reduce this life expectancy if urgent and sustainable action is not taken . The economically active and reproductive age-group (15-49 years) is the worst hit by the HIV infection.

Ghana has since the 1960s had a persistently high Total Fertility Rate (TFR) of 6.7. The rate has in recent times declined from 5.5 in 1993; to 4.6 in 1998 (GDHS, 1998). This figure is still high. Unfortunately, the use of contraceptives, including condoms, is quite low due mainly to the low level of literacy.

The age structure of the population also shows the predominance of youth, with 42% of the total population being under 15 years. (CWIQ, 1997). Even though children under one year old constitute 4% of the total population, they account for 15% of HIV/AIDS cases in Ghana. This situation poses an enormous threat to the gains made in reducing infant mortality rate. To date, there are no policies and strategies aimed at reducing mother-to-child transmission. Children aged 5-14, therefore, present a "Window of Hope" for managing the HIV/AIDS crisis principally because they have generally not begun their sexual lives. Increased attention to this age-group is critical the future response to the epidemic.

The distribution of HIV/AIDS in Ghana is higher in densely populated areas. Higher numbers of cases occur in the Southern regions of the country particularly in densely populated regional capitals like Kumasi, Koforidua and Accra. Prevalence of HIV/AIDS is also very high in mining towns like Obuasi and Tarkwa as well as in border towns. The implications are that, in high prevalence areas, a two-pronged approach is required. The first is to intensify action towards the reduction of transmission within these towns, and the second is to provide care and support for people living with HIV/AIDS (PLWHA) as well as support for people affected by HIV/AIDS like AIDS orphans. As rural areas have been less affected by the HIV/AIDS scourge, primordial preventive efforts in these areas need to be enhanced.

1.1.2 The Socio-Economic Factor

Even though poverty levels have been estimated to have dropped from 36% in 1987/88 to 29.4% in 1998/99, there are regional as well as rural-urban variations. Poverty and other economic pressures on individuals in the country constitute major factors in the spread of HIV/AIDS. For example, high youth unemployment, limited job opportunities and the rising cost of living are aspects of the poverty cycle that promote transactional sex and early sexual relations.

As evidenced in other countries, the spread of HIV/AIDS also impacts on both the supply and demand aspects of education. The gains made in the education sector, such as increased enrolment to above 70%, are impressive, but these will become increasingly difficult to sustain due to the following:

i. an increasing number of HIV/AIDS cases among teachers will reduce their availability to the educational sector; and

ii. there will be declining enrolment either through rising infection rates among the youth or as more families begin to require children to care for sick family members.

Ghana has a highly mobile population. Rural-urban migration, particularly by the youth in search of non-existent jobs, leaves them stranded in cities and thus further exposes them to the risk of transactional sex. Street children are vulnerable as transactional sex is common among them. There is also rural-rural migration to market places. In most of these areas sleeping conditions are deplorable and casual sex is rife. Long distance drivers, uniformed service personnel and itinerant traders are particularly exposed to the risk of casual sex, and hence to HIV/AIDS.

Ghana has a diverse ethnic and cultural composition that is reflected by different cultural practices and sometimes by different political orientations. A common feature of traditional life is the strong communal and family support system such as the extended family system. In recent times, particularly with urbanisation and the consequent rural-urban migration, these systems are breaking down resulting in the development of nuclear families. The price being paid is the inadequate social and family support for PLWHA and people affected by HIV/AIDS.

Other socio-cultural factors such as stigma and denial make the care and support for PLWHA and those affected by HIV/AIDS a daunting challenge. Polygamy, sexual attitudes and belief systems which underlie gender inequalities, make it difficult for women to negotiate on issues about sex, reproduction and condom use. Prevailing belief systems are also important in the reporting and management of STDs.

Ghanaians are generally very religious. The principal religions are Traditional, Christian and Islamic. Few religious bodies have, however, been adequately mobilised to respond appropriately to the HIV/AIDS epidemic and to help reduce the stigma and denial associ-

ated with HIV infection.
The economic cost of HIV/AIDS to employers (though not determined), in terms of care, absenteeism and re-training, is high and continues to rise. HIV/AIDS is expected to put severe stress on families, the health sector and other sectors of the economy. Recent estimates indicate that the annual cost of treatment of opportunistic infections in an AIDS patient can be as high as ¢545,000 (about US$ 80) per person. The cost of providing health care for AIDS patients alone far exceeds other health care costs thus affecting the provision of primary health care to the general public.

Finally, the rising number of AIDS orphans will put enormous pressure on households, communities and the nation as a whole. This is worse in rural areas where 66% of Ghanaís population lives and where levels of poverty are high because the majority are employed mainly in primary agricultural production.

1.1.3 Political Administration and HIV/AIDS in Ghana

Ghana is made up of 10 regions and 110 districts with a decentralised system of administration. Within this arrangement, the national level is responsible for policy and strategy development. The regional level is the intermediate level responsible for translating national policy into regional strategies and co-ordination of district actions. The district is the level at which all government policies are implemented.

The District Assemblies are the highest political and administrative authority at the local level. The District Assemblies, through their sub-committees, harmonise and co-ordinate plans and activities of all decentralised ministries. They also facilitate grassroots participation and community involvement in socio-economic development programmes and activities.

The District Assemblies are generally supportive of activities of decentralised departments. For example, district assemblies provide funding for National Immunization Days (NID) for the eradication of polio and are instrumental in the construction and supervision of schools, Kumasi Ventilated Improvement Pit-latrines (KVIPs), among others, and therefore present a good opportunity for multi-sectoral action.

Undoubtedly, the District Assemblies will be very important in the implementation and sustainability of a multi-sectoral response to HIV/AIDS. This opportunity has not been adequately explored and exploited. The focus at the district level will, however, require the re-orientation and capacity-building of its stakeholders.

1.2 Review of the National Response to HIV/AIDS in Ghana

HIV/AIDS in Ghana was first managed as a disease rather than a developmental issue. The national response has, consequently, been medically-oriented and directed by the Ministry of Health (MOH). The earliest national response was the establishment of the National Advisory Commission on AIDS (NACA) in 1985 to advise government on HIV/AIDS issues. In 1987 the National AIDS Control Programme (NACP) was established as

an arrangement within the Ministry of Health for both the implementation and co-ordination of the programme. Since then, a Short-Term Plan, and Medium-Term Plans I and II have been developed. In addition, a National HIV/AIDS and STI Policy has also been developed to guide the national response.

Since the beginning of the epidemic, there has been a flurry of activities to respond to it. Many stakeholders including numerous Non-Governmental Organisations (NGOs) are implementing a variety of programmes and projects in different areas. The capacity of most NGOs to implement HIV/AIDS programmes, however, is weak. Overall co-ordination of HIV/AIDS activities has so far also been weak at all levels - national, regional and district. Districts and communities have onlyrecently started to mobilise support for HIV/AIDS activities. Most public sector organisations are yet to appreciate their sectorís vulnerability and susceptibility to HIV/AIDS, and so do not yet have HIV/AIDS integrated into their programmes.

The NACP substituted for the absence of a national multi-sectoral arrangement. Consequently, demands on it were extensive. It has become increasingly obvious that the complexity of the HIV/AIDS epidemic requires a developmental, holistic, co-ordinated, and multi-sectoral approach to address the multi-faceted and multi-dimensional nature of the epidemic.

Progress towards establishing a co-ordinating committee at the national level is far advanced with the establishment of a multi-sectoral Ghana AIDS Commission. The Secretariat to the Commission is yet to be established. Little attention has, however, been paid to regional committees. At the district level, the District Response Initiative (DRI) in ten districts facilitated by the Ministry of Employment and Social Welfare (MESW) presents a good framework for managing activities at that level.

Funding for HIV/AIDS activities has been inadequate. Even when funding exists, procedures for accessing funds are very cumbersome. There are unanimous reports, of profound funding difficulties, particularly among NGOs irrespective of their size and proven track records.

Key interventions that have so far underpinned HIV/AIDS control have been:

Safer sex promotion: *Efforts at promoting safer sex have centred on three (3) main messages -abstinence, mutual faithfulness to one sexual partner and condom-use. Though these efforts have been intensified in recent years through both print and electronic media, perception of personal risk remains low. Peer education, school-based programmes and a good number of workplace activities have targeted specific groups but there are still gaps in intensity and geographical coverage. The use of social marketing strategies has improved access and utilisation of condoms. Condom sales are however still restricted to traditional outlets (Ministry of Health facilities and Chemical Sellers).*

Preventive clinical interventions: *Within the clinical care setting, the response has focused on broad activities that reduce HIV transmission such as management of Sexually*

Transmitted Diseases (STDs) and ensuring safe blood transfusion. Overall management of STDs in the health sector (both private and public orthodox and traditional providers) remains weak and linkages among the providers need to be strengthened. Substantial progress has been made to improve the capacity of the health sector to manage STDs. Programmes targeting commercial sex workers have also been initiated and are being implemented successfully. However,the overall coverage of commercial sex workers is still limited and needs to be expanded.

In the provision of safe blood transfusion, blood is now screened for HIV and Hepatitis B prior to transfusion. There are, however, occasional shortages of testing kit. Strategies towards reducing overall transfusions have not received adequate attention, and autologous (own blood transfusion) transfusion has also not been actively promoted. A number of Traditional Birth Attendants (TBAs), Wanzams (traditional circumcisors), traditional healers, barbers and beauticians have been given training in infection control but this has not been systematic.

Continuum of care for PLWHA: *The provision of an effective and integrated continuum of care for PLWHA in health institutions and at home has not received adequate attention. Health workers still lack the confidence to care for PLWHA for fear of being infected. Similarly, communities and households are yet to come to grips with the fact that they need to handle PLWHA, and to give them the attention and care they require as any other patient, without any feeling of stigma on the infection.*

Home-based care remains the least developed component of the continuum of care, and requires special attention. A limited number of private hospitals are providing care and support to PLWHA through outreach programmes. Religious, traditional, political as well as community and district systems will need to be mobilized to support and sustain home-based care.

Legal and ethical issues: *On account of the threat of stigmatisation and discrimination associated with HIV/AIDS, it is absolutely crucial to put in place an environment that promotes fundamental human rights and work ethics. These will require empowering PLWHA and people affected by AIDS to stand up for their rights; increasing awareness of the general public on issues of human rights particularly to the extent that it affects PLWHA; and mobilizing the legal system to be supportive of, and responsive to HIV/AIDS related human rights abuses. This area has received very little attention and needs to be emphasised.*

In conclusion, what emerges from the analyses of HIV/AIDS provides the basis for the development of a strategic framework which will identify key strategies aimed at reducing the spread of the HIV/AIDS epidemic.

Major Recommendations of the Response Analysis

- *Adopting a developmental approach to HIV/AIDS through the involvement of both health and non-health sectors;*
- *Strengthening the co-ordination of stakeholder responses at national, regional and district levels;*
- *Resource mobilisation and access to funds;*
- *Developing programmes to reduce Mother-to-Child Transmission (MTCT);*
- *Focusing action on the youth - both in and out-of-school;*
- *Developing innovative strategies for dealing with migrant and mobile populations including long distance drivers;*
- *Intensifying actions and efforts targeted at high risk groups and areas such as commercial sex workers and border and minig towns;*
- *Increasing awareness of individual, community and institutional (including the public and private sectors) vulnerability and susceptibility to HIV/AIDS in order to enhance appropriate response;*
- *Providing care and support for People Living with HIV/AIDS (PLWHA) and their families;*
- *Adopting the Distict Response Initiative (DRI).*

1.3 General Policy Environment

The prevailing favourable policy environment in the country inspired the development of this document. The 1992 Fourth Republican Constitution of Ghana enjoins Government to, among other things, ensure that the general population enjoys a good quality of life. The Ghana Vision 2020 document, which is the blue-print for the country's human and socio-economic development, also highlights the need for quality life and expansion of opportunities for all members of society under its human development component. It further goes on to stress the need to reduce the incidence of preventable diseases like HIV/AIDS .

In addition, the National Population Policy (Revised Edition, 1994) emphasises the harmful effects of STD/HIV/AIDS and calls for the institution of appropriate measures to prevent and control the epidemic. There are other policies which have made explicit or implicit references to HIV/AIDS management in Ghana. These include the National Youth Policy which identifies the provision of services to people living with HIV/AIDS as a priority; a draft Adolescent Reproductive Health Policy that has as one of its objectives, the implementation of programmes aimed at reducing or eliminating STD/HIV/AIDS. Others are the Reproductive Health Standards and Protocols, the Labour Bill, the Work Place HIV/AIDS Policy, draft Policies on Ageing and Gender as well as Affirmative Action Policy Guidelines to facilitate a process of ensuring gender equality and empowerment of women in all aspects of life.

Finally, there is a draft National HIV/AIDS and STI Policy document that has provided the impetus for the development of this strategic framework. There is, therefore, a conducive policy environment from which the HIV/AIDS strategic framework has drawn lessons and inspirations. It is hoped that this prevailing atmosphere would be sustained so that the implementation of the strategic framework would proceed unhindered.

1.4 Rationale

Recognising the need for a multi-sectoral action to scale-up current efforts, a comprehensive framework is needed to provide the basis for the mobilisation of all sectors - Ministries, Departments and Agencies (MDA), the Private sector, NGOs, District Assemblies, sub-district communities and other stakeholders ñ to implement the National HIV/AIDS and STI Policy.

The Strategic Framework, therefore, presents the overall goal, guiding principles and prioritised strategies on the prevention of HIV transmission as well as the provision of care and support to PLWHA and People affected by HIV/AIDS and an enabling legal and ethical environment. It will, therefore, form a basis for the monitoring and evaluation of the National HIV/AIDS and STI Policy. Finally, the framework outlines the overall institutional arrangement for decentralised implementation including capacity-building at all levels.

1.5 Process of Developing the National HIV/AIDS Strategic Framework

The Strategic Framework Formulation is the third phase in the process of developing a national Strategic Plan for HIV/AIDS. The first phase, which is the HIV/AIDS Situation Analysis, was completed in March 2000 followed by the Response Analysis in June 2000. Like the Situation and Response Analyses, the Strategic Framework formulation was carried out with a multi-sectoral and multi-disciplinary team using a participatory approach. The team maintained constant interactions with the HIV/AIDS Oversight Committee set up by the Government to oversee all HIV/AIDS Strategies.

Technical Team on HIV/AIDS Strategic Framework

A multi-sectoral and multi-disciplinary Technical Team of 16 experts with wide experience in HIV/AIDS and Strategic Planning was formed under the leadership of the National Population Council (NPC) to develop the framework. Other members were from National Development Planning Commission (NDPC), Ministry of Health (MOH), Ministry of Employment and Social Welfare (MESW), the Private Sector and NGOs. A one-week retreat was held to draft the framework.

Seven groups were set up to work on various aspects of the framework under the following agreed headings:

- *Introduction*
- *Promotion of Safer sex*
- *Preventive Clinical Intervention*
- *Community Care and Support*

- *Legal and Ethical Response*
- *Institutional Arrangement*
- *Costing*

The zero draft from the retreat was circulated to key stakeholders for their comments, and presentation was made to the Oversight Committee. The document was also presented to external consultants at the Meeting of the Technical Resources on Strategic Planning for a National Response Against HIV/AIDS in West and Central Africa in Ouagadougou, Burkina Faso. Based on comments received, the framework was reviewed and restructured.

Consensus Building Workshops

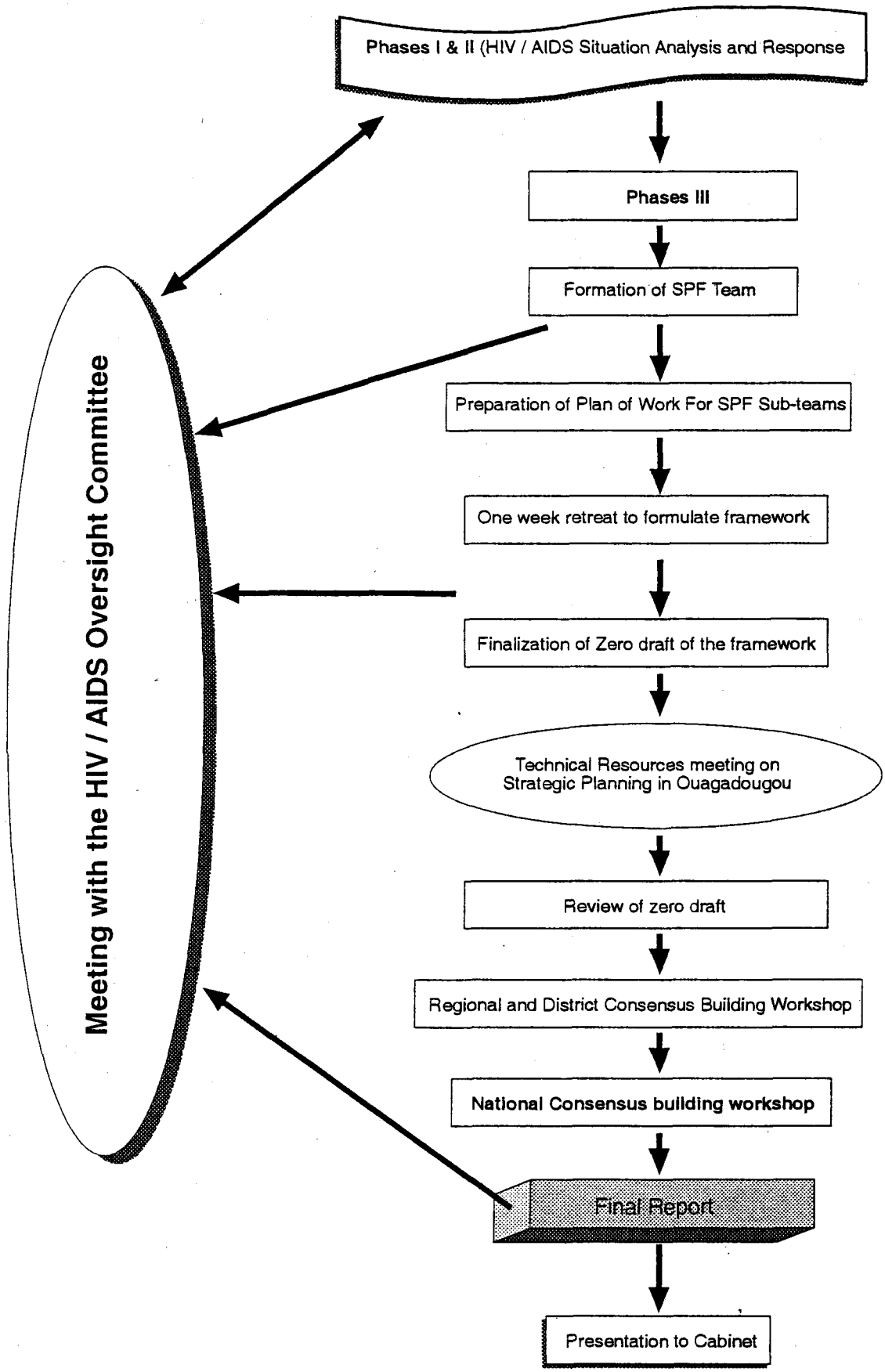
The next stage in the development of the framework was to build consensus and bring about ownership of the framework. In all, three zonal (Northern, Middle and Southern) consensus- building workshops were carried out in September. Regional and District Departmental Heads and District Assemblies participated in the consensus-building workshops.

A national workshop was also held to consolidate and finalise the framework. The objective of the consensus-building workshops was to ensure that when the framework is finalised and adopted, the next phase of development and implementation of sectoral, departmental and district plans would be facilitated.

Presentation to Cabinet Ministers

The National HIV/AIDS Strategic Framework was finalised and presented to Cabinet Ministers at a two-day retreat to inaugurate the Ghana AIDS Commission. The Framework has since been circulated to the donor community for the commencement of the Resource Mobilisation phase.

Fig. 3: Process of Developing the National HIV/AIDS Strategic Plan Framework



GOALS AND OBJECTIVES

2.1 Goal

The goal of the Strategic Framework is to prevent and mitigate the socio-economic impact of HIV/AIDS on individuals, communities, and the nation.

2.2 Objectives

The objectives are:

- *To reduce new HIV infections among the 15-49 age-group and other vulnerable groups especially the youth, by 30 percent by the year 2005.*

- *To improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and the communities by the year 2005.*

- *To reduce individual and societal vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the implementation of the national response.*

- *To establish a well-managed multi-sectoral and multi-disciplinary institutional frame work for coordination and implementation of HIV/AIDS programmes in the country.*

2.3 Guiding Principles

The fundamental principles to guide the implementation of the HIV/AIDS Strategic Framework are based on the fact that HIV/AIDS management requires:

- *A multi-sectoral partnership approach.*
- *Respect for fundamental human rights.*
- *Access to information and comprehensive services.*
- *Decentralisation, community participation and individual responsibility in all HIV/AIDS programmes.*
- *Adequate resources (financial and human) mobilisation to implement the Framework.*

2.4 Intervention Areas

To address the HIV/AIDS epidemic in Ghana, ***five key intervention areas*** have been proposed as components or main groups of strategies of the National Strategic Framework within which to develop a comprehensive response. Each area is supported by a set of broad strategies which will serve as the basis to guide the development of action plans by all Ministries, Departments and Agencies (MDAs), Non-governmental Organisations (NGOs) and other private sector institutions.

Intervention 1: Prevention of New Transmission of HIV

- Promoting safer sex particularly among the most vulnerable groups in the country;
- Providing effective management of STDs;
- Minimising the risk of transmission through blood and blood products;
- Reducing mother-to-child transmission;
- Promoting Voluntary Counselling and Testing (VCT).

Intervention 2: Care and Support for PLWHA

- Providing cost-effective institutional care;
- Providing Home-Based Care.

Intervention 3: Creating an Enabling Environment for National Response

- Creating a supportive legal, ethical and policy environment for HIV/AIDS programmes.

Intervention 4: Decentralised Implementation and Institutional Arrangements

- Strengthening national programme coordination and implementation
  - Mainstreaming HIV/AIDS into Ministries, Departments and Agencies (MDAs);
- Strengthening Regional institutions to implement HIV/AIDS programmes;
- Scaling-up the District Response Initiative (DRI) and strengthening Districts to implement and manage HIV/AIDS responses;
- Community level implementation.

Intervention 5: Research, Monitoring and Evaluation

- Strengthening Research, Monitoring and Evaluation systems including surveillance.

2.5 Broad Expected Outcomes

The following broad outcomes of the Strategic Framework, which will be developed into more measurable indicators over time, are expected by the year 2005 from the interventions to be implemented:

- Incidence of new HIV infections among the youth and other vulnerable groups reduced by 30% by the year 2005.
- Condom-use rate of casual sex increased to 60%.
- 30% of communities and health facilities with adequate arrangements to care for PLWHA attained by the year 2005.
- Necessary laws enacted and enforced on HIV/AIDS.
- Necessary institutions established at national, regional, district and community levels.

PREVENTION OF NEW INFECTION

The main objective of these strategies is to substantially reduce new HIV infections among the 15-49 age-group and other vulnerable groups by the year 2005. This objective would be achieved through the following broad strategies:

- Promoting safer sexual behaviour including condom use especially among the 15-49 age-groupgroups;
- Improving management of Sexually-Transmitted Diseases (STDs);
- Minimising the risk of transmission through blood and blood products;
- Reducing mother-to-child transmission;
- Promoting Voluntary Counselling and Testing.

3.1 Promoting Safer Sex Among the Youth and Other Vulnerable Groups

Heterosexual sex remains the highest mode of transmission of HIV/AIDS and accounts for 80% of all HIV infections. Promoting safer sex behaviour is, therefore, critical in raising personal risk perception which will ultimately lead to positive behavioural change and reduction in incidence of new infection.

The Challenge

The challenges for safer sex promotion are to:

- Significantly raise individual personal risk perception;
- Delay first sexual intercourse among the youth (especially among adolescents);
- Promote condom use among sexually active individuals;
- Promote positive behavioural change.

The Objectives

The broad objective is to have in place on-going programmes and activities that empower specific target groups and individuals to adopt safer sexual behaviour. The following are the specific objectives:

- To provide information to young people, especially adolescents, on the need for abstinence and safer sexual behaviour;
- To increase the median age at first sex from 17 years to 18 years by the year 2005;
- To increase the use of condoms among sexually active individuals and high risk groups from 15% to 30% by the year 2005;

- To achieve significant reduction in the number of sexual partners by sexually active individuals by the year 2005.

The Strategies

The strategies to be adopted to achieve these objectives are as follows:

1. Promoting effective and culturally appropriate IE&C strategies;
2. Promoting and increasing condom accessibility, availability and affordability;
3. Intensifying Poverty Reduction Programmes.

1. Promoting effective and culturally appropriate IE&C strategies

- Promoting culturally and religiously sensitive information, education and communication (IE&C) strategies will focus on abstinence and faithfulness to partners using both electronic and print media, and in as many local languages as practicable. Messages would be tailored towards individual risk perception and positive behaviour for different targets such as adolescents, women and high-risk populations like commercial sex workers;

- Intensifying and sustaining the use of the mass media and Faith-Based Organisations (FBOs) to educate and motivate various targets to adopt healthier lifestyles. Messages would sensitise the various target groups on the risk factors of early onset of sexual activity, infidelity and unprotected sex;

- Intensifying advocacy programmes aimed at eliminating socio-cultural factors that impact negatively on sexuality;

- Improving access to information, education and communication at the rural areas using appropriate media such as mobile cinema vans, drama etc. to carry rural specific IEC material in the various languages;

- Intensifying the use of interpersonal approaches like peer education among identifiable groups, for example, at workplaces and in schools, to create the necessary support to encourage individuals to adopt healthier sexual behaviours;
- Involving, as much as possible, persons living with HIV/AIDS to increase people's risk perception by encouraging them to share experiences or testimonies.

2. Promoting and increasing condom accessibility, availability and affordability

- Stepping up condom promotion and distribution in both urban and rural areas using non-traditional sale outlets, comprising community shops (e.g. kiosks and corner shops), hotels, restaurants, bars etc.;

- Paying special attention to the promotion of the female condom which is critical in

empowering women to negotiate for safer sex;

- Making condoms acceptable, accessible and affordable.

3. Intensifying Poverty Reduction Programmes

- Empowering women and young people economically;
- Promoting functional literacy programmes for women and other vulnerable groups;
- Linking safer sex promotion programmes targeted at specific groups, to poverty reduction programmes.

Expected Outcomes

It is expected that by the year 2005:

- The median age at first sex will increase from 17 years to 18 years.
- A significant reduction in the number of sexual partners by sexually active individuals will be achieved.
- The use of condoms among sexually active individuals will increase from 15% to 30%.

Programme Targeting

The strategies outlined will specifically target vulnerable groups such as the youth, women, commercial sex workers and their male clients, mobile and migrant populations, uniformed service personnel and the general public.

a. Youth

Young adults are people between the ages of 10 and 24 years. In general, they are either in school or out of school. As already indicated, children between the ages of five (5) and 14 years form the window of hope for the control of the epidemic. Imparting positive sexual behavioural attitude to this age-group, therefore, would delay the onset of sexual activities and reduce the incidence of infection among them.

i) In-school youth

Teachers will be re-oriented through in-service training on HIV/AIDS to effectively handle in-school programmes on HIV/AIDS. These programmes would be intensified in first and second cycle as well as tertiary institutions. To be able to do this, effectively, there would be an extensive development of appropriate IE&C materials including textbooks, brochures, and pamphlets for the different levels. The emphasis of safer sex promotion at the Primary, Junior Secondary School (JSS) and Senior Secondary School (SSS) levels will be on the delay of onset of sexual activities and abstinence, while at the tertiary level the 'ABC' of safer sex will be promoted.

ii) Out-of-school youth

Out-of-school youths are generally difficult to identify as a homogenous group, but they constitute a significant target group for the promotion of safer sex. To reach them, promotion of IE&C on STD and HIV/AIDS using Community Theatre, Radio, TV and other programmes conducted in different Ghanaian languages will be employed. Special IE&C materials will be designed for video and cinema houses as well as stadiums to be aired prior to the start of programmes. The use of inter-educational programmes such as drama will also be used. Peer education models will be developed and used. Generally, places where the youth meet will be targeted with information and services.

Additionally, there is the need to integrate STD, HIV/AIDS education into skill training for the youth. This is because poverty and lack of skills negatively impact on an individualís ability to make positive choices for behaviour change. Lastly, existing reproductive health service centres will be equipped to be youth-friendly to make it easier for the youth to turn up for service, especially for STD treatment. Sexually-active adolescents will be provided with family planning services including condoms.

b. Women

Due to the lack of economic empowerment coupled with negative socio-cultural practices, women are vulnerable to contacting HIV/AIDS. The promotion of economic empowerment of women through strengthening and expansion of existing income-generating and skills- development programmes would be intensified. Access to non-formal education for women would also be increased. Advocacy activities to encourage sustainable girl-child education programmes will be stepped-up. There will also be extensive education on the use of female and male condoms to promote their acceptability and usage.

Lastly, socio-cultural practices and norms that contribute to the spread of HIV/AIDS among women would be addressed through advocacy. Special IE&C programmes on HIV/AIDS, including mass media programmes, will be targeted at women to equip them with safer sex negotiation skills.

c. Commercial Sex Workers (CSW)

The prevalence of HIV among commercial sex workers in Accra is estimated at 25% among the 'Roamers' and 76% among the 'Seaters' with even higher levels reported for Kumasi. Commercial sex workers are, therefore, the most afflicted group in the country. The various programmes targeting commercial sex workers (CSW) in Accra and Kumasi have made a significant achievement and would be expanded to cover other high-risk areas such as border, port and harbour towns, and mining and industrial areas. CSW would be targeted through existing medical centres, as well as out-reach programmes. Peer education models would be used to assist sex workers to adopt safe sex measures.

The promotion of consistent use of both male and female condoms by commercial sex workers and their clients would be intensified. Programmes would be developed to ensure the consistent supply of good quality condoms to CSW and their clients, as well as to long-distance truck drivers, itinerant traders and uniformed personnel. Early treatment of STD will also be promoted. Holiday and tourist attraction spots would be mandated to promote and distribute condoms. CSW wishing to go into other commercial ventures would be supported to do so by linking them to poverty-reduction programmes and giving them access to credit.

d) Mobile, Migrant Population and Uniformed Service Personnel

Mobile, migrant populations and uniformed service personnel constitute a critical target group for safer sex promotion, as their mobility increases their vulnerability to high-risk sexual behaviours. Existing programmes would be expanded and new ones developed for the high migrant population. These programmes will incorporate training for the unemployed migrants and the provision of access to STD treatment. Companies, institutions and associations that have mobile populations will be assisted to develop programmes for their members. The thrust of the programme for these groups will be the reduction of the number of sexual partners, consistent condom-use and early treatment of STDs.

e) Workplace Programmes

The Ministry of Employment and Social Welfare would be assisted to accelerate the development of HIV/AIDS workplace programmes. Advocacy efforts would be intensified to get employers to develop workplace HIV/AIDS programmes and vote resources for their implementation. Promotion of IE&C on STD and HIV/AIDS would be directed through programmes designed at these workplaces. The peer education model would be useful in this setting to motivate peers to collectively support and uphold preventive behaviours.

f) General Public

It is expected that individuals who were missed by target-specific interventions, such as men and persons living with disabilities, will be captured in efforts directed at the general public. The mass media will be used to increase personal risk perception. Mass Media messages and IE&C activities will be culturally sensitive. The Ministry of Communication will be supported to design programmes for rural communities.

3.2 Prevention and Effective Management of STD

Sexually-Transmitted Diseases (STDs) have been shown to significantly increase the risk of sexual transmission of HIV/AIDS. Effective management of STDs is, therefore, a major preventive intervention in responding to the HIV/AIDS epidemic.

The Challenge(s)

The challenge(s) will be to ensure:

- Adequate and effective management of STDs; .
- Prompt treatment of STDs.

The Objective

The main objective is to ensure that 80% of all STDs in the country are correctly managed by the year 2005.

The Strategies

The major strategies are:

- Strengthening syndromic management of STDs in both government and private health institutions[1] including appropriate referral mechanisms and the drug procurement system in the country;
- Integrating syndromic management of STD into the curricula of all health-training institutions;
- Expanding the integration of syndromic management of STDs into other services, e.g. Family Planning Services;
- Increasing awareness of complications and prevention of STDs;
- Improving the monitoring of STDs in both public and private institutions in the country.

Expected Outcome

- An effective system would be put in place and strengthened to manage, at least, 80% of all STDs in the country.

Programme targeting

The targets are:

- The youth
- CSW
- Health Training Institutions
- Health Workers

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[1] Health Institutions include quasi government hospitals, and Private Health Institutions include private hospitals and clinics, company clinics, mission hospitals and maternity homes.

Key Sectors

The key sectors identified to implement activities are the Ministry of Health/ Ghana Health Service (MOH/GHS), Ghana Registered Midwives Association (GRMA), Ministry of Defence (MOD), Ministry of Communication (MOC), Ministry of Education (MOE), and Private Practitioners.

3.3 Prevention of HIV Transmission through Transfusion of Blood and Blood Products

Transmission of HIV through transfusion of blood and blood products is believed to account for about 5% of all transmission in Ghana. The National Blood Transfusion Service is already implementing a number of responses to minimize the accidental transmission of diseases through blood transfusion.

The Challenge

The challenge to be addressed is how to reduce the risk of HIV transmission through blood transfusion and blood products.

Objective

The main objective is to reduce by 50% the risk of HIV transmission through the transfusion of blood and blood products by the year 2005.

The Strategies

To achieve this, the following strategies would be adopted:

- Reducing the prevalence of preventable anaemia among women and children;
- Ensuring that all blood is screened before transfusion;
- Strengthening blood donation and transfusion services in the relevant health institutions in the country;
- Auditing of blood transfusion in hospitals;
- Minimising wastage of blood screening kits;
- Promoting autologous blood transfusion.

Expected Outcome

- HIV transmission through the transfusion of blood and blood products to be reduced by 50% by the year 2005.

Programme Targeting

These strategies would be directed at the following:

- **Women and Children** for the prevention of anaemia.
- **The public.**
- **Potential blood donors in ensuring that high risk groups do not donate.**
- **The National Blood Transfusion Service Providers.**
- **Maternal and Child Health (MCH) and Nutrition Service Providers.**
- **Laboratory service providers and clinicians.**
- **Health care providers** especially surgeons in both government and the private sector.

The key sectors are Ghana Health Service, the Ministry of Health (GHS/MOH) and the Private sector.

3.4 Minimising the Risk of Accidental HIV Transmission Outside the Clinical Setting

Accidental transmission of HIV is believed to occur outside the clinical setting through a number of routes. These include Traditional Birth Attendants' (TBAs) attended deliveries, traditional surgical procedures such as circumcision by Wanzams, female genital mutilation and scarification, and at the barber's or hairdresser/beautician's salon. These are believed to account for less than 1% of all transmissions.

The Challenge

The challenge is to minimise the risk of accidental HIV transmission outside the clinical setting.

Objective

It is expected that by the year 2005, the risk of accidental transmission of HIV by service providers outside the clinical setting would be reduced by 50%.

The Strategies

The strategies are.

- Fostering closer collaboration between government and private health institutions and between the formal and informal health sectors,
- Making the services of barbers and beauticians safer in the context of HIV/AIDS,
- Eliminating traditional practices that could facilitate HIV transmission,
- Providing post-exposure prophylaxis (PEP) to all victims of accidental exposure to HIV/AIDS such as health staff and rape victims.

Expected Outcome

The risk of accidental transmission of HIV by service providers outside the clinical setting would be reduced by 50% by the year 2005.

Programme targeting

The strategies would be targeted at the following:

- **Traditional Birth Attendants and Traditional Healers,**
- **Maternal and Child Health Services Outside the Clinical Setting,**
- **The Associations of Barbers and Beauticians,**
- **Traditional Authorities including Houses of Chiefs,**
- **District Assemblies,**
- **The general public.**

The key sectors are Ghana Health Service/Ministry of Health (GHS/MOH), the Private and Informal Health Sectors, the Judiciary, National Council for Women and Development (NCWD), MESW, Ghana Bar Association (GBA), the traditional authorities, Ministry of Local Government and Rural Development (MLG&RD), NGOs and FBOs.

3.5 Reducing Mother-to-Child Transmission (MTCT)

Mother-to-Child Transmission (MTCT) is estimated to account for about 15% of all HIV transmissions in Ghana. Much as MTCT is an important means of HIV transmission, there is no policy on it and there is no active on-going programme to reduce it.

The Challenges

The challenge is to make MTCT prevention services available and utilised.

The Objective

The objective is to develop a programme to reduce the risk of vertical transmission from mother to child by 30% by the year 2005.

The Strategies

The strategies are:

- Initiating programmes to reduce MTCT;
- Advocating the development and implementation of policies, protocols and standards on MTCT;
- Building the capacity of relevant stakeholders to implement MTCT programmes;
- Creating awareness on the risk of MTCT;

- Counselling male partners, apart from mothers on MCTC.

Expected Outcome

Vertical transmission from mother to child would be reduced by 30% by the year 2005.

Programme Targeting

The strategies would be targeted at the following sectors:

- **Women and Women's Associations;**
- **Health Institutions particularly Maternal and Child Health Services;**
- **NGOs, CBOs and other Community Networks;**
- **District Assemblies;**
- **Traditional Authorities;**
- **Civil Society.**

The key sectors to implement activities are MOH/GHS, NPC, NDPC, NCWD, MESW, MLG&RD, NGO and Traditional Authorities.

3.6 Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) Services are a client-friendly service that has been shown in other countries to attract many clients who want to verify their sero-status. The service is currently non-existent in Ghana and would be established in both public and commercial laboratories to provide appropriate services to clients.

The Challenge

The challenge of this strategic intervention is to make voluntary counselling and testing services available and patronised in areas with high prevalence rates.

The Objective

The objective is that VCT service would be made widely available and accessible, and well patronised throughout the country by the year 2005.

The Strategies

To achieve the above objective, the strategies to be adopted include:

Initiating a programme to establish Voluntary Counselling and Testing services,
Creating awareness on VCT services at all levels.

Expected Outcome

Voluntary Counselling and Testing (VCT) would be widely available and accessible, and well patronised throughout the country by the year 2005.

Programme Targeting

The strategies would be targeted at the following sectors:

- **Health Institutions especially ante-natal clinics;**
- **NGO, CBO and other Community Networks;**
- **District Assemblies;**
- **Traditional Authorities;**
- **Civil Society.**

The key agencies include MOH/GHS, MOC, NDPC, NCWD, MESW, PLWHA, NGOs, FBOs, Community-Based Organisations (CBOs) and the Ghana Journalists Association (GJA).

CARE AND SUPPORT

The provision of care for PLWHA both in health institutions and the community is inadequate and needs to be strengthened. The principle of Continuum of Care addresses the package of care and support for persons living with HIV/AIDS and people affected by HIV/AIDS.

Broad Strategies:

- Promoting Voluntary Counselling and Testing of individuals especially the youth (See also Preventive Strategies).
- Improving institutional care including access to drugs for PLWHA.
- Promoting community and social care and support including home-based care.
- Promoting effective linkages between institutional care providers and home-based care providers.

4.1 Institutional Care for PLWHA

Institutional care has remained one of the weakest parts of the continuum of care for PLWHA in the country. Care for PLWHA in health institutions is characterised by fear, ignorance, stigmatisation and discrimination in spite of the early attempt by the MOH to improve their care. Attempts to integrate the management of PLWHA into general wards have failed and affected patients do not benefit from the governmentís exemptions policy.

The Challenge

The challenge is to strengthen the institutional care for PLWHA.

The Objectives

- To improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and communities by the year 2005.
- To strengthen the capacity of health care providers to care for PLWHA by the year 2005.

The Strategies

To achieve the above objective, the following strategies would be adopted:

- Strengthening the capacity of health workers to provide care and support for, and to deliver appropriate services to PLWHA;

- Providing access to anti-retrovirals and drugs for opportunistic infections to PLWHA;
- Providing laboratory support in using anti-retrovirals and drugs;
- Regulating the importation, distribution and use of anti-retroviral and other HIV/AIDS drugs;
- Intensifying universal infection control procedures by health workers;
- Providing post-exposure prophylaxis (PEP) to health workers for accidental exposure to potentially HIV tainted blood or body fluid.

Expected Outcome

- Institutional and health care providersí capacities to care for PLWHA to be significantly improved.

Programme Targeting

These strategies would be directed at the following sectors:

* **People living with HIV/AIDS and their relatives;**
* **All health care providers (both Public and Private);**
* **Health Care Institutions;**
* **Laboratory Services Providers;**
* **District Assemblies;**
* **Civil Society will be provided with information on the availability of care and support for PLWHA in health institutions.**

The key sectors are Ghana Health Service and the Ministry of Health (GHS/MOH) and the Private sector.

4.2 Home-Based Care For PLWHA

Home-based care is an essential component of the continuum of care for PLWHA, which, with the increasing numbers of PLWHA, will take some pressure off the health facilities in the country. It involves the provision of psychosocial support and nursing to PLWHA at home.

The Challenge

To provide good quality home-based care for PLWHA.

The Objectives

The objective of home-based care is to achieve the following by the year 2005:

- Promote positive attitudes and a supportive environment from family members, friends and the community for PLWHA.

- Promote self-care and self-reliance of families and individuals infected and affected by HIV/AIDS.

- Provide good quality care for PLWHA and AIDS-orphans within a family environment.

Strategies

The strategies are:

- Providing adequate knowledge of HIV transmission and care for home-based care providers.

- Promoting culturally acceptable strategies to take care of PLWHA and AIDS orphans.

- Improving support from both traditional and orthodox health systems for home-based care.

- Improving the quality of, and access to counselling and continuous counselling of PLWHA, family and the community.

- Improving community-based financial, material and psycho-social support to PLWHA, carers and people affected by HIV/AIDS.

- **Providing Resources to support HIV/AIDS orphans.**

- Motivating Service Providers.

- Mobilising Funds for HIV/AIDS orphans.

- Building the capacity of community networks such as CBOs, FBOs and community volunteers in caring and supporting PLWHA and people affected by HIV/AIDS.

- Promoting the formation of Associations of PLWHA to guide the provision of care and support for PLWHA.

Expected Outcomes

- Good quality care and support would be provided for PLWHA and AIDS-orphans within a family and community environment by the year 2005.

Programme Targeting

These strategies would be directed at the following sectors:

- **People living with HIV/AIDS and their relatives;**
- **Community Networks;**
- **Traditional Authorities;**
- **Health Care Institutions (both Public and Private);**
- **District Assemblies;**
- **Civil Society.**

The key sectors are Ghana Health Service and the Ministry of Health (GHS/MOH), MESW, MLG&RD, Chieftaincy Secretariat, (Houses of Chiefs) and NGOs including FBOs.

ENABLING ENVIRONMENT

5.1 Creating a Supportive Legal, Ethical and Policy Environment for HIV/AIDS Programmes

In Ghana, HIV/AIDS is generally perceived as a shameful disease associated with acts of immorality. There are reports of stigmatisation and discrimination against PLWHA and PEOPLE AFFECTED BY HIV/AIDS in communities (including churches,) workplaces, homes and even in the use of health facilities and other services. For instance, some foreign Missions are known to deny visas to PLWHA. There is, therefore, a real fear of discrimination, disrespect and abuse of human rights of PLWHA and People Affected By AIDS.

While people with AIDS risk rejection and discrimination, those who suspect they have HIV may avoid getting tested and taking precautionary measures for fear of revealing their infection. They may even avoid seeking health care. Promoting human rights and tolerance is thus important in fighting HIV/AIDS.

Many factors and forces restrict peopleís autonomy and leave them particularly vulnerable to HIV infection and needless suffering once they are infected. These include intolerance of racial, religious or sexual minorities; discrimination against people with known or suspected HIV infection; lower status of women; abuse of power by older or wealthier individuals; scarcity of HIV counselling and testing facilities and of condoms; lack of care and support for those infected with or affected by HIV/AIDS; poverty and trafficking which lead to prostitution; domestic violence and rape; and labour migration which splits up families.

Vulnerability to AIDS is often engendered by a lack of respect for the following rights:

* The rights of women and children,
* The right to information and education,
* Freedom of expression and association,
* The rights to liberty and security,
* Freedom from inhuman or degrading treatment, and
* The right to privacy and confidentiality.

Where human rights such as these are compromised, individuals at risk of HIV infection may be prevented or discouraged from obtaining the necessary information, goods and services for self-protection.

The International Human Rights Convention, the African Charter on Human Rights, and the 1992 Constitution of the Republic of Ghana have constantly recognized and reaffirmed health as a human rights issue. Chapter Five of the 1992 Constitution of the Republic of Ghana guarantees the protection of the right to life (Act 13); the right to the protection of personal liberty (Act 14); right to respect for human dignity (Act 15); and the

right to equality and freedoms.

There is, therefore, no doubt that Ghana needs a rights-based response to HIV/AIDS. A response which recognizes societal vulnerability to HIVAIDS, and provides a coherent, normative framework for dealing with the HIV/AIDS issue. Specifically, Ghana should provide a legally- binding foundation for dealing with procedural, institutional and other accountability mechanisms related to HIV/AIDS in the society.

The challenge

The main challenge is to create an environment which protects civil society and facilitates the enactment and enforcement of appropriate policies and legislation to provide care and support for PLWHA at the workplace as well as in the community; and also to remove all stigma associated with the disease.

The Objectives

The objectives are:

- To reduce individual and societal vulnerability and susceptibility to HIV/AIDS.
- To promote and protect the rights of civil society as well as vulnerable groups such as PLWHA, commercial sex workers, the youth, AIDS-related orphans, etc.
- To create a supportive and caring socio-cultural environment.
- To promote the de-stigmatisation of PLWHA within the family, the community and the nation.

Strategies

The strategies are:

- Reviewing, enacting and formulating laws and policies to protect the rights of PLWHA and People Affected By HIV/AIDS;
- Promoting stricter enforcement of HIV/AIDS and related laws and policies;
- Advocating the elimination of negative socio-cultural practices that promote the spread of HIV/AIDS such as widow inheritance;
- Improving the knowledge of the general public on HIV/AIDS and the rights of PLWHA;
- Strengthening the capacity of the Judicial System, the Commission for Human Rights and Administrative Justice (CHRAJ), FIDA, the Legal Aid Board, etc, to address HIV- related issues;
- Promoting non-discriminatory policies and practices at workplaces, service delivery points, in communities and in families;
- Advocating the expansion of specific programmes for commercial sex workers;
- Promoting stricter enforcement of laws relating to human rights to ensure that civil society is protected.

Expected Outcomes

Positive attitudes and a supportive legal environment for PLWHA would be promoted among family members, friends, and communities.
Appropriate laws and policies that protect civil society including PLWHA and that reduce the rate of infection would be put in place.
Mechanisms for stricter enforcement of HIV/AIDS related laws to be put in place.

Programme Targeting

These strategies would be directed at the following sectors:

- **People living with HIV/AIDS and their relatives;**
- **Community HIV Networks and Traditional Authorities;**
- **Health Institutions and Health Care Providers (both Public and Private);**
- **MDAs and District Assemblies;**
- **Law Enforcement Agencies;**
- **Parliament and the Law Reform Commission;**
- **Department of Social Welfare;**
- **Employers' Associations and Trades Unions;**
- **Civil Society.**

The key sectors are the CHRAJ, the Ministry of Justice, the Judiciary, Parliament, the Ghana Police Service, Ghana Health Service and the Ministry of Health (GHS/MOH), MESW, MLG&RD, Chieftaincy Secretariat, (Houses of Chiefs), and the Private Sector.

DECENTRALISED IMPLEMENTATION AND INSTITUTIONAL ARRANGEMENTS

The HIV/AIDS epidemic requires an institutional response that takes cognisance of the very complex nature of the determinants of spread; the large number of stakeholders and peculiar circumstances in different parts of the country. In order to maximise the gains for all stakeholders, an effective and efficient institutional mechanism needs to be in place to ensure harmonisation of all responses to the draft National HIV/AIDS and STI Policy.

This chapter highlights the coordination and implementation approaches for the Strategic Framework. The approaches acknowledge not only the importance of articulating viable implementation arrangements, but also the need to mainstream HIV/AIDS into sectors and programmes. Through mainstreaming, each MDA or national programme is presented with an opportunity to promote simple internal activities for its own staff, and use its comparative advantage to support the implementation of the strategic framework.

Broad Strategies

- Formulating clear coordination and implementation man dates and responsibilities;
- Strengthening the Human Resources base;
- Mobilising Resources to Implement the Framework.

6.1 Coordination and Implementation Arrangements

The HIV/AIDS epidemic has been recognised as a multi-faceted issue. However, since the onset of the epidemic in Ghana, the Ministry of Health has been the dominant, if not the sole, stakeholder. More recently, stakeholders like the Ministries of Employment and Social Welfare, Communications, and Education, NGOs and political and traditional leaders have intensified their participation in HIV/AIDS activities. At the current level of the HIV/AIDS epidemic, broad participation by stakeholders at the national, regional, district, community and household levels, as well as among all partners in development, that is, public and private sectors and donors, is crucial. An effective co-ordination mechanism is essential to ensure this decentralised implementation.

Challenge

To establish a strong and functional institutional mechanism for implementing and coordinating the draft National HIV/AIDS and STI Policy at all levels.

Objectives

To establish a well-managed multi-sectoral and multi-disciplinary institutional framework

for coordinating and implementing the national response at all levels.

Strategies

- Establishing the Ghana AIDS Commission and its Secretariat;
- Mainstreaming HIV/AIDS into activities and programmes of all MDAs, Private Sector and NGOs;
- Promoting regional response to the epidemic;
- Scaling-up the District Response Initiative (DRI);
- Building the capacities of stakeholders at all levels.

Expected Outcomes

- A multi-sectoral and multi-disciplinary institutional framework for managing HIV/AIDS would be established at all levels.
- HIV Response would be placed firmly on the political agenda.
- HIV/AIDS to be integrated into the development planning process at all political and administrative levels.
- Capacity of stakeholders to be built at all levels.
- DRI to be scaled-up and formed in all districts.
- Regions to be strengthened to support districts and facilitate linkages.

6.1.1 Ghana AIDS Commission and Secretariat

A multi-sectoral National HIV/AIDS Commission has been established within the Office of the President and shall have the following functions:

- Advise the Government of Ghana on policy issues relating to HIV/AIDS;
- Provide high-level advocacy for HIV/AIDS;
- Expand and co-ordinate the total national response, including formulation of national plans and guidelines;
- Monitor and evaluate all on-going HIV/AIDS activities;
- Identify, mobilise and manage all funds and other resources for HIV/AIDS and related programmes;
- The Commission will form Technical Advisory Committees when necessary on key issues.

A National HIV/AIDS Secretariat has been established to serve the Commission and implement its decisions and programmes. The Secretariat shall co-ordinate, monitor and manage funds for HIV/AIDS and related activities in the country.

6.1.2 Ministries, Departments and Agencies (MDA), Private sector and Civil Society

All Government MDAs shall develop sector-specific programmes. For example:

- The National Development Planning Commission will ensure the integration

and mainstreaming of HIV/AIDS concerns into development policies and programmes of MDAs and District Assemblies.

- The National Population Council will ensure the integration of HIV/AIDS issues into population programmes, and also advocate for the effective implementation of HIV/AIDS programmes.

- MOH will facilitate the development of programmes on institutional care for PLWHA, STD management, Blood Products and MTCT.

- The National Council on Women and Development will facilitate the mainstreaming of gender issues in HIV/AIDS programmes.

Furthermore, private-sector organisations, NGOs, Community-Based Organisations, traditional authorities, religious institutions, professional bodies and associations, youth groups etc. shall develop and implement respective programmes in accordance with priorities and intervention strategies outlined in this document.

6.1.3 Regional HIV/AIDS Committees

In order to decentralise the functions and activities of the Ghana HIV/AIDS Commission, a Regional Committee will be established with the Regional Minister as Chairperson. The functions of these committees shall be to:

- Maintain oversight responsibilities over the regionís local-level responses to the epidemic.
- Lobby for Resources and Funding.
- Advocate for appropriate policy formulation to facilitate and meet the needs of local responses in the region.
- Establish vertical and horizontal linkages for cross-district learning and integration of lessons learned and "best practices" from community and district levels into regional level policy formulation.
- Facilitate district-level capacity-building activities.

At the regional level, the location of the initiative within the Regional Co-ordinating Council (RCC) reflects its overall harmonisation, advisory and political mobilisation roles. The RCC is, therefore, required to provide the necessary administrative and logistical support, such as a regional-level location for the programme.

The need for functional mechanisms to provide both technical and financial support directly to institutions, CBOs, NGOs and communities is recognised. With regard to technical assistance, Regional Technical Resource Networks must be set up within the Regional Coordination Council or Regional AIDS Committee to, more appropriately, provide these inputs. Technical assistance will often be a mix of public and private resource persons who can be called upon in a more cost-effective manner, to support district and community initiatives. With regard to direct fund disbursement to districts, central institutions will need to develop their capacity to monitor multiple financial reports.

6.1.4 District, Community and Family Level Implementation

The 110 districts of the country represent different and unique environments and sets of circumstances. Districts and local communities have different levels of capacity to support the local response to HIV/AIDS. They have different traditional set-ups, financial capabilities, vulnerable groups and levels of HIV prevalence. Each district also has its own set of developmental priorities articulated in District Development Plans, vying for increasingly limited resources. All these combine to create specific contexts within which management and implementation of the District Response Initiative to HIV/AIDS must take place.

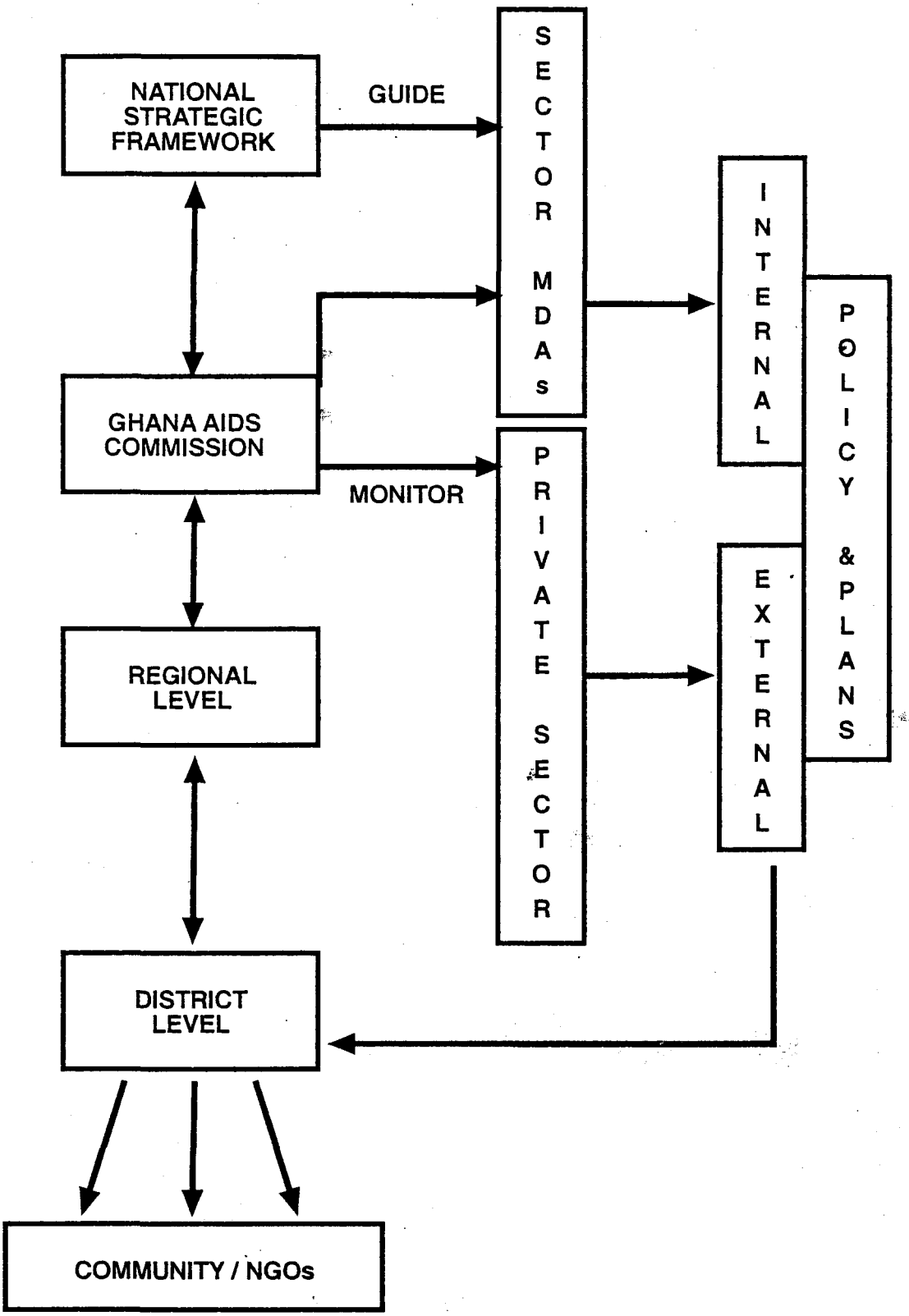
At the district level, a Committee on HIV/AIDS would be established to co-ordinate, monitor and supervise all HIV/AIDS activities. The District Chief Executive would chair the Committee. The composition of the District HIV/AIDS Committee would include all MDAs, NGOs, religious bodies, traditional authorities, youth and womenís associations, private sector institutions, PLWHA and other individuals who are competent in developmental issues. At the Community level, the Unit Committee would be the point of reference for all HIV/AIDS programmes.

To accelerate the involvement of more districts, the DRI and existing institutional structures will be used as far as possible to expand local responses, and where required, the necessary institutional capacity will be built to manage and implement local HIV/AIDS activities by:

- Providing the required technical assistance and inputs for local stakeholders to **strategically manage** their own plans, strategies and multi-sectoral HIV/AIDS activities, and to document these activities; and

- Directing financial and human resources for implementation of HIV/AIDS activities, such as advocacy, prevention activities, district sero-surveillance, care and support for PLWHA, etc.

Fig. 4 - Institutional Arrangement



RESEARCH, MONITORING AND EVALUATION

Effective implementation of the Strategic Framework depends largely on a well laid-out research, monitoring and evaluation (RME) mechanism that will guide stakeholders to establish the extent to which input deliveries, work schedules and target outputs are proceeding according to plan. RME shall be a cross-cutting intervention to inform policy formulation at all levels.

7.1 Research

Research activities that relate to each area of intervention will be carefully developed. The results of researches would be disseminated at national, regional and district levels. The aim is to get the inputs of people affected by the implementation of the programme as well as other policy and decision-makers in order to review the entire programme strategy as may be appropriate.

Objective

To strengthen and expand the national capacity to plan, implement and coordinate HIV/AIDS and related researches.

Strategies

- The National Research Protocol developed by the National Population Council would serve as a useful guide.
- Baseline data collection, where appropriate, would be initiated as early as possible.
- A logical frame with objectively-verifiable indicators (OVI) to guide data collection would be developed.
- Capacity-building, both institutional and human, would be undertaken at all levels for HIV/AIDS and related researches.

Expected Outcome

Research will be a major tool for reviewing, evaluating and improving the national response to HIV/AIDS.

7.2 Monitoring

As a management tool, monitoring systems would be developed to identify strengths and weaknesses in programme implementation at all levels. These systems will take into consideration decentralised management structures. This means that each implementing agency would put in place its own monitoring system, including routine reporting and field visits. Monitoring and evaluation should be adequately budgeted for and not subsumed under any budget-line.

Strategies

- HIV/AIDS Surveillance would be strengthened.
- Improved systems of reporting would be developed using appropriate information technologies.

The National HIV/AIDS Secretariat shall be responsible for the overall monitoring of the strategic framework. The Secretariat shall facilitate the development of guidelines for monitoring. For example, field visits would be planned and based on the following:

* elements from the workplan for the period;
* issues identified during previous visits and which require follow-up; and
* examination of records on site.

Where monitoring is to be made through progress reports, the major components that are to be included are the specific objectives and activities that were to be accomplished during the period, the degree to which each was completed, identification of constraints/ obstacles that explain why certain objectives/activities were not completed as planned and items to be followed up during next visits.

The Secretariat will put in place mechanisms to ensure that all implementing bodies of this programme adhere strictly to the guidelines for monitoring and evaluation and submit regular reports to that effect to feed into the preparation of the national report.

7.3 Evaluation

In addition to the continuous overview of programme implementation, there would also be periodic programme evaluation to determine the relevance, effectiveness and impact of activities. Since the purpose of the evaluation is to provide information to the managers of the HIV/AIDS programmes to enable them improve the programme quality and implementation as well as to assess the design of the programme, there would be both internal and external evaluations.

The process shall include a mid-term evaluation to be conducted after two and a half years and an end-of-programme evaluation to be conducted at the end of the five-year period of the programme. These evaluations could be either a one-person review or analysis, or conducted by a group of experts. The evaluation would assess the extent to which the programme has achieved its outputs and make recommendations for the next programme cycle.

For a comprehensive evaluation to be made, it would be conducted along the major intervention areas such as prevention, care and support, legal and ethical response, etc. This thematic evaluation will focus on an examination of the concepts and specific approaches used in the implementation of the activities, the role of UNAIDS and other donors and government in support of the planned activities and implementation issues such as results achieved, problems and reasons for success or failure. A baseline survey would be con-

ducted at the start of the programme to provide information against which progress would be measured.

CONCLUSION AND THE WAY FORWARD

The successful implementation of the activities in the strategic framework will depend on the collective will, commitment and responsibility of all partners in the fight against HIV/AIDS. Since it is the hope of Government that all its citizens enjoy good quality life as enshrined in the 1992 Constitution, Ghana Vision 2020, the National Population Policy (Revised Edition, 1994), the HIV/AIDS Policy and other policy documents, all concerned parties are expected to work in concert to fight the disease. This means that the partnership among government, non-governmental organisations, the private sector and donor agencies should be strengthened.

The HIV/AIDS pandemic, as already noted, goes beyond a health problem. That is why the strategic framework deals with all its ramifications. It is expected that in the implementation of the programmes outlined in the framework, the integrated approach would be adopted so as to achieve maximum output for the objectives set in the framework. To ensure that the Plan becomes fully operational, the following issues have to be addressed.

1. **Approval and Adoption of the HIV/AIDS Strategic Framework.** The administrative and bureaucratic procedures necessary for the framework to become operational are to be speeded up in order not to lose time during implementation. Since the establishment of the National HIV/AIDS Commission may delay, a Multi-Sectoral Committee including the NACP should be given the interim responsibility for the implementation process pending the formal establishment of the Secretariat. Similar arrangements must be made at the Regional, District and Community levels.

2. **Strong Political Will and Commitment** have to be demonstrated by all policy makers in the political arena. This has to be reflected in public speeches made on AIDS at every opportunity by Government officials and politicians as well as in their manifest support for PLWHA.

3. **MDAs, NGOs, Private Sector, District Assemblies, Communities** should liaise with the interim Committee to develop their respective sector plans within the context of the National HIV/STD Strategic Framework. Such Sector or District Plans, though to be unique, should keep in focus the objectives and targets set in this Strategic Framework. In effect, any evaluation should be able to assess the contribution of each sector or district towards the attainment of the overall goal of the National HIV/AIDS and STI Policy.

4. **Mobilisation of Resources**

- The successful implementation of the Framework and the accompanying Strategic Plans depends on the availability of both financial and human resources. It is estimated that, to effectively implement the framework, an equivalent amount of $118,930,000 would be needed. (See Appendix 1) Since each sector and district would develop its own plan, they are to make budgetary provision for it in their Medium Term Expenditure Framework (MTEF) submitted to the Ministry of Finance (MOF).

- Government should also make a presentation to both multi-lateral and bilateral donors for support. Funds released for the implementation of activities are to be judiciously used and accounted for in accordance with the agreed terms between the donor and government.

- Qualified personnel have to be attracted to all sectors and districts to oversee programme implementation. Adequate provision has to be made for their motivations so as to ensure retention of staff.

APPENDIX I : SUMMARY OF STRATEGIC INTERVENTIONS

PREVENTION OF NEW INFECTIONS

Main Objective: To substantially reduce new HIV Infections among the youth and other vulnerable groups

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To significantly raise individual personal risk perception To delay onset of sexual activity among youth (especially among adolescents) To promote positive behaviour change To promote condom use among sexually active individuals	To increase the median age at first sex from 17 years to 18 years by the year 2005. To achieve significant reduction in the number of sexual partners by sexually active individuals by the year 2005. To increase the use of condoms among sexually active individuals from 15% to 30% by the year 2005	Promoting effective and culturally appropriate IE&C strategies, Intensifying Poverty Reduction Programmes Promoting and increasing condom accessibility, availability and affordability.	Youth, women, Commercial Sex Workers, mobile and migrant populations and the general public.	The median age at first sex increased from 17 years to 18 years. A significant reduction in the number of sexual partners by sexually active individuals achieved The use of condoms among sexually active individuals increased from 15% to 30%.	Ghana AIDS Commission	$28,000,000

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To ensure the adequate and effective management of STD To ensure prompt treatment of STD	To ensure that 80% of all STD cases in the country is adequately managed by the year 2005	Strengthening syndromic management of STD in both government and private health institutions[2] including appropriate referral mechanisms and the drug procurement system in the country, Integrating syndromic management of STD into curricula of all health-training institutions, Expanding the integration of syndromic management of STDs into other services e.g. Family Planning Services, Increasing awareness on complications and prevention of STD, Improving the monitoring of STD in both public and private institutions in the country.	The youth, CSW, Health Training Institutions, Health Workers	An effective system put in place and strengthened to manage at least 80% of all STD cases in the country.	MOH/GHS, GRMA, MOD, MOI, MOE, and the Private Practitioners.	$5,800,000
To reduce the risk of transmission through blood transfusion and blood products	To reduce the risk of transmission through the transfusion of blood and blood products by 50% by 2005	Strengthening blood donation and transfusion services in the relevant health institutions in the country, Minimizing wastage of blood screening kits to ensure that all blood is screened before transfusion, Promoting autologus blood transfusion, Reducing the prevalence of preventable anaemia among women and children.	Women and children The general public Potential blood donors The National Blood Transfusion Service Laboratory services Health care providers Maternal and Child Health Service Providers	HIV transmission through the transfusion of blood and blood products reduced by 50% by the 2005.	Ghana Health Service and the Ministry of Health (GHS/MOH) and the Private sector.	$1,810,000

[2] Government Health Institutions include quasi government hospitals, and Private Health Institutions include private hospitals and clinics, company clinics, mission hospitals, maternity homes, etc.

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To minimise the risk of accidental HIV transmission outside the clinical setting.	To reduce the risk of accidental HIV transmission by service providers outside the clinical setting by 50% by the year 2005	Fostering closer collaboration between government and private health institutions and between the formal and the informal health sectors, Making the services of barbers and beauticians safer in the context of HIV/AIDS, Eliminating traditional practices that could facilitate HIV transmission, Providing post-exposure prophylaxis (PEP) to all victims of accidental exposure to HIV/ AIDS e.g. health staff and rape victims.	The general public The traditional birth attendants and traditional healers The maternal and child health service The association of barbers and beauticians Traditional authorities District assemblies	The risk of accidental transmission of HIV by service providers outside the clinical setting reduced by 50% by the year 2005.	Ghana Health Service/ Ministry of Health (GHS/ MOH), the Private and Informal Health Sectors, the Judiciary, NCWD, MESW, Ghana Bar Association, the Traditional Authorities, MLG&RD, NGO and FBO.	$4,200,000
To make MTCT services available and utilised.	To develop a programme to reduce the risk of vertical transmission from mother to child by 30%, by 2005.	Initiating a programme to reduce MTCT. Advocating for development and implementation of policies, protocols and standards. Building the capacity of the relevant stakeholders to implement the policy, Creating awareness on the risk of MTCT and the availability of services at all levels. Counseling not only mothers but other partners on MTCT	Civil society Health institutions NGO, CBO and community networks District Assemblies Traditional authorities	Vertical transmission from mother to child reduced by 30% by the year 2005.	MOH/GHS, NPC, NDPC, NCWD, MESW, MLG&RD, NGO and Traditional Authorities.	$5,000,000
To make VCT services available and patronised	To makeVoluntary Counselling and Testing services available, accessible and patronised throughout the country by 2005.	Initiating a programme to establish Voluntary Counselling and Testing Services, Creating awareness on VCT services at all levels. Strengthening the monitoring system	Civil society, Health Institutions, NGO, CBO and other Community Networks District Assemblies, The Traditional Authorities	Voluntary counselling and testing (VCT) is widely available, accessible and well patronised throughout the country by the year 2005	MOH/GHS, MOC, NDPC, NCWD, MESW, PLWHA, NGOs, FBOs, CBOs and the GJA.	$4,000,000

CARE AND SUPPORT

Main Objective: To improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and the communities by the year 2005

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To strengthen the institutional care for PLWHA	To improve service delivery and mitigate the impact of HIV/AIDS on individuals, families and the communities by 2005 To strengthen the capacity of health care providers to care for PLWHA by 2005	Strengthening the capacity of Health workers to provide care and support and to deliver appropriate services to PLWHA, Improving access to anti-retrovirals and drugs for opportunistic infections to PLWHA, Regulating the importation, distribution and use of anti-retroviral and other HIV/AIDS drugs, Intensifying universal infection control procedures by health workers, Providing post-exposure prophylaxis (PEP) to health workers for accidental exposure to potentially HIV tainted blood or body fluid.	PLWHA and their relatives All health care providers Health care institutions Laboratory services District Assemblies Civil Society	Institutional and health care providersf capacity to care for PLWHA significantly improved.	GHS, MOH and the private sector	$42,000,000

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To provide good quality home-based care for PLWHA	Provide good quality home-based care for PLWHA and AIDS orphans within a family setting Promote positive attitudes and a supportive environment from family members, friends and community for PLWHA Promote self-care and self-reliance of families and individuals infected and affected	Improving the knowledge, skills and attitudes of home-based care providers, Improving support from both traditional and orthodox health systems for home based care, Improving quality and access to counselling and continuous counselling of PLWHA, family and community, Improving community based financial, material and psycho-social support to PLWHA, carers and people affected by HIV/AIDS, Promoting culturally sensitive strategies to take care of PLWHA orphans, Motivating Service Providers Mobilising funds for HIV/AIDS orphans Building the capacity of community networks such as CBO, FBO and community volunteers in caring and supporting PLWHA and people affected by HIV/AIDS, Promoting the formation of Associations of PLWHA to guide the provision of care and support for PLWHA.	PLWHA and their relatives The general public Community networks The traditional authorities Health care institutions District health management teams The monitoring system District assemblies	Good quality care and support provided for [Ö%] of PLWHA and AIDS-orphans within a family and community environment by the year 2005.	GHS/MOH, MESW, MLG&RD, Chieftaincy secretariat and NGOs	$1,980,000

ENABLING ENVIRONMENT

Main Objective: To reduce individual and societal vulnerability and susceptibility to HIV/AIDS through creating an enabling environment for the implementation of the strategic framework.

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To enact and enforce appropriate legislation to facilitate the provision of care and support to PLWHA.	To reduce individual and societal vulnerability and susceptibility to HIV/AIDS. To promote and protect the rights of civil society especially vulnerable groups like PLWHA, CSW etc. To create a supportive and caring socio-cultural environment. To promote de-stigmatisation of PLWHA within the family, the community and the nation.	Review existing laws and enact new laws and policies to protect the rights of PLWHA and People affected by HIV/AIDS. Improve the knowledge of the general public on HIV/AIDS and the rights of PLWHA Promote stricter enforcement of HIV/AIDS related laws and policies. Promote stricter enforcement of human rights laws Strengthen the capacity of the judicial system - CHRAJ, FIDA, The Legal Aid Board to address HIV related issues. Promote non-discriminatory policies and practices at workplace, service delivery points, communities and in families. Advocate for the expansion of specific programmes for commercial sex workers.	People living with HIV/AIDS and their relatives. Civil Society Community Networks and the Traditional Authorities Health Institutions and Health Care Providers (both Public and Private). District Assemblies. Law Enforcement Agencies Parliament and the Law Reform Commission Department of Social Welfare.	Positive attitudes and a supportive environment for PLWHA promoted among family members, friends and community. Appropriate Laws and Policies that protect PLWHA and reduce the rate of infection put in place. Mechanisms for stricter enforcement of HIV/AIDS related laws put in place.	CHRAJ, MOJ, The Judiciary, Parliament, the Ghana Prison Service, Ghana Health Service/ MOH.	$1,140,000

DECENTRALISED IMPLEMENTATION AND INSTITUTIONAL ARRANGEMENTS

Main Objective: To put in place an effective and efficient co-ordination mechanism that will enjoy universal coverage, harmonise responses and maximise the gains of all stakeholders

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To establish a *strong and* functional arrangement for implementation and co-ordination of the framework.	Establish a well-managed multi-*sectoral and multi-disciplinary* institutional framework for co-ordination and implementation of the national response.	Establish the Ghana AIDS Commission. Mainstream HIV/AIDS into activities and programmes of all MDA. Set up relevant regional institutions for coordination and implementation. Scale-up the District Response Initiative (DRI).	GAC RCC DA NGO and CBO MDA	A multi-sectoral and multi-disciplinary and institutional framework for managing HIV/AIDS established at all levels. Response is firmly on the political agenda. HIV/AIDS is integrated into the development planning process at all political and administrative levels. Capacity of stakeholders is built. Regions are strengthened to support districts and facilitate linkages. DRI is scaled up.	GAC, MESW, MLG&RD	$22,600,000

RESEARCH, MONITORING AND EVALUATION

Main Objective: To effectively implement the strategic framework to achieve the overall objective of minimising the spread of HIV/AIDS.

Challenges	Specific Objectives	Strategies	Programme Target	Expected Outcome	Lead Agencies	Cost
To ensure effective implementation of the strategic framework	To strengthen and expand the national capacity to plan, implement and coordinate HIV/AIDS related researches.	**Research:** National Research Protocol developed by NPC would serve as a useful guide Baseline studies would be conducted A logical frame with objectively verifiable indicators (OVI) to guide data collection would be developed. **Monitoring:** Improved systems of reporting would be developed using appropriate technologies HIV/AIDS Surveillance would be strengthened. **Evaluation:** There would be a continuous overview of programme implementation There would be mid-term evaluation as well as end of programme evaluation Evaluation would be conducted along the major intervention areas.	All levels of implementation and coordination.	Research would be a major tool for reviewing, evaluating and improving the national response to HIV/AIDS. System of monitoring and evaluation institutionalised . Epidemiological surveillance of HIV/AIDS actively pursued.	GAC	$2,400,000

APPENDIX II: TECHNICAL TEAM

NAME	ORGANISATION	RANK
Core Members		
1. Apewokin, E. (Mrs.)	NPC Secretariat.	*Director, (Leader)*
2. Attipoe, D. (Dr.)	MOH	*Reg. HIV/AIDS Coordinator (Alternate Leader)*
3. Adjei, Sam. (Dr.)	GHS	*Dep. Director-General*
4. Yeboah, Kwaku (Dr.)	NACP	*Programme Coordinator*
5. Addae, E. (Dr.)	MOH	*Senior Medical Officer*
6. Annan, J. S. (Dr.)	JSA Consult	*Director*
7. Grey, S.E.A (Mr.)	NPC Secretariat.	*Head, Policy Unit*
Others		
1. Addai, E. (Mr.)	CEDEP	*Programme Officer*
2. Addo, Akwei N. (Dr.)	MOH	*Volta Reg. HIV/AIDS Coordinator*
3. Asare-Bediako,-C. (Mrs.)	MESW	*Asst. Director 1*
4. Bleboo, M. (Ms.)	Ad Vantage PR	*Director*
5. Johnson, P. (Mrs.)	NDPC	*Ag. Director, Social Sector Div.*
6. Kwankye, S. (Mr.)	PIP, Legon	*Associate Director*
7. Lithur, Nana Oye	FIDA	*Deputy Executive Secretary*
8. Lokko, K. (Mr.)	GSMF	*Programme Officer*
9. Stegman, P. (Dr.)	JSA Consult	*Associate Consultant*
Support Team		
1. Aboagye-Nyarko, F. (Mr.)	NPC Secretariat	*Programme Officer (Secretary)*
2. Owusu-Afranie, Dan (Mr.)	NPC Secretariat.	*Programme Officer (Secretary)*
3. Adaletey, Denis (Mr.)	NPC Secretariat.	*Programme Officer*
4. Cofie, Esther (Ms.)	NPC Secretariat.	*Programme Officer*

APPENDIX III: OVERSIGHT COMMITTEE MEMBERS

NAME	ORGANISATION
Adibo, Moses (Dr.)	Ministry of Health (Chairperson)
Addy, Patrick (Professor, Dr.)	Ministry of Youth and Sport, Accra (Chairperson)
Accorsi, Sanaro	EU Ghana Office, Accra
Addae, Elvis	CEDEP
Adusei, Kofi	Traditional Medical Directorate, MoH, Accra
Adjei, Sam (Dr.)	Ghana Health Service, Accra
Adofo Felicia (Mrs)	GES, SHEP, Accra
Amofa, G.K. (Dr.)	MoH/PHD
Amuzu, S.K (Dr.)	USAID, Accra
Armah-Attoh, Daniel	NPC Secretariat
Avorkey, Fenella	WHO, Accra
Awittor, Evelyn (Dr.)	World Bank
Budu Smith, Grace	CRDD/MOE
Bugri, Sam (Dr.)	MoH/HQ
Dennis, Juliana	Ministry of Food and Agriculture, Accra
Dramé, Mohamed (Dr.)	GTZ, Accra
Eledu, Cynthia	UNAIDS, Accra
Ellonye, H. M.	Ministry of Youth and Sports
Gaere, Liz	DFID Field Health Office, Accra
Issah, Yahaya	Ministry of Communication, Accra
Khonde, Nzambi (Dr.)	CIDA, Accra
Lefevre, Bruno	UNESCO, Accra
Lokko, Kojo	GSMF
Mensah, E. N. (Dr.)	GHS
Mukasa, Moses	UNFPA, Accra
Opoku, Kwasi	MOF
Reale, Luana	EU/MOF, Accra
Tsameye, Felix	Min. of Employment & Social welfare, Accra
Yeboah, Ampadu K.	Ghana Employers Association, Accra
Turkson, Richard B. (Dr.)	National Population Council, Accra
Yeboah, Kwaku (Dr.)	MoH/NACP, Accra

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