REPUBLIC OF GHANA

NATIONAL HIV/AIDS STRATEGIC FRAMEWORK II

2006-2010

Ghana AIDS Commission

"Scaling up Towards Universal Access and Working Actively and in Partnership to Combat HIV/AIDS"

September, 2005

Table of Contents

List of Figures

Executive Summary

Introduction

In 2004, approximately 400,000 Ghanaians were estimated to be HIV-positive and this number is expected to reach 500,000 by 2015. HIV prevalence rates have increased from 2.6 percent in 2000, to 3.6 percent in 2003, and 3.1 percent in 2004 (National AIDS/STI Control Programme, GHS, 2005). Within this general pattern are considerable variations by geographic region, gender, age, occupation, and, to some degree, urban-rural residence. There have emerged pockets of high infection which have had considerable impact on the socio-cultural and economic situation of such areas.

This National Strategic Framework 2006–2010 (NSF II) recognises the HIV/AIDS epidemic as a socio developmental challenge and, therefore, incorporates issues dealing with recent evolutions in the epidemic, the social forces driving the epidemic, the socio-cultural environment, and the experiences from the first strategic framework 2001–2005 (NSF I).

Guiding Principles for National Strategic Framework 2006–2010

This NSF II is designed to provide an overall planning guide for a vastly expanded effort to deal with the epidemic including improvements to the supporting environment, preventing infections, targeted behaviour change programmes to the general population as well as specific vulnerable groups, treatment, care and support, and combating stigma and discrimination. These strengthened and expanded efforts will take place within the framework of the "Three Ones" Principles:

- One HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority with a broad based multisectoral mandate for HIV/AIDS overall policy and co-ordination; and
- One agreed country level monitoring and evaluation system.

In addition, the implementation of this NSF II is underpinned by the fact that HIV/AIDS management requires:

- A multi-sectoral partnership approach;
- Respect for fundamental human rights;
- Access to information and comprehensive services;
- Effective coordination of the decentralisation response of organizations, communities, individuals, and PLWHA participating and sharing responsibilities in all HIV/AIDS programmes; and
- Mobilization of adequate resources, financial and human, to support the Framework.

Structure of NSF II and Key Interventions

S**even key intervention areas** are identified in NSF II around which comprehensive action plans including budgets will be prepared for implementation.

The key intervention areas are organized into chapters. In each chapter are objectives, key issues, strategic results, challenges, strategies, the lead agency and key actors in programming. These seven key intervention areas are indicated below.

1. Policy, Advocacy and Enabling Environment: The favourable socio-political environment within the country inspired the development of NSF I and NSF II. The 1992 Constitution recognizes and affirms the basic rights of citizens. The President also serves as the Chairman of the Ghana AIDS Commission, and the involvement of key Ministries, the private sector, traditional and religious leaders and civil society have helped to create a favourable response to the epidemic. One of the challenges is the utilization of this social and political commitment in the development and implementation of effective programmes and activities. Some of the intended programmes are likely to be controversial and require social and attitudinal change in diverse areas such as enforcement of laws against stigma and discrimination, norms regarding transactional sex, and multiple sexual partnerships. NSF II recognises the need to develop and operationalise laws and policies to protect the rights of PLWHA, meet the challenges posed by stigma and discrimination, as well as new demands involved in expanding prevention, treatment, care and support. Advocacy and social mobilization will constitute important tools in addressing socio-cultural issues such as eliminating stigma and discrimination against PLWHA and improving the rights and status of women, orphans and other vulnerable persons.

2. Coordination and Management of the Decentralised Response: Coordination and management of the national response through the decentralised system constitute key components of HIV/AIDS programme implementation. The Ghana AIDS Commission (GAC) as the national coordinating body blends both political focus and technical dimensions to ensure a harmonised national response. Among the strategies needed to achieve an effective decentralised response will be the strengthening of the Ghana AIDS Commission, establishing clearly defined roles and responsibilities for all implementers and stakeholders, and capacity building of all participants – National, Regional and District levels, NGO, CBO and the private sector – to implement and monitor all the steps necessary to combat the HIV/AIDS epidemic. In NSF II the private sector, civil society, organized labour, religious and traditional leaders will be mobilised for programmes and to ensure that HIV/AIDS is kept at the centre stage of the political aspects of coordination, policy direction and guidance, and the development of partnerships.

3. Mitigating the Social, Cultural, Legal and Economic Impacts: The HIV/AIDS epidemic poses a developmental and social challenge to Ghana. The spread of HIV is strongly influenced by the social, cultural and economic environment. The sexual, social and spatial milieus in which people operate, and the political structures which provide the

framework for governance, have implications for the pattern of spread and the nature of responses to the epidemic. Affecting the most active, productive and the reproductive members of the society, HIV/AIDS impacts on a country in diverse ways. At the economic level it lowers productivity and increases the cost of business. The challenges involve identifying and enhancing the positive social aspects that may help to reduce transmission and mitigate the effects of the epidemic, such as reinforcing and supporting strong families and communities. At the same time, the programme will identify and eliminate negative social aspects, such as the subjugation of women and other gender issues that have implications for the spread, prevention and mitigation of the impact of the epidemic. The economic impact of the epidemic is large and growing, and it will affect the national economy in many ways. Mitigating the impact of the epidemic at the societal level will involve mainstreaming HIV/AIDS into a number of national programmes -- the Poverty Reduction Strategy, addressing gender-based vulnerability, domestic violence, coercion and marginalization of women -- and harmonizing some national laws with the international laws that various Governments of Ghana have signed and which have implications for the management of HIV/AIDS and rights of persons. Programmes will also be pursued that will provide PLWHA with resources (e.g. micro credit) to improve their wellbeing and survival.

4. Prevention and Behavioural Change Communication: One of the challenges of the national response is developing the next generation of interventions, including Behaviour Change Communication (BCC), which focus on changing individual risky sexual behaviour as well as community perceptions and attitudes about HIV/AIDS and PLWHA. Such programmes will target the general population, specific vulnerable groups, such as sex workers and their clients, STI clinic attendees, migratory populations, youth (particularly those on the street), itinerant traders, women (especially subgroups that suffer disproportionately from the disease such as those not currently in marital unions) and middle class employed persons. Also geographic areas where there is high prevalence, and places such as bars, markets, border towns and truck stops where unprotected, casual sex takes place will be targeted in a non-stigmatising manner.

5. Treatment, care and support: Opportunities for comprehensive treatment, care and support have expanded rapidly within the last five years. For example, antiretroviral drugs have become increasingly accessible and affordable and are currently being supplied to an increasing number of people. ARV therapy has been simplified and funding has become increasingly available in developing countries as a result of stronger bilateral and multi-lateral partnerships and strengthened international commitments to the fight against HIV/AIDS. These developments set the stage for a rapid scaling-up of treatment programmes. Adopting this plan implies working towards the goal of providing treatment to all people who require it. This may lead to substantial shortages in the availability of drugs at some period during the scaling-up. Therefore it will require the development of access policies which include gender and age equity. At the same time, care and support programmes for PLWHA will require substantial expansion of institutional, community, and family efforts, and an appropriate manpower mix which is feasible, affordable, and meets the needs of all who require care and support. The solution will be a combination of professional personnel and volunteers, all of whom will require substantial training and continuing support.

6. Research, Surveillance, Monitoring and Evaluation: NSF II will be guided by evidence-based strategies and programmes. This requires institutions capable of conducting high quality research, as well as systems for collating, storing and disseminating quality data and information in a timely manner. Through research, surveillance, monitoring and evaluation activities, chosen strategies in NSF II will be assessed throughout the entire process of programme implementation. Periodic assessments that provide status, trends and changes in inputs, outputs and outcomes will help managers to monitor programmes, and make adjustments as and when necessary. Strategies to strengthen these areas include developing clear priorities for research and a national research agenda; updating and operationalising the national monitoring and evaluation plan; and the timely dissemination of data and information at various levels. These activities will call for the strengthening of institutional mechanisms for conducting research, surveillance, monitoring and evaluation to ensure that desired changes in sexual behaviour are occurring, stigma and discrimination are declining, the incidence of HIV is declining, and that PLWHA and others affected by the epidemic receive needed treatment, care and support.

7: Mobilization of Resources and Funding Arrangements: Resource mobilization and utilization are critical elements in meeting the huge human, financial and material resources required for the expanded and diversified programmes envisaged. Under NSF II, resource mobilisation and funding will be enhanced and effectively coordinated through a partnership forum under the leadership of GAC. The objective is to ensure that resources committed to HIV/AIDS activities from all sources are pooled into an integrated system to support the national response. In addition, the Framework will ensure sustainable availability of resources to implement national HIV/AIDS priority activities. Strategies for accomplishing this will include re-engineering the GARFUND into a coordinated multi-donor funding arrangement, strengthening the transparent and consultative mechanism for the disbursement of funds developed under NSF I, as well as mechanisms for monitoring disbursed funds, and improving the capacity of staff at all levels.

Conclusion

As an epidemic affecting the productive and the reproductive components of the population, the socio-economic and human impacts of the epidemic are vast. Therefore, responding to the epidemic will require changes in some cultural practices including early marriage of females, sexual norms, beliefs and behaviours which create dependency of women and promote multiple sexual partnerships, transactional sex, and intergenerational sex. So also will be the need for adherence to the “Three-Ones” principle for the management of the epidemic as well as an expanded system of resource mobilization and utilization. This strategic framework deals with the diverse ramifications of the epidemic. The successful implementation of NSF II will depend on the collective will, commitment and responsibility of all partners - government, ministries, departments and agencies, non-governmental organisations, traditional and religious leaders, private sector, donor agencies, civil society, with everybody working in concert.

Chapter 1: Introduction

1.1 Background to the Epidemiology of HIV/AIDS

The first case of AIDS in the country was diagnosed in 1986, and by the year 2004 an estimated 380,000 adults and 14,000 children were HIV-positive (UNAIDS, 2004a). By 2004, the cumulative number of people diagnosed with AIDS was 36,000 (Figure 3). Prevalence rates increased from an estimated 2.6 percent in 2000, to 3.6 percent in 2003, and 3.1 percent in 2004 (National AIDS/STD Control Programme, GHS, 2005).[1] The nature of the epidemic in the country has exhibited a different pattern from that found in Eastern and Southern Africa where prevalence rates have exceeded 25 percent within a short period.

Considerable variations also exist by geographic region, gender, age, occupation, and, to some degree, urban-rural residence. According to the 2003 sentinel surveillance report based on clients of antenatal clinics, prevalence rates in the country's ten regions varied from below 2 percent in the Upper West Region to around 4 percent in Greater Accra, to almost 7 percent in the Eastern Region (Figure 1). These regional data remain very similar in the 2004 Sentinel Survey. Eight of the 30 sentinel surveillance locations reported prevalence of more than 5 percent in 2003, and six of 35 sites in 2004. These pockets of high rates indicate that "severe epidemics, by Ghana standards, are raging in various non-contiguous parts of the Country" (Ghana AIDS Commission, 2002: 1–2).

Females are estimated to be 1.3 times more likely to become infected than males. This sex ratio has declined sharply since the early stages of the epidemic when it was around 3:1, still indicating that the risk of infection for females is higher than males (National AIDS/STD Control Programme, GHS, and MOH, 2003). The 2003 DHS found that females who are widowed, divorced or separated have significantly higher rates than those who were in marital unions. Similarly, the DHS found that females with two or more sexual partners in the last year had HIV infection rates three times higher than females with only one partner.

The 2004 Sentinel Survey showed that there was a decline in mean HIV prevalence among the 15 to 24, 20 to 24, and 15 to 49 age groups (see Fig 2). The 15 to 19 and 25 to 29 years age group recorded a slight increase of 0.1% from the prevalence of 2003 from 1.9% to 2% and 4.4% to 4.5% respectively. The 25 to 29 year group is the age group with the highest prevalence and in the 45 to 49 age year group, out of 53 samples collected, no one was HIV positive hence the dramatic drop to 0% prevalence recorded. Among age groups 30 to34, 35 to 39 and 40 to 44, decrease in mean HIV prevalence was observed.

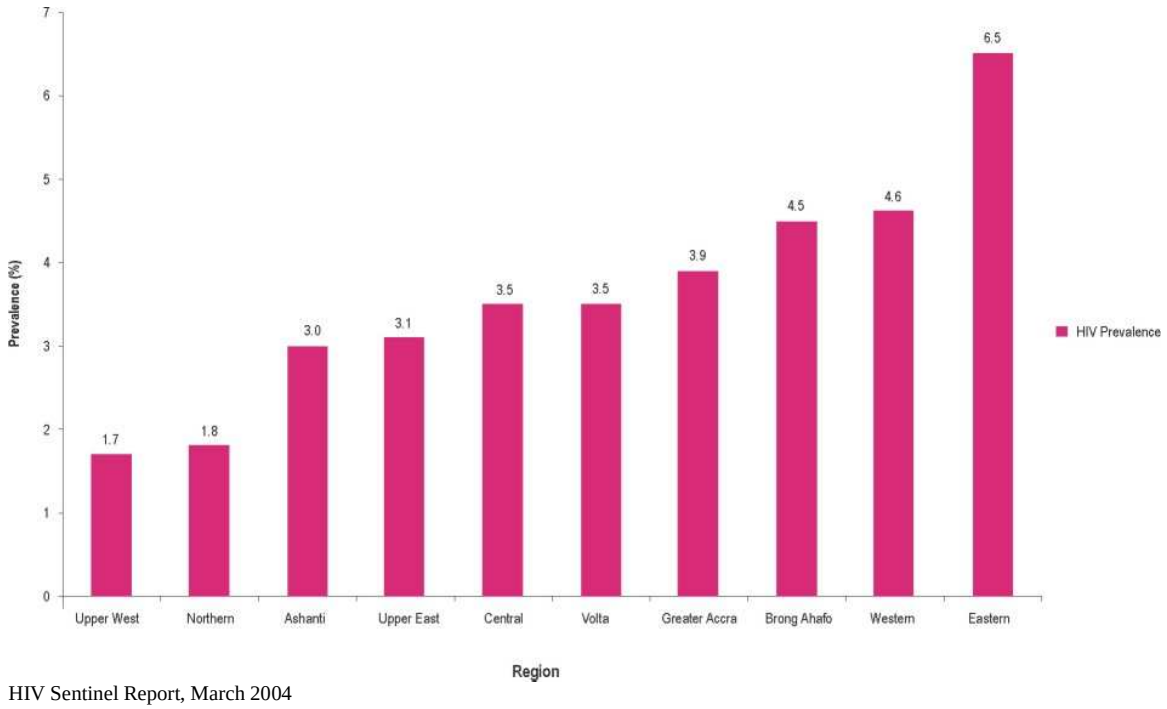
Cote et al. (2004) have estimated that transactional sex accounts for about 84 per cent of HIV infections among males aged 15–59 years in Accra. In addition to sex workers and their clients, other groups believed to have above-average prevalence rates include uniformed service personnel, teachers, and miners, prisoners, long-distance truck drivers,

[1] In contrast, prevalence rates in Southern and Eastern Africa expanded much more rapidly over the same period, exceeding 25 percent in some countries. Neighbouring Cote d'Ivoire has shown still another pattern, generally maintaining a rate between 10 and 15% for most of the period.

national service volunteers, cross-border traders, and female long-distance traders (Anarfi et al., 1997 cited in Ghana AIDS Commission, 2003, p. 9). Female STI clinic attendees at Adabraka (in Accra), a clinic that also serves sex workers in Greater Accra Region, had a prevalence rate of 39 percent in 1999, reinforcing the well documented close association between HIV and other sexually transmitted infections. The 2003 GDHS results show high rates of infection among employed middle income groups. This differs from the prevailing view of the epidemic being associated with poverty. There is, therefore, an emerging trend which needs to be understood and which will require new thinking and strategies about target groups.

Figure 1.

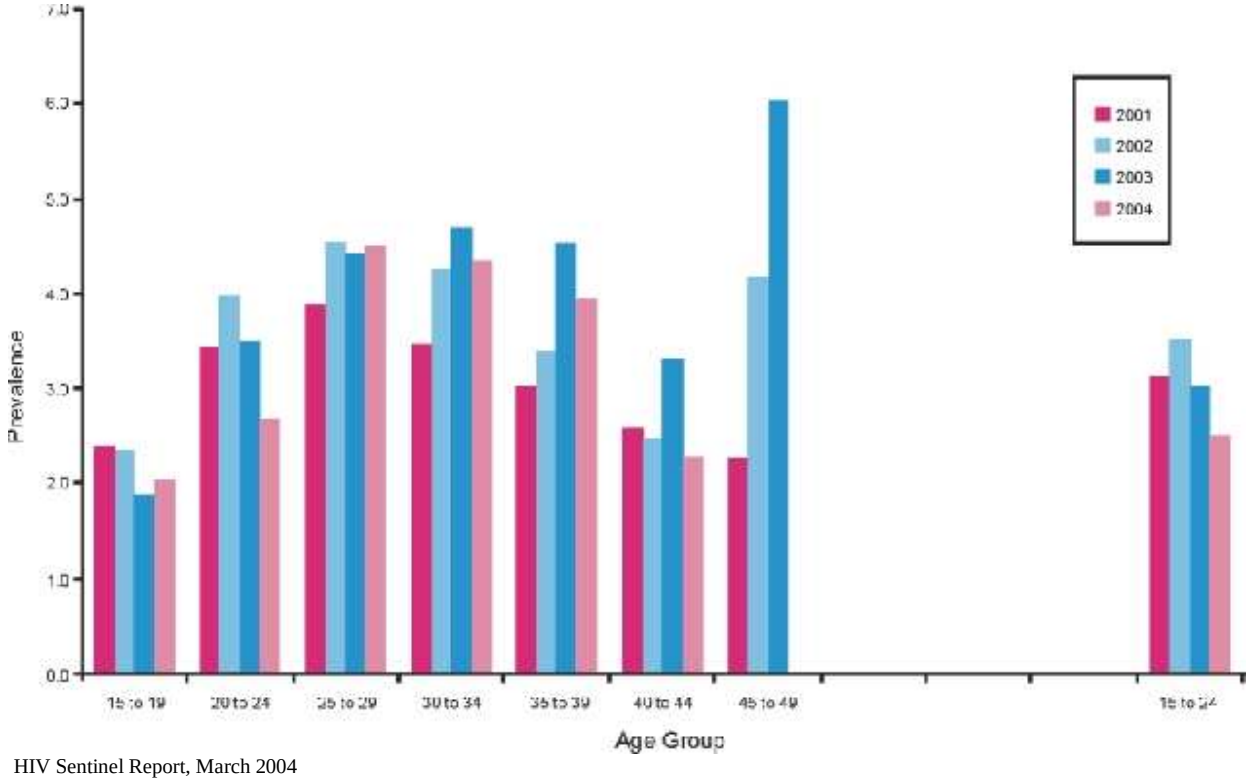
HIV Prevalence by Region



HIV Sentinel Report, March 2004

The observed patterns of high rates of five per cent or more in some areas, the male-female variations, the extremely high rates among some sections of the population and the emerging increasing rates among people in the middle income group have formidable implications for the socio-economic development of the country. As an epidemic affecting people in their productive and reproductive ages, it will affect the number of people available for work, health, and the economy, and create an orphan population with which the existing social system may be unable to cope. Thus, if not checked, the effects of the epidemic can negate developmental efforts.

Figure 2. Mean HIV Prevalence by Age and Year (2000-2004)



HIV Sentinel Report, March 2004

1.2 Behavioural Factors in the HIV/AIDS Epidemic

One of the clearest findings from research in the country is that there is near-universal awareness of the HIV/AIDS epidemic and this has been the case for more than a decade now. Furthermore, results from the Ghana Demographic and Health Surveys (GDHS) of 1998 and 2003 have shown that 88 percent of men and 81 percent of women knew that condoms could be used to avoid HIV/AIDS infection (Ghana Statistical Service and MacroInternational, 1999; 2004). In the 2003 GDHS survey, more than 80 per cent of men knew that a healthy-looking person could be HIV/AIDS positive. Despite widespread and generally correct information on HIV/AIDS, the majority of Ghanaians do not feel personally vulnerable to HIV infection (Ghana Statistical Service and MacroInternational, 2004) in part because many do not think of themselves as promiscuous, and do not realize that their vulnerability is related to infidelities of their spouse or partner (Appiah, Afrane, and Price, 1999). As Hochbaum (1958) demonstrated almost 50 years ago, a belief in personal vulnerability is essential to ensure appropriate preventative health behaviour.

Although Ghanaians are aware of HIV/AIDS issues, knowledge of how to prevent HIV was frequently inadequate, including among some high-risk populations such as sex workers in Accra and Obuasi, male police officers in Accra, and male miners in Obuasi (Research International and Family Health International, 2001).

Results from the 2003 GDHS indicate that although some women reported being aware of the protective effect of condoms, they were not able to influence their partners to use a condom during sex due to poor bargaining power. Some women have been found to be *overconfident* in relying on fidelity as a strategy to avoid HIV/AIDS infection. Two-thirds of women indicated that AIDS can be avoided by "sticking to one partner." However, monogamous women may underestimate the threat from husbands who may not be monogamous. The cultural pattern of postpartum sexual abstinence for women, *but not for men*, promotes multiple partnerships and sexual networking which are contributing factors to the spread of HIV. Other cultural practices, such as early marriage, genital cutting, subordination of women to men, relative powerlessness in sexual decision-making, and inadequate sex negotiation skills, all contribute to women's vulnerability to HIV infection.

The proportion of men aged between 15 and 49 years who reported not having had sex in the entire year prior to the DHS survey increased from 21 percent in 1993 to 34 percent in 1998. Of those cohabitating, 79 percent of women and 62 percent of men reported they were faithful during the past 12 months. Among those who were married, 96% of women and 84% of men had no extra-marital sex over the same 12 month period. These results point to some possible behavioural changes taking place and the next generation of HIV/AIDS information and communication will include messages that aim at reinforcing these positive changes.

1.3 The Demographic Context and HIV/AIDS

Since the start of the HIV/AIDS epidemic in the 1980s, the number of people infected with HIV in Ghana has risen steadily. In 1994, an estimated 118,000 Ghanaians were living with HIV and the number more than tripled to about 400,000 by 2004. Population growth is expected to increase the incidence of HIV/AIDS over the next six years. In addition, improvement in the care and treatment of PLWHA, especially with the use of ART and HAART, will lead to improved survival. Thus, the number of PLWHA is expected to increase to about 500,000 by 2015 even if new strategies are developed to reduce the spread of the virus.

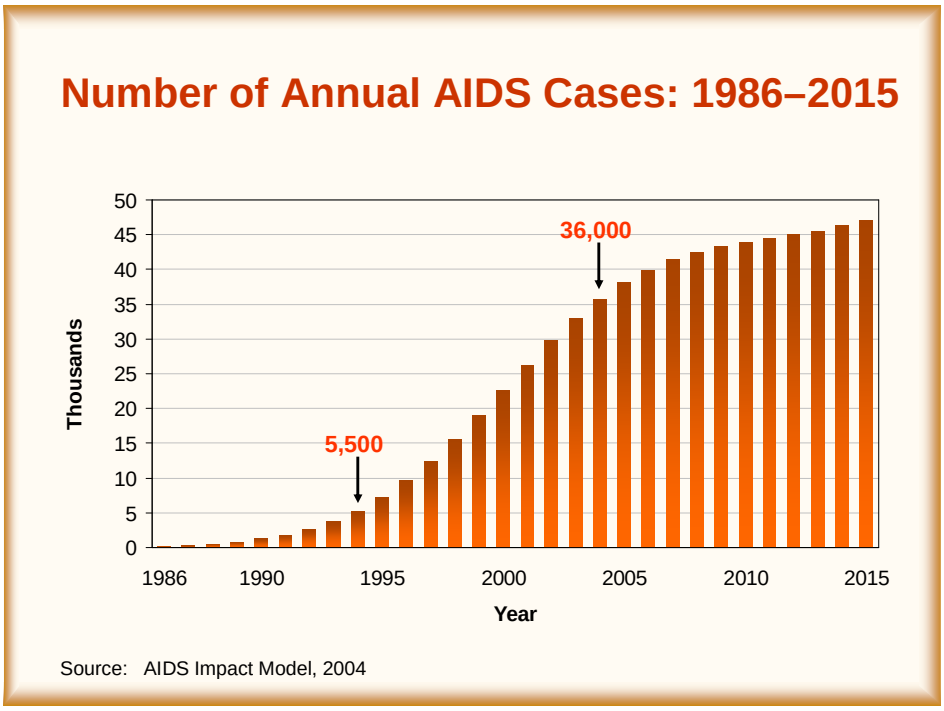
The number of new AIDS cases has increased dramatically over the last 10 years – from an estimated 5,500 in 1994 to 36,000 in 2004 (Figure 3). Both the annual number of new AIDS cases and the annual number of AIDS deaths are projected to increase to over 45,000 by 2015. In addition, the estimated number of AIDS orphans (children under the age of 15 who have lost one or both parents to AIDS related causes) is likely to double over the next 10 years – increasing from 132,000 in 2004 to 291,000 by 2015.

The results from the 2000 Population and Housing Census indicated that the country had a population of 18.9 million. Between 1984 and 2000, the population grew at an annual rate of 2.7 percent. Population density doubled from 36 persons per square kilometre in 1970 to 70 in 2000 (Ghana Statistical Services, 2002). Since 1960, the proportion of the population in urban areas has increased substantially. The proportion increased from 23 per cent in 1960, to 29 percent in 1970, to 44 percent in 2000. The increase in urban population is worth noting because, with a few exceptions, HIV prevalent rates are higher in urban areas, such as regional capitals, than rural areas.

Young people aged 10-24 years account for 30 per cent of the population while the proportion of the population aged 65 years and above is about five per cent. Life expectancy has increased from 50 years for males in 1984 to 55 years in 2000, and from 54 years for females to 60 years during the same period. These overall changes reflect persistently high but declining fertility, improvement in health conditions -- apart from HIV/AIDS – and progress in socio-economic development. These positive achievements in socio-demographic conditions can be eroded by high rates of HIV/AIDS infection.

The demographic context has implications for HIV/AIDS programming. Prevention efforts are required almost everywhere, but urban areas and other "hot spots" require additional targeted efforts. The provision of treatment, which requires substantial expansion, can reasonably start in large urban centres, and regions with higher prevalence, and spread to District Capitals and beyond as experience and resources become available. The population aged 5-14 years is frequently referred to as a "window of hope," and will require concerted effort to ensure that they remain uninfected.

Figure 3.



1.4 The Socio-Economic Context

Ghana has made some progress in reducing poverty levels in the 1990s. Between 1991/92 and 1998/99, the proportion of the population in extreme poverty declined from 37 per cent to 27 per cent (Ghana Statistical Service, 2000). Within this national pattern, considerable poverty still exists in some areas and in pockets around the country. For

instance, eight out of ten persons in the three northern regions were classified as poor in 1998/99. Within regions and urban areas, pockets of extreme poverty exist. The general observation is that poverty and other economic pressures on individuals constitute pre-disposing factors for HIV infection. For example, unemployment, limited job opportunities and the rising cost of living are aspects of the poverty cycle that promote rural-urban migration of young people, transactional sex and early sexual relations (Tanle, 2003).

The available evidence indicates that over 70 per cent of HIV/AIDS infected persons are aged 20-39 years due mostly to high sexual risk-taking behaviour by individuals or their partners/spouses. Results from the 2003 GDHS also points to a new pattern of infection. According to the results, employed, middle income persons and those with primary or junior secondary education were disproportionately infected (Ghana, 2004). These are people in their economically productive period and HIV infection among this population has implications for the national economy. It will affect the proportion of the population available for work, training, and the pace of work. The economic costs of HIV/AIDS to employers in terms of care, absenteeism and retraining, is high and will continue to increase if the trend is not reduced. Thus, the current pattern of HIV/AIDS infection poses a threat to the economy of the country.

HIV/AIDS also impacts on both the supply and demand aspects of education. The gains made in the education sector, such as an increase in the proportion of children in school will be difficult to sustain if an increase in HIV/AIDS cases among teachers reduces their availability. HIV/AIDS among teachers can put adolescent females at risk due to sexual relationships between male teachers and female students (Social Surveys Africa and Health Development Africa, 2004). As more adults become infected, their children are likely to drop out of school because these children will be required to care for sick family members and/or may not be able to pay for their up-keep in school.

Ghana has a highly mobile population. Rural-urban migration, particularly by young people 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 (Anarfi, 1997). There is also rural-rural migration which exposes migrants to new lifestyles, including transactional sex, if they are young adults who travel alone. Long distance drivers, uniformed service personnel and itinerant traders are believed to be particularly exposed to the risk of casual sex (and sex as a component of business deals), and hence HIV/AIDS infection.

The country has a diverse ethnic and cultural composition, leading to differing cultural practices and perspectives on social issues. In spite of these differences, there are common features such as strong communal and family support based on the extended family system. In recent times, particularly with urbanization and the consequent rural-urban migration and Westernization, these systems are breaking down, resulting in the development of nuclear families. A side-effect of this process emerging in some parts of the country is the inadequate social and family support for PLWHA and people affected by HIV/AIDS.

Gender issues are basic to confronting the HIV/AIDS epidemic. Women frequently suffer from relative powerlessness compared with men. As a result, women and girls are often subjected to humiliating practices, while some experience subjugation from relations, boyfriends, partners, and husbands. This powerlessness makes it difficult for girls to decline sexual advances from older males, such as teachers, without facing coercion, violence or retaliation (Health Development Africa, Social Surveys Africa, 2004). The conditions also limit women's ability to access a wide range of services or make decisions about their lives. Therefore, gender equity is critical to assuring women's empowerment in sexual and economic matters, as well as full access to information and services that can help reduce vulnerability to infection or mitigate the effects of AIDS.

Other socio-cultural factors such as stigma, discrimination, and denial make the care and support for PLWHA and those affected by HIV/AIDS a daunting challenge. Polygyny, and sexual attitudes and beliefs which underlie gender inequalities, make it difficult for women to negotiate on issues about sex, reproduction and condom use, or to influence the sexual networking of their partners . Prevailing belief systems about the causes of the epidemic also have implications for the reporting and management of infection. For example, people immediately associate HIV/AIDS infection with a promiscuous lifestyle even in cases of faithful wives infected by their husbands (Appiah, Afrane, and Price, 1999).

The costs of providing health care for opportunistic infections for AIDS patients, and increasingly for antiretroviral therapy, will make substantial demands on the health care system which will affect health care for the general public. In rural areas especially, the rising number of AIDS orphans will put enormous pressure on households and communities. Thus, HIV/AIDS infection will put severe stress on families, the social system, the health sector and the economy.

1.5 The Political and Policy Environment

The country has the benefit of continuing political commitment to HIV/AIDS issues. The President serves as Chairman of the Ghana AIDS Commission (GAC), providing it the highest mandate. The Commission consists of the President as Chairman and up of 15 Ministers of State and other stakeholders, and is serviced by a Secretariat. A Steering Committee provides the technical backstopping for the activities of the Secretariat. The GAC regularly conducts its work through technical committees which are composed of experts and representatives from stakeholders, including MDA, development partners, NGO, and Civil Society organizations (CSO).

The establishment of the GAC followed the development of the first National HIV/AIDS Strategic Framework of 2001-2005. GAC was set up in 2001 by Act 613 of Parliament as a supra-ministerial body under the Office of the President to coordinate the multi-sectoral national response to HIV/AIDS. Since its creation, the GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation, research, and has provided strategic vision for the coordination of the national response. Much of these have been achieved through strong political support to the national response, the establishment and use of decentralised

institutional structures, enactment of supportive policies and legislation and widespread participation of civil society.

The 1992 Fourth Republican Constitution guarantees the protection of the right to life (Act 13); the right to the protection of personal liberty (Act 14); the right to respect for human dignity (Act 15); and the right to equality and freedoms. Article 37(4) also mandates the Government to enact laws on population whenever necessary. The Ghana Poverty Reduction Strategy of 2003 (Government of Ghana, 2003), which is the blueprint for the country's human and socio-economic development, also highlights the need for improved quality of life and expansion of opportunities for all members of society under its human development component.

The National Population Policy (Revised Edition, 1994) emphasizes the harmful effects of STD/HIV/AIDS and calls for the institution of appropriate measures to prevent and control the epidemic. Numerous other policies make an explicit or implicit reference to HIV/AIDS in Ghana. These include: the National Youth Policy which identifies the provision of services to young people living with HIV/AIDS as a priority; Adolescent Reproductive Health Policy that has as one of its objectives the implementation of programmes aimed at reducing STD/HIV/AIDS; the Reproductive Health Standards and Protocols; the Labour Bill; the National HIV/AIDS/STI Policy, Policy Guidelines on Orphans and Vulnerable Children, Gender and Children Policy, the National Work Place HIV/AIDS Policy; draft Policies on Ageing and Gender; and Affirmative Action Policy Guidelines to facilitate a process of ensuring gender equality and empowerment of women in all aspects of life. Finally, experiences from NSF I and a Joint Review Report on the National Response have inspired the development of this new NSF II (Ghana AIDS Commission, 2004b).

1.6 Ghana and Its International Commitments in the Context of HIV/AIDS

The Government has either signed or subscribed to a number of continental and international treaties, conventions and declarations on HIV/AIDS. It has endorsed The Abuja Declaration of 1998 and The Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. As a signatory to the two Declarations, Ghana re-affirmed its commitment to HIV/AIDS, including protection of PLWHA from discrimination under the section on HIV/AIDS and Human Rights. In fulfilment of its commitment to UNGASS, indicators on HIV/AIDS activities have been submitted to UNAIDS. At the 2003 African Union Meeting in Maputo, all Heads of State, including Ghana's, renewed their commitment to reduce the impact of the epidemic. Commitments to these obligations have informed some of the strategies that have been adopted so far.

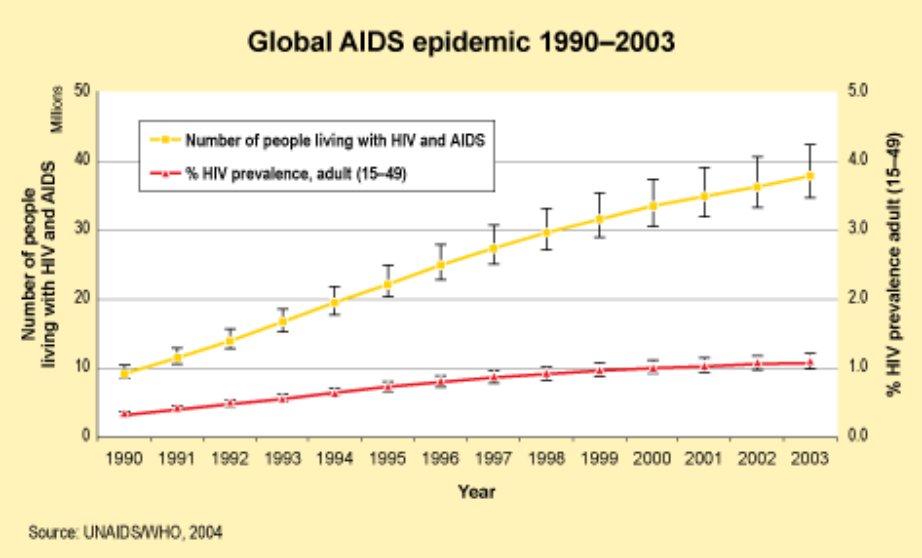
Among the international conventions which have implications for the management of HIV/AIDS and which Ghana has endorsed are the Universal Declaration of Human Rights, the International Convention on Economic, Social and Cultural Right, the African Charter on Human and People's Rights, Convention on the Elimination of all forms of Discrimination against Women (CEDAW), NEPAD Declaration, and the Convention on

the Rights of the Child (CRC). Ghana was the first country to sign the latter, indicating strong commitment to the rights of children.

1.7 The Challenge of HIV/AIDS

UNAIDS reports that, in 2004, there were 4.9 million new HIV infections, which was more than in any year before (Figure 4). Some 39.4 million people are living with HIV/AIDS, which killed 3.1 million in 2004, and over 20 million since the first cases of AIDS were identified in 1981 (UNAIDS, 2004a). Available evidence indicates that about 60 percent of infected persons and nearly 80 percent of all new infections are in sub-Saharan Africa. The infection is at its peak in a continent which is the least developed, making it an epidemic associated with poverty and under-development. It is partly within this context that the Millennium Goal 6 seeks to address the problem of HIV/AIDS, malaria and other diseases.

Figure 4.



Since 2002, both multilateral and bilateral agencies have renewed their commitment to fighting the epidemic. Donors have considerably increased their funding and are also exploring innovative ways to channel resources to where they are most needed to combat HIV/AIDS more quickly and efficiently. The cost of antiretroviral medicines has decreased considerably, and concerted efforts are being made to extend treatment to millions of people in low- and middle-income countries. Together, many of these approaches are making a difference in curbing the spread of HIV and restoring quality of life to infected people and their families.

Experience has shown that the natural course of the epidemic can be changed with the right combination of leadership and comprehensive action. Forthright national leadership, widespread public awareness and intensive prevention efforts have contributed to decline in new HIV infections in some countries. At the same time, we now have antiretroviral medicines that can prolong life and reduce the physical effects of HIV infection. Coordinated national and international action has greatly reduced the prices of these medicines in low- and middle-income countries. Associations of people living with HIV have become global force and are providing leadership in responding to the epidemic in a number of countries (UNAIDS, 2004a).

Recognizing the possible impact of HIV/AIDS on health and socio-economic development generally, Government seeks to respond to the epidemic through this Second National Strategic Framework for the period 2006-2010.

Chapter 2: Strengthening the National Response

2.1 Introduction

The country responded to the challenges of the epidemic before the first case was reported. The first Technical Committee on AIDS was formed in 1985, a year before the first case was recorded. This Committee, working with the Ministry of Health and the World Health Organization (WHO), was charged with developing a short-term plan for AIDS prevention and control. In 1987 blood screening was introduced and a medium-term plan was developed with WHO's Global Programme on AIDS by 1988. In 1989, the National AIDS/STD Control Programme was created in the Ministry of Health, with responsibilities for prevention, management, and control. Activities such as mass-media campaigns and workshops were organised to inform the public on ways to reduce high-risk behaviour, especially by promoting condom use. Some of these activities such as the promotion of condom use were supported by NGOs, such as the Planned Parenthood Association of Ghana, the Ghana Social Marketing Foundation, FHI, WAPCAS, and Johns Hopkins University.

In 2000, the demands of managing the HIV/AIDS epidemic prompted the government to adopt a multi-sectoral approach to address the developmental challenges of the epidemic—a departure from the earlier health-oriented approach. With international financial support, an HIV/AIDS National Strategic Framework was adopted to cover the years 2001–2005, and a National HIV/AIDS and STI Policy was developed and finally published in 2004. The Ghana AIDS Commission and its Secretariat were established by an Act of Parliament (Act 613) in 2001 to coordinate the national response. Established under the Office of the President, the Commission assures high-level representation of all key sectors and provides leadership in HIV/AIDS activities.

2.2 The National Strategic Framework (NSF I) 2001-2005

The first National Strategic Framework (NSF I) which was for the period 2001-2005, successfully guided the implementation of the national response, leading to some major achievements. The implementation of NSF I triggered the enactment of several policies and guidelines to create an environment conducive to the delivery of effective HIV/AIDS services. It stimulated the preparation of policy documents, such as the 2004 National HIV/AIDS and STI Policy, the National HIV/AIDS Workplace Policy, the 2002 Guidelines for Anti-retroviral Therapy, the Policy on HIV/AIDS for Faith Based Organisations, the 2003 National Guidelines for the Development and Implementation of HIV Voluntary Counselling and Testing, National Policy Guidelines on Orphans and Vulnerable Children, 1999 Draft National Guidelines for Blood Safety and the National Monitoring and Evaluation Plan of 2001-2005.

NSF I provided broad guidelines for sector Ministries, Departments, Agencies and District Assemblies, NGOs, and civil society to develop specific HIV/AIDS plans and activities appropriate to their circumstances. The high level of consultation during the preparation and the implementation of activities promoted in NSF I encouraged the

development of a national consensus on combating the epidemic. This consultation process also generated social and political support from national, traditional and religious leaders. Over the five-year period, there was increased awareness, community participation and support from development partners.

2.3 Limitations of NSF I

Since the development of the NSF I, gaps in the national response have emerged and areas requiring strengthening have been identified. For example, the role of the media and the need for promoting information sharing, dissemination and documentation were not adequately addressed in NSF I. While NSF I dealt with behaviour change directed toward the general public and specific vulnerable groups, the issue of the division of proportionate efforts was inadequate, and attention to specific targeted interventions required greater focus. The use of evidence-based interventions in guiding the response at various geographic levels was not as extensive as expected.

The private health and business sectors were not adequately included in NSF I, although they account for a large proportion of employed persons. Furthermore, the increase in the number of infected people and developments in new prevention and treatment technologies created demand and the need for an expanded care and support activities.

NSF I was developed concurrently with some sectoral plans, a situation which did not make it possible for specific guidelines to be given to the stakeholders for sector-wide planning. Some sectoral plans did not adequately map out priority geographical areas and target populations. In addition, the skills for monitoring performance appeared limited. For example, in-depth behavioural surveys were not included as sources of data for the national response. The mechanisms for coordination of HIV/AIDS activities within ministries, departments, and agencies were also not adequately detailed in NSF I.

2.4 Rationale for NSF II 2006-2010

Since the development and implementation of NSF I, the environment in which the national response operates has changed substantially. For instance, the establishment of the Ghana AIDS Commission under the Office of the President has given the multi-sectoral response, a high profile. Some traditional and religious leaders have also given their support to the national response. Available evidence indicates that there is a high level of awareness about the epidemic. There is also increased awareness that the epidemic is driven by high risk sexual activity. Antiretroviral drugs have become increasingly accessible and affordable. Resources are more available as a result of stronger bilateral and multi-lateral partnerships. A national monitoring and evaluation plan has been developed to guide the monitoring and evaluation of programmes, activities and the pace of the epidemic. Ghana has also demonstrated commitment to international conventions and declarations on the HIV/AIDS epidemic such as the Abuja Declaration, UNGASS, Millennium Development Goals and the “Three Ones” Principle.

NSF II, thus, takes account of the changing dynamics of the epidemic and the socio-economic environment, the emerging HIV/AIDS treatment technologies, new relevant research findings and the lessons learnt from implementing NSF I.

2.5 Key Programmatic Areas

The NSF I covered four key areas: programmes and policies; institutional arrangements, coordination and management; funding and resource mobilisation; and research, monitoring and evaluation. The NSF II, which builds on NSF I, has identified seven key areas (Chapters 4-10).

Experience from NSF I and from other countries has shown that a supportive socio-political environment is important for achieving the objectives of any strategic response. The decentralized system, as the mode through which national programmes are being implemented, is one of the priority areas. The coordinating and supporting role of GAC in guiding the decentralised multi-sectoral response to ensure local participation and ownership of programmes will be a priority area.

Various studies indicate that prevention through behaviour change programmes that focus on abstinence, postponement of sexual debut, mutual fidelity, partner reduction, and condom use have the potential to change the course of the HIV/AIDS epidemic. This is especially the case when behaviour change communication (BCC) and educational programmes with interpersonal components are targeted at vulnerable and high-risk groups in a non-stigmatizing and empowering manner. Adolescents constitute a 'Window of Hope' in the pattern of HIV/AIDS infection. Yet they can be at increased risk of HIV infection because of their propensity to be involved in multiple partnerships, and intergenerational and/or transactional sex associated with lack of economic opportunity and power imbalances (Social Surveys Africa and Health Development Africa, 2004).

Voluntary counselling and testing (VCT) can be a critical intervention that informs individuals of their HIV serostatus and helps them gain access to appropriate services. For individuals testing negative, VCT services can reinforce correct behaviour, and encourage behavioural change to reduce future risk when necessary. For individuals testing positive, VCT services, as well as programmes on stigmatisation and discrimination, provide links to behaviour change interventions to help prevent further spread of the infection and direct individuals to support, care, and treatment facilities. VCT programmes will need to be strengthened because of the enormous stigma associated with the disease, lack of recognition of personal vulnerability, and inappropriate behaviour among some health personnel (Appiah, Afrane and Price, 1999).

Stigma and discrimination constitute major problems for PLWHA, making it difficult for them to disclose their status, seek preventive and health care, and lead productive lives. Since there is a widespread view that HIV/AIDS results from immoral behaviour, a positive diagnosis presents devastating social consequences. These may include the termination of employment, divorce, social isolation, abandonment and ridicule (as well as death). It is estimated that there are 200,000 orphans and other vulnerable children, many of whom can be classified as HIV/AIDS orphans. With the increasing recognition

of the implications of this situation for young people, support for HIV/AIDS orphans and other vulnerable groups is expected to receive much greater emphasis.

The prevailing socio-cultural conditions can either promote or hinder the implementation of policies and programmes meant to mitigate the impact of the epidemic. As part of mitigation, gender issues will need to be addressed. This will require advocacy programmes to ensure that new laws are enacted and existing laws are enforced to address the problems of discrimination and the rights of women, girls, PLWHA, and other vulnerable groups.

Care and support for people living with HIV/AIDS includes individual care, prevention and treatment of opportunistic infections, supportive social services to help individuals deal with discrimination, legal counselling, and nutritional assistance (see also Ch. 6). Care and support increasingly also includes VCT, prevention of mother-to-child transmission and use of highly active anti-retroviral therapy. Recently, highly active anti-retroviral therapy has been made available at some public and private programmes and is expected to be expanded substantially. This expansion will provide challenges to the health establishment, resource mobilization, and attitudes and perceptions about the epidemic in view of the hope for survival that therapy provides.

Research and surveillance data will provide the basis for the development of the next generation of programmes, while monitoring and evaluation will be used as tools to guide the implementation of programmes and activities. More efficient and effective resource mobilization, financial arrangements and coordination will be critical for achieving the objectives of the national response.

2.6 Conclusion

While a number of these issues were identified and tackled during NSF I, there is now the need for more concerted effort to re-orient and focus interventions in view of the changing nature of the epidemic, accumulated knowledge on the social and cultural dimensions driving the epidemic, increased international support and technological developments in treatment and care. This is what NSF II seeks to achieve.

Chapter 3: Goals, Objectives and Guiding Principles of NSF II

3.1 Introduction

This strategic framework builds on the perspectives identified and indicated in the first National Strategic Framework, the National HIV/AIDS/STI policy and national and international commitments to fight the epidemic.

3.2 Goals

The goals of the Strategic Framework, derived from the National HIV/AIDS policy, are:

- Reducing new infections among vulnerable groups and the general population;
- Mitigating the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; and
- Promoting healthy life-styles, especially in the area of sexual and reproductive health.

3.3 Objectives

The overall objectives of NSF II are to:

1. Strengthen the decentralized, multi-sectoral national response to the HIV/AIDS epidemic;
2. Reduce the proportion of men and women who engage in risky sexual behaviour;
3. Empower women and other vulnerable groups to reduce their vulnerability;
4. Reduce stigma and discrimination, especially towards PLWHA and others affected by the epidemic;
5. Mitigate the economic, socio-cultural, and legal impacts of the epidemic
6. Provide appropriate treatment, care and support for PLWHA, OVC, and other affected persons;
7. Promote strong research, surveillance, monitoring and evaluation to inform programmes and activities;
8. Mobilize adequate resources and provide funding arrangements to support the implementation of all required programmes;
9. Encourage healthy lifestyles through appropriate media campaigns, advocacy, etc.

More detailed objectives are found in a box at the beginning of each chapter on intervention areas.

3.4 Guiding principles

The current HIV/AIDS coordination and management framework is based on the "Three Ones" Principle of:

- One HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority with a broad based multisectoral mandate for HIV/AIDS overall policy and co-ordination; and
- One agreed country level monitoring and evaluation system.

Within the context of this Framework, the "One HIV/AIDS Action Framework" will be developed in two stages. The first is the general framework for NSF II. The next stage is to develop specific action plans, activities, and budgets. These two components together will constitute the "Action Framework." The "One national HIV/AIDS coordinating authority" as per Act 613 of 2001 is the Ghana AIDS Commission. The "one agreed country level monitoring and evaluation system" was developed by GAC for 2001-2005, and will be updated to meet new demands.

In addition, the implementation of this NSF is underpinned by the fact that HIV/AIDS management requires:

- A multi-sectoral partnership approach.
- Respect for fundamental human rights.
- Access to information and comprehensive services.
- Effective coordination of the decentralised response of organizations, communities, individuals, and PLWHA participating and sharing responsibilities in all HIV/AIDS programmes.
- Mobilization of adequate resources, financial and human, to support the Framework.

Based on the goals and objectives, seven intervention areas are identified for NSF II, and these are discussed in turn in the chapters that follow.

Chapter 4: Policy, Advocacy and Enabling Environment

Objectives

- To ensure the review, formulation, enactment and the enforcement of policies and laws that protect the rights of PLWHA, OVC, people within workplaces and other vulnerable groups
- To promote programmes that empower PLWHA, OVC and other vulnerable groups to be involved in all aspects of HIV/AIDS activities.
- To ensure improved positive attitudes and a supportive social and legal environment for PLWHA, OVC and affected family members.
- To ensure the continuous supportive socio-political environment for addressing the challenges posed by the epidemic
- To work comprehensively and in innovative ways to reduce stigma and discrimination faced by PLWHA

4.1 Introduction

Available evidence indicates that strong political leadership and commitment, administrative and legal frameworks constitute crucial elements in HIV/AIDS programming (Hogle, 2002; Singh et al., 2002). Cultivating and maintaining a favourable socio-political environment will constitute one of the important strategies in the implementation of activities under NSF II.

NSF II responds to the substantial challenges that emerged during the implementation of NSF I and the National HIV/AIDS and STI Policy. One challenge is to develop strategies to honour commitments under international agreements such as the Abuja and UNGASS Declarations. Other challenges are developing programmes designed to eliminate stigma and discrimination against PLWHA and improve the rights and status of women and improving the socio-cultural environment for promoting prevention, treatment, care and support programmes and activities. Further challenging areas include the scaling-up of new programmes necessary to combat the epidemic, such as ART, VCT, PEP and PMTCT services, and targeted behaviour change communication programmes.

Responding to these challenges requires a multi-sectoral approach which deals with HIV/AIDS as an urgent public health and socio-economic developmental issue. In keeping with the public health dimension, NSF II encourages stakeholders to work at containing the epidemic, focussing on both the general population and the most vulnerable groups at the national, regional and local levels.

4.2 Policy

In 2004, the Ghana AIDS Commission published the National HIV/AIDS and STI policy to guide activities in the country, based on Act 613 of 2001 which established the Ghana AIDS Commission. The policy framework clarifies the functions of various entities involved in HIV/AIDS activities. For instance, the Act mandates the Secretariat of the Commission to play a key coordination role regarding all activities associated with HIV/AIDS in the country as well as the roles of MDA and decentralised agencies.

Strategic Results

1. Enhanced multi-sectoral response at all levels;
2. Updated policies relating to HIV/AIDS and STI as appropriate;
3. Formulated and enacted guidelines, policies and laws that protect PLWHA, OVC and vulnerable groups where appropriate; and
4. Established mechanisms for the enforcement of HIV/AIDS related guidelines, policies and laws.

Challenges

- Ensuring that the comparative advantages of various entities function as expected;
- Ensuring multi-sectoral approach based on the "Three Ones" Principle;
- Achieving the overall objectives of the national HIV/AIDS/STI policy; and
- Ensuring adequate monitoring of the policy environment.

Strategies

1. Review, formulate, enact, and enforce laws and policies protecting the rights of PLWHA and people affected by HIV/AIDS;
2. Advocate review of the criminal code to fully address the issue of intentional transmission of HIV to protect the uninfected; and
3. Ensure an increased involvement of PLWHA in the planning and programming of activities at all levels.

4.3 Advocacy

Available evidence suggests that there is widespread stigma and discrimination against PLWHA and people affected by HIV/AIDS in communities (including in religious institutions), workplaces, and homes, partly as a result of the nature and beliefs about the infection in the country (Social Surveys Africa, 2004). In some cases, this has led to disrespect and abuse of the fundamental human rights of PLWHA and people affected by AIDS. Where people with AIDS risk rejection and discrimination, those who suspect they are HIV positive are not likely to get tested and take precautionary measures for fear of

revealing their infection. Similarly, when individuals know they are infected, they may avoid seeking needed treatment, care and support.

Lack of respect for the rights of various groups, particularly PLWHA, women, and children, affects their rights to information and education, freedom of expression and association, liberty and security, freedom from inhuman or degrading treatment, privacy and confidentiality. These contribute to the vulnerability of some people to infection or exacerbate their conditions. Mann and Tarantola (1996) have provided a framework for individual, societal and programme vulnerability for young people, which has implications for dealing with the epidemic. NSF II recognises these dimensions of vulnerability to HIVAIDS (also see Chapter 6).

To ensure the development of effective programmes and to promote advocacy, PLWHA will play an integral role in the planning and implementation of activities at all levels of the national response. This will enable PLWHA to be involved and influence the design of programmes, and support advocacy for their own behavioural change. There will be an affirmative action programme to ensure that qualified PLWHA are involved in various activities of prevention, treatment, care and support. The subsequent empowerment of PLWHA will facilitate the emergence of individuals and groups who will help educate others.

Strategic Results

1. Reduced individual and societal vulnerability and susceptibility to HIV/AIDS;
2. Implemented programmes which protect the rights of vulnerable groups such as PLWHA, sex workers and their clients, the youth in and out of school, and OVC;
3. Strengthened support in the socio-cultural environment for PLWHA and affected families; and
4. Improved positive attitudes and supportive legal environment for PLWHA, OVC and affected family members.

Challenges

- Lowering stigma and discrimination against PLWHA, OVC and others affected by the epidemic;
- Empowering PLWHA, OVC and other vulnerable groups through improved skills and self-development;
- Reducing societal prejudices; and
- Having health workers recognize the implications of their behaviour for HIV/AIDS management.

Strategies

1. Strengthen the capacity of all institutions involved in dealing with stigma and discrimination such as the Judicial System, the Commission for Human Rights

and Administrative Justice (CHRAJ), FIDA, the Legal Aid Board, WAJU and the Department of Social Welfare;
2. Assist PLWHA and other vulnerable groups to form associations to encourage mutual and community support to deal with all dimensions of prevention, treatment, care and support; and
3. Promote non-discriminatory policies and practices at workplaces, service delivery points, communities and in families, and ensure the development of programmes aimed at improving the knowledge of the general public on the rights of PLWHA.

4.4 Enabling Environment

The socio-political environment which provides the framework for policy development and implementation contains essential elements for successful programming to combat the epidemic. The President of Ghana, serving as Chairman of the Ghana AIDS Commission (GAC), provides the highest level leadership in creating a supportive environment. One of the important socio-political structures in the country is chieftaincy. It is an institution which a number of people identify with, and has the potential for effective social mobilization to combat HIV/AIDS at the community level. Some of the important chiefs have identified themselves with HIV/AIDS campaign. In addition, some Queens have taken up HIV/AIDS issues, especially the care of orphaned children. Within this supportive environment, the multi-sectoral national HIV/AIDS response has accumulated political capital. Certain essential, uncompleted tasks, such as eliminating stigma and discrimination and empowering women and marginalized groups, may require using some of this capital.

Strategic Result

1. Enhanced continuous supportive socio-political environment for addressing the challenges posed by the epidemic.

Challenges

- Sustaining the existing positive environment;
- Facilitating the enactment and enforcement of policies and legislation relevant to the stigma, discrimination, prevention, treatment, care and support regarding HIV/AIDS;
- Sustaining the interest of civil society in social mobilization; and
- Ensuring a focus on changing high risk sexual behaviours.

Strategies

1. Encourage the Executive, Ministers, traditional, religious, and opinion leaders to speak about HIV/AIDS discrimination, stigma, prevention, treatment, care and support at every opportunity.

2. Ensure social mobilization to sustain interest in issues associated with HIV/AIDS at the community, local and national levels.

Lead Agency

Ghana AIDS Commission

Key Actors

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, NPC, Chieftaincy Secretariat, (Houses of Chiefs), the Private Sector; Organized Labour, GIPA and Other PLWHA associations

Chapter 5: Coordination and Management of the Decentralised Multi-sectoral Response

Objectives

- To strengthen the Ghana AIDS Commission in its leadership role of coordinating and managing the national response and carrying out fully its mandate
- To promote strategic management practice that ensure sustainability of the expanded, decentralised, multi-sectoral response;
- To ensure effective and efficient coordination and management of MDAs, RCCs and DAs responses
- To ensure adherence of MDAs, RCCs, DAs and other institutions to assigned mandates and responsibilities
- To ensure sustained commitment to mainstreaming HIV and AIDS programmes in the operations of MDA, RCCs, DAs;
- To promote strong linkages with MDAs, academic institutions, private sector and civil society in order to achieve effective and efficient coordination and management
- To enhance the capacity of RAC, DAC and DRMT to coordinate, monitor and supervise regional and district responses
- To empower associations of PLWHA, communities and civil society to design and implement programmes which address their specific needs.
- To improve donor coordination to enable better programming and coordination of resources

5.1 Introduction

The implementation of the expanded, decentralised, multi-sectoral national response to the HIV/AIDS epidemic takes cognisance of the complex nature of the factors driving the epidemic, the large number of stakeholders and the diverse HIV situation in the country. Implementation strategies will involve the coordination and management of diverse processes, such as facilitating communication, sharing of experiences, developing knowledge of best practices, planning and monitoring among stakeholders, as well as mobilizing and deploying resources (human, financial and material) to achieve optimal results. Furthermore, strengthening the coordination, institutional framework and the management capacities of all stakeholders will be critical for ensuring the achievement of the overall goals of the national response.

The complexity of the HIV/AIDS epidemic also demands a national response that places the mainstreaming of HIV/AIDS high on the agenda of all stakeholders. Also important is strong leadership that ensures full and active involvement of all stakeholders. This includes Sector Ministries and decentralised agencies, development partners, civil society, NGO, FBO, private sector, traditional and religious authorities and CBO at community, sub-district, district, regional and national levels. Stakeholders require clear

definitions of roles and responsibilities. Within this Strategic Framework, all stakeholders will be responsible for and accountable for achieving the desired results within their mandates and respective roles.

5.2 Management of the National Response

One of the objectives in this section is to promote strategic management practices that will ensure sustainability of the national response. Achieving this objective will involve a strategic approach which harmonises and guides the activities of implementing agencies and development partners. This Strategic Framework, therefore, provides the overall direction and basis for the formulation of medium term sectoral and district strategic plans, which will in turn guide annual planning cycles, including the development of annual programmes of work at each level. These processes will be coordinated by GAC, as mandated in ACT 613, while relevant MDA, other institutions and development partners will provide technical support and other resources.

Management is about the effective use of information and resources to support policy formulation and programming. An important element in management is human capital which will guide and ensure the development, implementation, monitoring and evaluation of activities. It also involves the mobilization of resources, including financial and other inputs, required for effective implementation of activities in the spirit of transparency and accountability.

Strategic Results

1. Coordinated and well managed decentralised multi-sectoral HIV/AIDS response aimed at generating local responses, and empowering institutions, communities and individuals to deal effectively with the challenges of the HIV/AIDS epidemic;
2. Strengthened capacity of GAC to coordinate the National Response;
3. Strengthened national arrangements and decentralised institutional frameworks for multi-sectoral coordination and response to the epidemic;
4. Clearly defined roles and responsibilities for all implementers and other stakeholders; and
5. Strengthened linkages with the private sector.

Challenges

- Operationalising a management framework that ensures efficient and effective implementation of the decentralised multi-sectoral response; and
- Building the capacity of key agencies to enable them to develop and implement their policies and programmes.

Strategies

1. Coordinate the management of the decentralised multi-sectoral response to ensure sustainability;
2. Enhance the development of strategic plans and annual planning processes at all levels; and
3. Assist in strengthening the capacity of partners and other stakeholders to develop, implement and manage their plans.

5.3 Institutional Framework for Implementation and Coordination

With the current patterns and levels of the HIV/AIDS epidemic, the level of awareness among the population and the commitment of stakeholders, two ingredients are crucial for ensuring collective ownership and participation in the national response. These are an effective coordination mechanism and clearly defined roles and responsibilities assigned to implementing agencies.

5.3.1 Ghana AIDS Commission (GAC)

The GAC, as the highest policy decision-making body on all matters relating to HIV/AIDS, is charged with the following functions, as contained in the Act 613:

- Advise the Government on policy issues relating to HIV/AIDS;
- Provide high-level advocacy for HIV/AIDS;
- Expand and coordinate the total national response, including the formulation of national plans and guidelines;
- Monitor and evaluate all on-going HIV/AIDS activities; and
- Identify, mobilise and manage all funds and other resources for HIV/AIDS and related programmes.

The Commission consists of a Secretariat and a Steering Committee which serves as the governing board, and six technical committees. The technical committees are: Prevention and Advocacy; Legal and Ethics; Care and Support; Research, Monitoring and Evaluation; Resource Mobilisation; and Project Review and Appraisal. Composed of stakeholders with relevant expertise, these multi-sectoral committees are responsible for technical advice to the Commission.

The Commission is serviced by a Secretariat which translates policies into programmes and activities for implementation by stakeholders. With the adoption of the principle of "One Coordinating Body," the GAC, as the national coordination body, will continue to provide strong leadership to ensure that all agencies develop and implement their activities within this institutional framework.

To meet the challenges of an expanded national response, there will be the need for a review of the existing structure of the Secretariat.

Strategic Results

1. Achieved decentralised multi-sectoral response under the leadership and coordinating role of the GAC as the one coordinating body.

Challenges

- Developing human capacity to sustain implementation of the HIV/AIDS response at all levels;
- Supporting implementing agencies to fulfil their defined roles and responsibilities;
- Encouraging development partners and implementers to report on their HIV/AIDS activities to GAC in a timely manner; and
- Mobilizing adequate resources to meet the demands of the expanded response.

Strategies

1. Strengthen the capacity of the Ghana AIDS Commission and the lead collaborating agencies to coordinate and manage all aspects of the response;
2. Facilitate the development of medium term strategic and annual action plans of MDAs, regions and districts to achieve the objectives of this Strategic Framework;
3. Ensure that all implementers and stakeholders follow through on their defined roles and responsibilities;
4. Create a forum for regular interactions among the implementing agencies and development partners;
5. Enhance the capture and dissemination of information for the strategic management of the HIV/AIDS epidemic;
6. Strengthen mechanisms for monitoring the use of human, financial and other resources at all levels; and
7. Review the existing structure of the Secretariat in view of the expanded response.

5.3.2 Ministries, Departments and Agencies (MDA)

The Government of Ghana recognizes the epidemic as a developmental challenge with implications for all dimensions of national life. As a result, 15 Ministers, including Cabinet Ministers, serve on the Commission, while other MDA serve on technical committees of the Commission. The involvement of the Ministries at the highest policy decision-making level of the Commission signifies the importance attached to the national response.

In the context of this Framework, all MDA will be expected to mainstream HIV/AIDS into their core functions. As part of the process, the activities of institutions will also include but not be limited to:

- Revising their medium term sectoral plans in the light of this Strategic Framework and the GPRS to provide the basis for effective mainstreaming and monitoring of progress and achievements;
- Developing and implementing an annual programme of work (POW) with particular focus on both internal and external responses;
- Coordinating strategic partnerships and linkages with relevant implementing partners and documenting the internal and external responses of the MDA;
- Creating an AIDS Management Committee, where one does not already exist, with clearly defined roles, including coordination and management of internal and external responses;
- Assigning an HIV/AIDS focal person and other technical staff to steer the MDA response;
- Facilitating and supporting all mainstreaming activities at the district and other decentralised levels;
- Collaborating with external stakeholders/clientele in pursuit of mainstreaming activities; and
- Developing human capacity for effective delivery and sustainability of responses.

Some MDA, by their mandate, will play specific roles. These are:

1. The National Population Council will ensure the integration of HIV/AIDS issues into population and sexual and reproductive health programmes, and also advocate for the effective implementation of HIV/AIDS programmes;
2. The National Development Planning Commission (NDPC) will ensure the integration and mainstreaming of HIV/AIDS activities into the development policies and programmes of MDAs and District Assemblies.
3. The Ministry of Health/Ghana Health Service (MOH/GHS) will facilitate the development of programmes on sexual and reproductive health, institutional care for PLWHA, STI management, Blood Products, VCT and PMTCT;
4. The National AIDS Control Programme (NACP) will provide technical support to the national response;
5. The Ministry of Women and Children Affairs will facilitate the mainstreaming of gender issues in HIV/AIDS programmes.
6. The Department of Social Welfare will facilitate community activities on welfare issues of PLWHA, affected families and communities, orphans and vulnerable children.
7. The Ministry of Local Government and Rural Development will be responsible for the supervision of decentralized institutional structures.
8. The Ministry of Education and Sports will be responsible for providing, supervising and coordinating all pre-professional educational activities and programs related to HIV/AIDS.
9. The Ministry of Agriculture will be responsible for formulating and implementing agricultural policies and strategies in response to HIV and AIDS.

Strategic Results

1. Developed policies to guide the mainstreaming of HIV/AIDS into MDA core mandates;
2. Instituted mechanisms for information flow within MDA establishments;
3. Ensured networking among the various MDA; and
4. Achieved adherence to the "Three Ones" Principle among the MDA.

Challenges

- Encouraging MDA to identify the developmental challenge of HIV/AIDS to their institutions;
- Ensuring the mainstreaming of HIV/AIDS activities into programmes and activities; and
- Ensuring that MDA adhere to the "Three Ones" Principle and the multi-sectoral response.

Strategies

1. Mainstream HIV/AIDS programmes into the core businesses of the MDA;
2. Coordinate the implementation of HIV/AIDS programmes for MDA internal and external clientele;
3. Promote inter-MDA interaction in order to share experiences, especially on best practices;
4. Provide technical support within their mandates to support the response;
5. Mobilize additional resource to support programmes and activities within their institutions; and
6. Develop human capacity for effective delivery and sustainability of the responses of MDA.

5.3.3 Regional AIDS Committees

In line with the decentralisation policy of Government and the Ghana AIDS Commission, Regional AIDS Committees (RACs) have been established with the Regional Minister as Chairperson. Located in the Regional Coordinating Council (RCC), the Regional AIDS Committee is to coordinate all HIV/AIDS activities in the region. In addition, Regional HIV/AIDS Monitoring and Evaluation focal persons have been appointed with the responsibility to coordinate the activities of the various implementing agencies within the region, collate and analyse reports for onward transmission to GAC (see Appendix 1).

The placement of the RAC within the Regional Co-ordinating Council (RCC) is to ensure overall regional harmonisation, advisory and political mobilisation at that level. The RCC is, therefore, required to provide the necessary administrative and logistical support, along with strong political leadership, for social mobilisation to combat the epidemic.

Strategic Results

1. Strengthened capacity of the RAC to undertake its oversight responsibility effectively;
2. Improved capacity of regional monitoring and evaluation focal persons to ensure effective coordination of decentralised MDAs, civil society and private sector activities at the regional level;
3. Improved information flow and dissemination of best practice within the districts in the region;
4. Ensured social and resource mobilization within the region to support the national response; and
5. Improved monitoring and reporting of regional level HIV/AIDS activities.

Challenges

- Assisting RAC and the regional monitoring and evaluation focal persons to perform their coordinating and oversight roles within the decentralised system;
- Reducing the disruptive impact of transfers and reassignment of focal persons;
- Ensuring effective reporting of district focal persons to the regional focal persons;
- Integrating HIV/AIDS efforts into the activities of RAC and districts within the region.

Strategies

1. Strengthen the capacity of the RAC to undertake its oversight responsibility effectively;
2. Strengthen the capacity of regional focal persons to ensure effective coordination of the MDA, and private sector and organized labour activities at the regional level;
3. Improve information flow through the RAC and the regional focal person on the activities in the districts within the region; and
4. Ensure the participation of PLWHA, OVC and other vulnerable persons in all HIV/AIDS activities in their region.

5.3.4 Metropolitan/Municipal/District Response

The 138 districts of the country represent different and unique environments and sets of circumstances. The available epidemiological data indicate the existence of different and specific local epidemics resulting from a complex combination of factors. Also, districts and local communities have different levels of capacity to support the local response to HIV/AIDS, different traditional set-ups, financial capabilities and vulnerable groups. Each district also has its own set of developmental priorities as articulated in District Development Plans. All these combine to create specific contexts within which districts and communities will react to the management and implementation of the national HIV/AIDS response.

District Assemblies have established District AIDS Committees (DAC) and appointed HIV/AIDS focal persons. The District Chief Executive chairs the DAC, a multi-sectoral Committee whose members include representatives of all the decentralised agencies (MDA), NGO, religious and traditional leaders, youth and women's groups, private sector institutions, PLWHA and individuals involved in developmental issues. Resources from the GARFUND, District Assembly Common Fund and other sources have led to accelerated district and community responses throughout the country. Under NSF I, some assemblies developed capacity for monitoring district and community level responses. During the period of NSF II, the capacity of some DAC will be developed particularly those of the new districts while others will be strengthened to enable them play their coordinating roles more effectively within the decentralised institutional framework.

Developing and strengthening the capacity of DAC will enable them to access resources from GAC and other donors and disburse funds directly to NGO, FBO, CBO, traditional councils and other civil society organisations to scale up the district response. Improved human capacity will also help to promote accountability and responsibility among implementing partners.

Strategic Results

1. Strengthened capacity of the Metropolitan /Municipal/ District AIDS Committees and DRMT to monitor programmes and activities within their localities;
2. Improved skills of district monitoring and evaluation focal persons to ensure effective coordination;
3. Improved information flow and the sharing of best practices among district-level stakeholders.

Challenges

- Sustaining commitment to the decentralised multi-sectoral nature of the strategic response at the local level;
- Achieving effective local responses through the mobilization of human, financial and other resources;
- Strengthening the capacity of DAC to mobilize resources and manage the response effectively at the district level;
- Ensuring the integration of HIV/AIDS into all activities and programmes in the district; and
- Empowering PLWHA, OVC and other vulnerable groups to be involved in all HIV/AIDS activities.

Strategies

1. Strengthen the capacities of Metropolitan /Municipal/ District Assemblies, stakeholders and other implementing agencies to mainstream HIV/AIDS into their activities at the local level;

2. Strengthen the capacity of DCE, including M/E focal persons, to assist with social and resource mobilization to support the expanded local response; and
3. Ensure the participation of PLWHA, OVC and other vulnerable persons in all HIV/AIDS activities in their district.

5.3.5 Community Levels

Within each district are sub-district councils and unit committees which are the building blocks of district assemblies. These sub-structures constitute the lowest level of the decentralised system. At the Community level, the Unit Committee is the point of reference for all HIV/AIDS activities. It is expected that the HIV/AIDS activities in the local areas will be integrated into the harmonised plans of metropolitan, municipal and district assemblies.

One of the features of the existing administrative system in Ghana is the co-existence of modern and traditional structures. The 1992 Constitution recognises National and Regional Houses of Chiefs. Hence, traditional leaders continue to be key influential persons in the body politic of Ghana and in Ghanaian communities. Considered to be the embodiment of the traditions and culture of their people, chiefs and traditional leaders have a large following and command respect. Some community-based HIV/AIDS programmes have been initiated by traditional leaders and some of these are yielding positive results among both infected and affected persons. Nonetheless, the full potential of traditional leaders as strong advocates has not been sufficiently utilised. Community responses must actively involve chiefs, queens and traditional councils to increase participation of traditional leaders and ensure community ownership of the response.

In addition to chiefs, religious leaders are important at the local level. Some of these religious leaders have a large following and wield as much influence as traditional rulers and administrators at both the national and local levels. As with chiefs, the potential of some of these religious leaders was utilized during NSF I, although not to the full extent possible. Also at the local level are private-sector organizations, NGO, CBO, professional associations, youth and women's groups. Some of these organizations are already at the forefront of HIV/AIDS activities, while the potential of some of other groups is yet to be tapped.

The driving force of the community response will be active community mobilisation which can be most effectively carried out through a partnership of traditional and religious leaders, NGO, CBO, private sector and other civil society organisations. The process of community mobilisation, while dealing with the soft elements of sensitisation, awareness creation, empowerment, and commitment to safer sex practices, will also focus on treatment care and support activities including ART, PMTCT, VCT, home-based care, psychosocial support and nutritional programmes. Community mobilisation will be used to expand the demand for services and increase uptake of services. Community responses will vigorously promote partner reduction, abstinence, condom use, openness about HIV/AIDS, de-stigmatizing and compassion for PLWHA. At the community level, PLWHA will also be at the forefront of activities as part of the process to achieve behavioural change, reduce stigma and prevent new infections.

Community response will be an integral part of the district HIV/AIDS strategic plan and funded through the DAC. In addition, monitoring and evaluation will be in line with the district monitoring and evaluation procedures as indicated in the national M&E framework.

Strategic Results

1. Ensured social mobilization of the general population including traditional, religious and other opinion leaders within the communities to respond to the HIV/AIDS epidemic;
2. Ensured continuing support of the traditional, religious, and other leaders who have provided leadership; and
3. Enhanced capacity of PLWHA Associations, NGO, CBO and other civil societies to utilize the potential of the identified groups at the community level.

Challenges

- Ensuring social, financial and other resource mobilization within the community;
- Harnessing the potential of traditional and religious leaders, CBO, PLWHA Associations and other civil society to facilitate local ownership;
- Strengthening the capacity of local leaders and civil society to mobilize people and other resources at the local level; and
- Promoting mechanism for the sharing of experiences among traditional, religious and other local leaders, CBO, PLWHA Associations, and other components of civil society.

Strategies

1. Strengthen the social and resource mobilization and utilization capabilities of unit committee operatives, PLWHA Associations, NGO and FBO;
2. Improve information flow within the units and with the monitoring and evaluation focal person; and
3. Strengthen the capacities of traditional rulers and religious leaders for the national response;

5.3.6 The Private Sector

The private sector accounts for the majority of employed persons in the country. Identified as the core area for the growth and development of the economy, the activities of the private sector in the management of HIV/AIDS are paramount. Currently, the sector is represented on various bodies of GAC. Some organizations and institutions have developed HIV/AIDS workplace policies with the support of the Tripartite Committee and the GAC. In particular, the Ghana Employers Association (GEA) and Private

Enterprise Foundation (PEF) will play a major role in mobilizing the private sector on the issue of HIV/AIDS.

Mainstreaming HIV/AIDS in the private sector is all important. The mainstreaming process should first focus on the development of workplace policies and workplace programmes to address the needs of employees and their families. Workplace programmes need to be broad enough to address the priority intervention areas of this Strategic Framework. Specifically, workplace programmes must be holistic and include reduction of new infections, as well as protection and care of employees and their families.

Coordination of the private sector response will be through the establishment of a Business Coalition through which umbrella organisations and individual companies voluntarily participate in sharing best practices, expertise and collaborate on the basis of agreed operational procedures. The Business Coalition shall have a secretariat with professional staff to manage and coordinate its activities. The Business Coalition will be facilitated by the GAC.

Strategic Results

1. Enhanced capacity of the private sector to develop work place HIV/AIDS policies and implement programmes;
2. Adopted the " Three Ones" Principle in private sector HIV/AIDS activities; and
3. Enhanced representation of the sector in HIV/AIDS activities in the country.

Challenges

- Encouraging private sector institutions to develop policies and initiate programmes for their employees and their dependents;
- Ensuring the adherence of private sector companies to the "Three Ones" Principle.

Strategies

1. Strengthen the capacity of the private sector to develop HIV/AIDS policies and programmes;
2. Enhance the linkage between public and private sectors to implement or intensify workplace HIV/AIDS programmes and activities; and
3. Ensure the mobilization of the human and financial resources of the sector to support the national response.

5.3.7 Coordination of Development Partners

Development partners have provided substantial resources since the 1980s to support the implementation of activities identified under the national response. These resources have been varied, ranging from financial aid, and technical assistance, to capacity building, and have largely sustained the national response. In addition to resource flows, development partners have made significant contribution to the creation of the enabling policy environment currently driving the national response. Through the Joint Review process, development partners have agreed to commit themselves to the "Three Ones" Principle to ensure effective harmonisation and coordination of their responses. Accordingly, World Bank, DANIDA, DFID and UN agencies have agreed to pool funds to support the expanded national HIV/AIDS response through Multi-sectoral HIV/AIDS Programme (M-SHAP), a sector-wide HIV/AIDS programme (also see Chapter 10). It is expected also that the Global Fund for TB, malaria and HIV/AIDS will be channelled into the pooled funds.

In line with the recommendations of the Joint Review (Ghana AIDS Commission, 2004b), partner coordination will take place through joint planning and implementation processes within the framework of a partnership forum. Development partners will work in close collaboration with the GAC to achieve the goals and objectives of this Strategic Framework. Within the Framework, GAC will coordinate efforts of development partners.

Strategic Results

1. Enhanced capacity of GAC to coordinate donor activities under the NSF II;
2. Established partnership forum for development partners.

Challenges

- Becoming more proactive in sharing information related to the contributions of partners to the implementation of the National Strategic Framework; and
- Adhering to established institutional structures for coordination and management of the strategic response.

Strategies

1. Strengthen the capacity of GAC to effectively coordinate all resources and efforts of development partners for the national response; and
2. Create a congenial environment for development partners to pool resources.

Lead Agency:

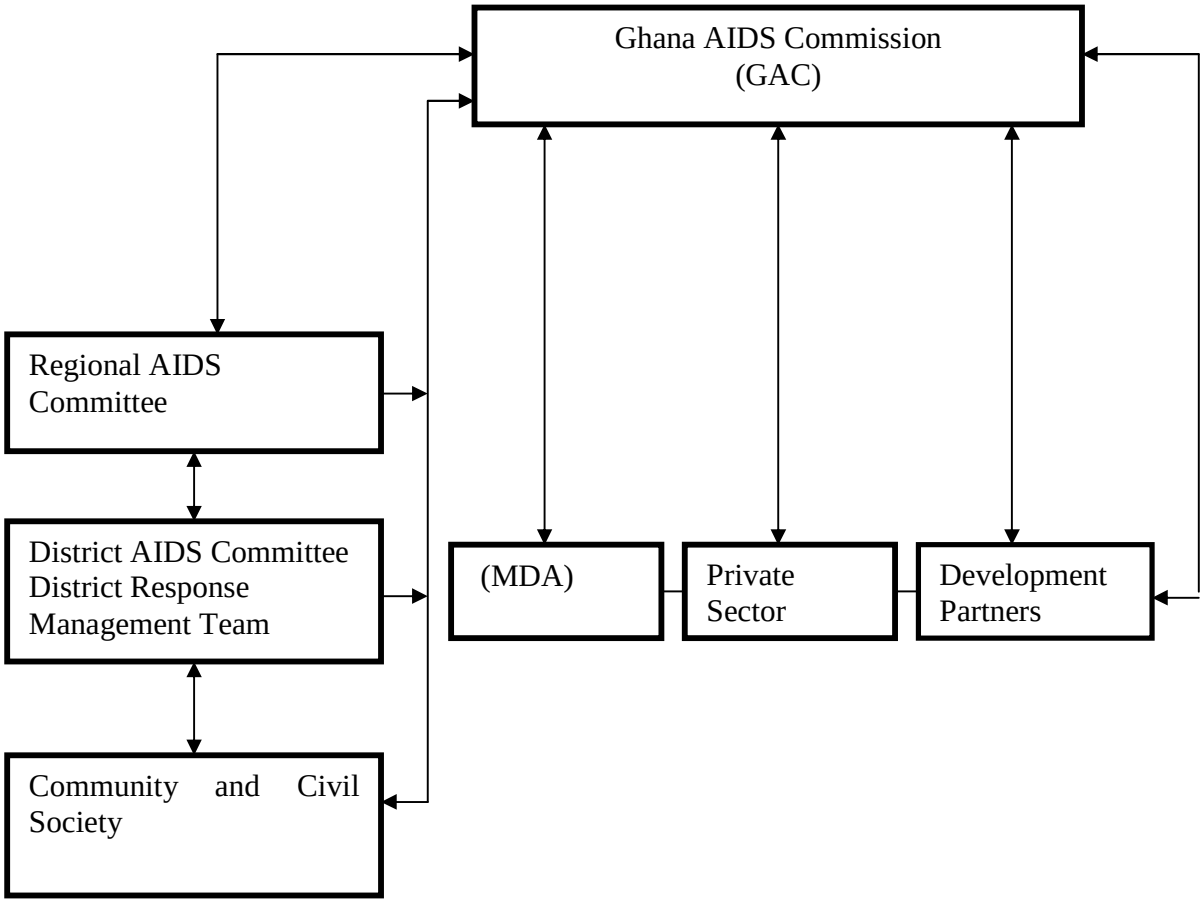
Ghana AIDS Commission

Key Actors

Ministry of Local Government and Rural Development; MOH/GHS and other Ministries, Departments and Agencies, Office of the Civil Service, NPC, NDPC, Organized Labour, Policy Project and Development partners

Figure 5 - INSTITUTIONAL ARRANGEMENTS

The institutional arrangement is depicted below:



Chapter 6: Mitigating the Economic, Socio-cultural and Legal Impacts

Overall Objectives

- To strengthen institutional and human capacity to address HIV and AIDS related stigma and discrimination at the workplace
- To support activities designed to reduce the economic impacts of HIV and AIDS on infected and affected households, OVC, and other vulnerable people
- To ensure the identification and adoption of socio-cultural practices which promote relevant HIV prevention, care and support and reinforce positive behavioural change
- To enhance mechanisms for social mobilization to support activities meant to reduce the socio-cultural burden of HIV and AIDS on PLWHA, OVC other vulnerable persons
- To ensure the passing and enforcement of laws that promote the rights of HIV and AIDS infected and affected persons
- To enhance the capacity of stakeholders to address issues relating to HIV and AIDS, human rights and the rule of law.

6.1 Introduction

The spread of HIV is strongly influenced by the surrounding social, cultural and economic environment. The socio-cultural and spatial milieus in which people operate, and the political structures which provide the framework for governance have implications for the pattern of spread and the nature of responses to the epidemic. Depending on the level of infection, HIV/AIDS in turn affects the socio-cultural and economic systems of a country. Strategies for mitigating the impact of the epidemic are also influenced by many factors: individual behaviour and attitudes; pattern of socio-economic development; some aspects of cultural beliefs, attitudes and practices; the legal environment, including the extent of emphasis on upholding, respecting and guaranteeing basic human rights of infected and affected persons; and the level of openness in dealing with the HIV/AIDS epidemic. For instance, inequalities in development and access to social services generate migration (e.g.rural-urban and north-south) that have implications for sexual networking (Tanle, 2003).

Economic and socio-cultural dimensions of HIV/AIDS infection and mitigation can be positive or negative. The positive aspects include the strong traditional family structure, traditional community leadership and organization patterns that can be harnessed to strengthen care and support. Some negative practices hamper education, prevention, treatment, care, and support necessary for reducing new HIV infections and mitigating its impact. These include the subjugation of women, post-partum sexual abstinence for females but not males, and tacit acceptance of multiple partners for males.

For the management of HIV/AIDS and STIs, understanding gender issues is basic to confronting the epidemic. Generally women are perceived as subordinate in status to men and thus do not have equal access to resources. Inadequate negotiation skills for women in such diverse areas as sexuality and health-seeking behaviour, and lack of autonomy in economic issues, make them vulnerable to HIV infection. Compared to men, women suffer from relative powerlessness, and in some homes face coercion and/or violence. Similarly, young girls, undergo practices, such as infant betrothals and genital mutilation, which affect their health and general well-being. Among the challenges are identifying and enhancing the positive social aspects that may help to reduce transmission and mitigate the affects of the epidemic, as well as identifying and eliminating the negative socio-cultural aspects.

6.2 Mitigating Economic Impact

The economic burden of HIV/AIDS has been found to occur at least at three levels. These are the impact on the individual, the community and the country. As an epidemic mostly affecting people in their productive years, HIV/AIDS will affect the economy in a number of ways: loss of workers and the investment in their training and education, increased cost to business due to absenteeism, labour replacement, recruitment, and the need for new training, medical costs and funeral expenses. All these in turn adversely affect productivity, national economic output, household income, and the overall health of the population. Thus, high rates of infection result in the diversion of resources to uses that would not have been necessary in the absence of HIV/AIDS. According to an impact study conducted in a brewery in 2000, re-training costs and productivity losses due to HIV/AIDS amounted to about 22 percent of total operating costs for the firm. An additional 14 percent of the operating cost was lost through staff absenteeism and labour turnover.

Mitigating the impact of the epidemic on the economy will also have to occur at various levels. At the national policy level, the Ghana Poverty Reduction Strategy, which seeks to create wealth, provides a framework for reducing national vulnerability. At the community and individual levels, strategies such as micro finance, which provides capital for small and medium level entrepreneurs, would need to target people infected by HIV/AIDS and their family members for support, to reduce their vulnerability and susceptibility. Ensuring safety nets and enhanced services for extremely poor households and communities impacted by the epidemic as well as other individuals will be built into any activities meant to mitigate the impacts of the epidemic.

To ensure that enterprises consider the impact of HIV/AIDS on their activities, organized labour in the country and the International Labour Organization (ILO) have advocated for the development of workplace policies to guide industry-specific responses. Some establishments have responded to the challenge and developed workplace policies while others are yet to start.

Strategic Results

1. Developed and implemented strategies for mitigating the socio-economic impact of the epidemic on individuals, families, groups, businesses and the larger society;
2. Created nationwide awareness on the socio-economic impact of HIV/AIDS on individuals, families and communities;
3. Mobilized stakeholders to provide resources to support activities geared towards reducing the economic impact of HIV/AIDS on PLWHA, affected individuals, families and communities;
4. Instituted mechanisms for MDA, employers and the private sector to develop policies for reducing the economic impact of the epidemic on their establishments and employees;
5. Improved access of PLWHA, OVC and other vulnerable persons to resources (e.g. micro-credit) and employment within their capabilities; and
6. Well functioning Business Coalition.

Challenges

- Ensuring mainstreaming of activities on HIV/AIDS in all public and private enterprises to ensure the reduction of the economic impact of the epidemic;
- Advocating policies that address the socio-economic conditions that make some people vulnerable;
- Promoting strategies that provide resources to PLWHA and infected persons;
- Promoting research that will help to identify vulnerable persons; and
- Ensuring development of indicators for monitoring and evaluating assistance to PLWHA.

Strategies

1. Review existing workplace and labour policies and practices to ensure that they conform to the 10 key ILO principles and code of practice, and promote the development and implementation of workplace policies and programmes where they do not exist;
2. Empower women, PLWHA, their family members and other affected individuals through micro-financing, education and skill development;
3. Seek to finalize the Social Protection Strategy being developed within the context of the Ghana Poverty Reduction Strategy (GPRS);
4. Promote partnerships among government, organized labour, civil society and community groups at all levels to develop comprehensive impact mitigation interventions that respond to the impact of the epidemic on local economies; and
5. Promote increased private sector involvement in all aspects of AIDS programming.

6.3 Mitigating Predisposing Socio-cultural Practices

Both the laws of Ghana and the traditions of various ethnic groups prohibit customary practices which dehumanise or are injurious to the physical and mental well-being of a person. Nevertheless, there are some cultural practices (some relating specifically to sex and sexuality, such as female genital mutilation, and wife inheritance) that have negative effects on individuals, or render them vulnerable to HIVAIDS infection. Alternatively, there are some positive cultural practices such as the traditional mutual support system and strong community spirit which can be used to develop strategies for prevention, support and the mitigation.

Regardless of the existence of laws to protect children, various cultural practices continue to put some children at risk. Among these cultural practices are female ritual slavery (such as *Trokosi),* betrothal, female genital mutilation and discrimination against girls for formal education. NSF II will need to target cultural practices that put young girls at risk. Furthermore, with increases in the number of infected adults in the reproductive ages, the number of AIDS orphans will increase. This will require programmes to deal with the problem beyond the traditional approach of relying on extended families members to foster such children.

Strategic Results

1. Identified socio-cultural practices that have positive and negative implications for the transmission of HIV;
2. Promoted strategies to increase awareness about the link between some negative socio-cultural practices and HIV/AIDS infection; and
3. Established mechanisms for resource and social mobilization to support activities that will reduce the impact of negative socio-cultural factors on HIV transmission and the care and support of OVC.

Challenges

- Eliminating some socio-cultural practices that contribute to putting people, especially the youth and women, at risk of HIV/AIDS infection;
- Developing strategies to help people identify and accept the implications of their actions and inactions on their own lives and on the lives of others; and
- Mobilising civil society to re-examine itself and identify positive and negative practices that have implications for HIV/AIDS transmission and prevention as well as the lives of infected and affected persons.

Strategies

1. Document socio-cultural practices that enhance and those that negatively influence disease prevention, transmission and the care of infected and

affected persons among various ethnic groups, and develop appropriate strategies to deal with them; and
2. Advocate gender mainstreaming and protecting the rights of children, especially females, as part of the national response to HIV.

6.4 Legal Aspects

Promoting and protecting human rights are essential components in preventing the transmission of HIV and reducing the impact of the epidemic. A rights-based response to the HIV epidemic involves creating conditions for respecting the rights of persons as indicated in the Constitution as well as in both national and international laws and conventions. International Conventions, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC), offer legal protection to women, children and other vulnerable groups. The 1992 Constitution also guarantees the protection of the rights to life, protection of personal liberty and respect for human dignity. Other provisions in the Criminal Code provide protection from abuse. The Children's Act and the 1992 Constitution contains extensive provisions aimed at protecting children from acts that render them vulnerable to HIV infection.

Legal aid centres and legal aid systems exist to provide services to women and children. However, they are not specialised in HIV/AIDS case work. The Women and Juvenile Unit of the Ghana Police Service has also emerged as an avenue for dealing with issues associated with domestic violence, abandonment and infringements of rights. Traditional rules on property exist alongside formal laws in the country. Thus, there are services and outlets for dealing with issues associated with rights and protection of minors and vulnerable persons.

There are no national laws specifically on AIDS. Also, there are no general anti-discrimination laws to protect PLWHA and especially vulnerable groups (e.g. children, refugees, displaced persons, sex workers, MSM, prisoners) from human rights abuses. Some of these gaps in the legal system have been identified and attempts have been made to draft laws to rectify them. Among the laws that have been drafted but are yet to be passed are the Domestic Violence and the Human Trafficking Bills. In addition there will be the need to draft, enact and enforce laws which address gender-based vulnerability, including violence, coercion, protection of property rights and the marginalization of women. Further, there will be the need to harmonize some national laws with international laws which have implications for the management of HIV/AIDS and the rights of persons.

Strategic Results

1. Advocated for the programmes meant to protect and uphold basic human rights of PLWHA, women, orphans and other vulnerable groups;
2. Enhanced capacity of stakeholders, including PLWHA, MDA, NGO, CBO and the private sector to effectively promote and protect the rights of vulnerable groups;

3. Promoted HIV/AIDS human rights-based advocacy at all levels;
4. Increased resources to key stakeholders to support activities that provide legal protection and avenues for redress of socio-cultural and economic issues for civil society, PLWHA and affected persons; and
5. Advocated enforcement of laws on the protection of children, women and other vulnerable groups.

Challenges

- Popularizing the legal protection measures for women and children which have been clearly articulated in the laws of the country;
- Gaining commitment to the enforcement of existing laws to protect women from harmful traditional practices and offences which increase women's and children's vulnerability to HIV infection;
- Ensuring the passing of laws that have implications for HIV/AIDS and STI prevention which have been drafted but not passed;
- Ensuring the identification and drafting of laws that help to promote the welfare and dignity of persons, especially those likely to influence the course of the epidemic; and
- Strengthening legal support services, and enforcement of local and international laws protecting PLWHA, women, children and other vulnerable groups.

Strategies

1. Promote the review of all laws which affect reproductive health and rights with the view to bringing them into consonance with national and international laws;
2. Support the development of expertise and documentation on HIV/AIDS related legal, ethical, and human rights issues in all sectors, institutions and among NGO/CBO/FBO and the judicial branch of government;
3. Promote the review of sectoral HIV/AIDS plans and codes of ethics for their rights-based components;
4. Strengthen the capacity of PLWHA organizations to participate in all HIV/AIDS-related policies, programmes, and activities.
5. Develop portfolio on ethical issues to guide practice of NGO/CBO/FBO involved in HIV/AIDS programmes.

Lead Agencies:

Ministry of Employment, Manpower Development and Social Welfare/
Commission for Human Rights and Administrative Justice

Key Actors:

Ministry of Finance, Ministry of Women and Children's Affairs, Ministry Employment, Private Sector Development, Ghana Employers Association, Private Enterprise Foundation, Organized Labour, National Council for Women and Development (NCWD), private sector corporate bodies, NGO, CSO, FBO, National House of Chiefs, Ghana National Commission on Children, NPC, GAC, Women and Juvenile Unit of the Ghana Police Service, Commission for Human Rights and Administrative Justice, Ghana Health Service, Manpower Development and Social Welfare, CBO, Judicial Service, Attorney General's Office, Women and Juveniles Unit (WAJU) of the Ghana Police Service, Legal Aid Board.

Chapter 7: Prevention and Behaviour Change Communication

Objectives

- To develop, implement, and manage targeted IEC/BCC and other prevention programmes
- To increase the proportion of the sexually active population who practice faithfulness, or use condoms at every higher risk sexual encounter
- To promote programmes to ensure increase in the median age at sexual debut among young people
- To promote availability and utilization of quality STI, VCT, PMTCT and PEP services to vulnerable groups, rape victims and the general population.
- To minimise the risk of HIV transmission through blood and blood products
- To reduce the incidence of occupational exposure to HIV and other infections

7.1 Introduction

Effective behavioural change communication (BCC) programmes and ultimately reductions in new infections require integrated, multi-level, tailored messages, targeted at particular groups and employing a variety of communication channels including mass communication, peer-to-peer and other interpersonal communications. The new generation of BCC programmes will go beyond provision of knowledge to provide life saving skills/abilities, the confidence and ability to initiate and sustain changes. Information aimed at changing behaviour shall be provided in a timely, relevant, culturally sensitive and appropriate way in a non-stigmatising manner. Due to the interconnectedness of individual behaviour, social norms, and socio-economic structures, it will be necessary to promote together programmes designed to change individual behaviour with those targeting social and community behaviours. Behavioural change communication will also have to respond to issues such as compliance, and some of the new attitudes expected to emerge with the scaling-up of anti-retroviral therapy. For instance, some people on ARV may abandon other preventive measures since they might consider themselves as being "cured." Accomplishing these formidable tasks in a cost-effective manner will require new research knowledge to guide relative emphasis on different strategies and programme components (see also Chapter 9).

Preventive efforts will also require examining legal issues that will have implications for educational programmes that target marginal groups such as sex workers and prisoners. It will also involve developing supportive services, such as counselling and management of STI.

7.2 Programme Targeting

To achieve the goals set out in this framework, the needs of various categories of people will have to be addressed with general and specific HIV/AIDS educational programmes. These categories include sex workers and their clients, PLWHA, affected persons, OVC, adult men and women, youth and children, and people in geographic areas (e.g. rural-urban, peri-urban, slum areas). Available evidence has identified risky behaviours, risky environments and risky periods for HIV infection (Anarfi, 2000). For maximum impact, it will be important to focus on interventions which aim at averting new HIV infections among vulnerable groups and in the general population. Targeting, therefore, will involve identifying some high transmission areas (PLACE methodology) as part of targeting geographic areas and vulnerable groups or behaviours.

7.2.1 General Population

The prevalence rate and pattern of HIV/AIDS in the country fall within the definition of a generalised epidemic. In a generalised epidemic, intensive social mobilisation strategies are needed to implement programmes that promote individual as well as collective positive behavioural change. By targeting the general population, stigma associated with group targeting will be reduced. For the general public, the mass media shall continue to play a significant role in the dissemination of information to achieve behavioural change. Culturally acceptable media and channels will be used to reach groups of people in a timely and relevant manner. In addition, local mobilization, through group and individual interaction, will be used for behavioural change and support for PLWHA and affected members of the community.

Within the general population, there are underserved populations, such as those in rural and deprived urban enclaves. In some parts of the country, prevalence rates are higher in rural than urban areas. These patterns present a challenge for dealing with the factors that predispose people in such areas to infection.

7.2.2 Geographical Targeting

Infection rates in the country are not evenly spread, with higher rates in some geographic areas than others. Even within a Region or District known for its high or low HIV prevalence, infection is higher within certain "*hot-spots,*" which deserve additional focus in prevention activities. Among these are locations on highways and market centres (Anarfi et al., 1999). There are also periods when certain activities (e.g. local festivals, funerals) take place that expose people to higher risk. While information exists in some form (e.g. sentinel surveillance and surveys) to guide geographic targeting, additional information will be needed to further guide interventions during NSF II. Such information will include factors which influence behaviours that occur at such events locations, so that they can be appropriately managed. Some of these events and places will vary with time and will need constant review in order to understand patterns related to varying rates of infection.

7.2.3 Vulnerable group targeting

Targeting social groups with known high HIV prevalence and risky behaviours that are likely to facilitate the spread of HIV is a highly efficient way of preventing further spread of the epidemic. Some of these vulnerable groups, such as sex workers, and clients of sex workers are well documented. However, the selection of other high risk groups will have to be based on a combination of biometric and behavioural studies.

The available evidence suggests that other vulnerable groups in the country include youth, women in a marital union, uniformed service personnel, refugees, displaced persons, prisoners and people living at border towns. Specific issues related to these groups are highlighted below.

Women

Lack of economic empowerment coupled with low literacy and negative socio-cultural and religious practices continue to beset women and increase their level of vulnerability to HIV infection. Due to lack of socio-economic opportunities, such as education, and cultural practices, women lack control over their sexuality and are expected to serve men's needs. Increases in formal education help to reduce HIV infections among women. To this end, advocacy to encourage sustainable girl-child education will be systematically pursued and increased, as well as continuing access of women to non-formal education. Women's economic capacity will be improved through strengthening and expanding existing income-generating and skill-development programmes, especially for women not in marital unions. HIV prevalence in this group is about three times that of women in marital unions (Ghana Statistical service, 2004). The assumption is that increased education, income generation and skill development opportunities will help reduce the level of economic dependency of women and improve their ability to negotiate safer sex. Considering that the uptake of female condoms has been slow, extensive promotion of female condom use among both males and females should increase women's ability to have some control over their exposure to risk.

Effective advocacy programmes are needed which address the negative socio-cultural practices and economic vulnerability of women and young girls to HIV/AIDS infection. Some key issues that have negative impact on the health of women, such as violence and coercive sex, will be targeted in mass media campaigns and comprehensive community participatory learning approaches. The messages and activities will focus on gender dimensions of development and infection, changes in the epidemic, perceptions of individual and group vulnerability, value of ABC strategies, and skills in negotiating safer sex.

Youth

Youth, defined as young people between the ages 10 and 24 years, account for about a third of the country's total population (Ghana Statistical Service, 2004). Several studies, both national and international, have shown that many young people have unplanned sex and often fail to protect themselves against disease and unwanted pregnancy, especially at their first sexual encounter. Young people also underestimate their own vulnerability to infection, while some of them, especially young females, are victimized by sexual violence and sexual abuse. Available evidence also suggests that young people do not report STI infections for various reasons. They may not think that the infection is a serious issue, and they may be concerned about negative attitudes of service providers. They are also influenced by the behaviour and activities of their peers.

For young people, structured youth activities, peer education and youth friendly services will be strengthened and, the best practices in and out of the country will be replicated. Services for young people require strong skill building components aimed at reducing their vulnerability. This will also include encouraging those yet to initiate sex to delay sexual debut, and for those already sexually active to stick to one sexual partner, and adopt dual protection measures.

In-School Youth

In-school youth constitute a captive audience who can easily be reached with well packaged programmes. Youth in first and second cycle institutions as well as tertiary institutions will be reached with appropriate HIV/AIDS information through their teachers, and equipped with appropriate life skills in relation to HIV/AIDS. Safer sex practice, with emphasis on the delay of the onset of sexual activities and abstinence, will continue to be promoted among youth in the first and second cycle institutions. Messages on the ABC of HIV/AIDS prevention will be promoted among youth in tertiary institutions. Both male and female condoms will be promoted and made readily available in tertiary institutions. While the general link between education and HIV/AIDS prevention is positive, there are also emerging negative aspects associated with formal education. For instance, some girls are compelled to enter into transactional sexual arrangements to be able to pay their school fees. Some experience sexual abuse in school (Ankomah, 1998; Awusabo-Asare et al, 1999). Intensive community education will be pursued to promote support for female education in a safe environment.

Teachers constitute a major group in the intervention process for young people. Although in some cases teachers have been found to abuse young school girls, collectively, they constitute a resource that will have to be tapped for intervention. In-service training will be provided on HIV/AIDS issues to teachers at various levels, including instructors at institutions serving students with special needs, such as the blind, hearing and physically impaired. This requires the development and periodic review of available educational materials, including text books, leaflets, pamphlets, documentaries and interactive video-drama series. Teachers in training institutions will be given adequate education and skills to impart sensitive material on HIV in a youth friendly manner. The abuse of school girls by teachers will also have to be addressed as an issue in professional and personal ethics.

Out-of-School Youth

There are two main categories of out-of school youth: the organized, who may be employed, or serving as apprentices, and the unorganized, who are not employed, or who only have street hawker positions, or are at home. Both categories of youth have varied information needs and also respond differently to the available information (Dartey, 2003; Glover, et al., 2003). The out-of-school youth present one of the biggest challenges in HIV/AIDS prevention. Some of them engage in high risk sexual behaviour while some of the girls are subjected to sexual coercion (Awusabo-Asare et al, 2004). Tailor-made, culturally sensitive and relevant messages with appropriate visual aids will be developed to serve the varied needs of different groups. To achieve this objective, both the human and institutional capacities of NGO, CBO, and civil society will be enhanced to enable them to communicate effectively with young people, thereby increasing the probability of achieving positive behaviour change. Both primary and secondary abstinence will be vigorously promoted, especially among males and females aged eighteen years and below. "ABC" and partner reduction will be the main messages for the sexually active. Condom promotion, STI management and sexuality counselling services will be made widely available and accessible.

Sex Workers and their Clients

A number of women are drawn into sex work for various reasons, including poor economic conditions. Although the number of sex workers in the country is unknown, it is generally believed to be increasing and to include PLWHA (Ahiadeke et al., 2004). With the introduction of HAART, some infected persons will continue to be sex workers, putting themselves and their clients at further risk. Extensive education programmes will be needed to raise awareness of sex workers and their clients on the importance of using condoms in each sexual act, and periodically using STI and VCT services. An important feature of STI reduction programmes will be condom promotion for both males and females. There will be BCC messages to encourage the reduction of multiple sexual partnerships and consumption of alcohol. Linkages with relevant organisations will be encouraged to initiate and sustain initiatives which assist sex workers to find alternative employment. Clients of sex workers require education on vulnerability, risks, and consistent use of condoms.

Prisoners

A number of youth and adults in their prime years are incarcerated in prisons and remand homes. Prisoners become vulnerable to HIV due to rape, and consensual unprotected penetrative anal intercourse. However, owing to stigma associated with incarceration, prisoners often delay accessing medical services, thus delaying the timely diagnosis and treatment of infections. Condom use is non existent as prison authorities prohibit condom distribution in prisons. Tailored BCC programmes and services will be promoted in the prisons to ensure early detection and reporting of STIs, as well as promotion of support from prison authorities to address issues such as HIV/AIDS education and condom distribution.

Mobile/ Migrant Populations, Cross-border Traders, Refugees, and Uniformed Service personnel

Mobile, migrant population, cross border traders, refugees, internally displaced persons, and uniformed service personnel are believed to be more vulnerable to HIV because their mobility increases their vulnerability to high risk sexual behaviours. The country has long and porous borders with its neighbours which have higher rates than Ghana (UNAIDS, 2004a). Located in a central position along the West African Coast, Ghana is involved in the Corridor Project spanning five countries. As part of the intervention, there will be strategies to improve access of these groups of people to condoms. Access to STI treatment will also be improved and the mobile population motivated to utilise the services. BCC programmes will focus on partner reduction, consistent condom use, abstinence, and early treatment of STIs.

Sites such as border towns, guest houses, and night clubs, drinking bars and hotels and brothels tend to be places where people meet sexual partners, and in some cases sexual activity takes place on site. It is generally accepted that there are few HIV prevention BCC programmes or condoms at most of these high risk sites (Ghana AIDS Commission, 2004a). Ghanaian military and police personnel have been involved in international and local peace keeping over the years. Those involved face isolation from social and family support which is likely to put them at risk. Recognizing the potential risks, the security personnel have developed programmes for serving members. Capacity building programmes shall be organised for managers of night clubs, and serving personnel, whilst educational activities will have to be strengthened to ensure that BCC activities are tailor-made for the various categories of people.

Workplace Programmes for the Employed

Large enterprises, companies, MDA, small and medium-sized industries account for about one quarter of the employed work force (Ghana Statistical Service, 2004). Some of these workers are organised under labour unions which can easily be mobilised for HIV/AIDS programmes, while others are not unionized. During the period of NSF I, some institutions developed and implemented workplace policies. Those institutions will be supported to review and expand their programmes. Within the period of NSF II, institutions without work place policies will be assisted to develop and implement HIV/AIDS policies and programmes. Advocacy efforts will be intensified to ensure that resources are made available. The peer education model will be promoted to motivate peers to collectively support preventive behaviours, such as abstinence, partner reduction, condom use and mutual fidelity.

Farmers, fishermen, and other informal sector workers

According to the 2000 Housing and Population Census, about 60 percent of the employed adult population are in agriculture, fishing, and the informal sectors of the economy (Ghana Statistical Service, 2004). These are people who are not involved in any work

place programmes. The assumption is that they will be covered in community-based programmes. However, the work patterns of some of them (e.g. market women and farmers) are such that they are not covered by a number of programmes. These categories of people will be targeted differently through municipal/district assemblies, and in their community-based organizations.

Strategic Results

1. Reduced number of new HIV infections, especially among vulnerable groups;
2. Operationalised National Integrated IEC/BCC Strategy;
3. Strengthened implementation of BCC programmes;
4. Increased levels of abstinence among young people, mutual faithfulness among those with partners, and condom use;
5. Reduced stigma and discrimination; and
6. Improved quality and utilization of STI and VCT services;

Challenges

- Strengthening the effectiveness of prevention-oriented interventions;
- Reducing high risk behaviour, promoting preventive behaviours, and implementing appropriate information and services specific to each vulnerable and/or high risk group.

Strategies

1. Finalise and operationalise a National Integrated IEC/BCC Strategy addressing the gender-specific needs of the general population, physically challenged persons, and particular high risk/vulnerable groups;
2. Reinforce cultural values and practices that reduce the risk of HIV infection.
3. Strengthen capacity to develop and implement BCC programmes;
4. Promote dual protection through ensuring access to, as well as correct and consistent use of male and female condoms;
5. Improve access of all youth to quality, evidence- based, and culturally sensitive life planning skills and user-friendly reproductive health services with the view to reducing new infections;
6. Improve awareness of complications and prevention of STIs, especially among young people, high risk and vulnerable groups;
7. Ensure improved access to VCT, including the use of mobile VCT services;
8. Strengthen quality syndromic management and monitoring of STI in both government and private health institutions;
9. Integrate syndromic management of STI into the pre-service curricula of all health training institutions and expand the integration of syndromic management of STI into other services;
10. Build the capacity of relevant stakeholders to integrate, implement, coordinate, and improve the delivery of PMTCT services to antenatal patients;

11. Ensure improved attendance at supervised delivery points in order to improve access of infected infants to ART;
12. Promote standardised provision and awareness of the availability of PEP, improve access to PEP services for occupational exposure to HIV and rape, and ensure the availability of PEP in health institutions;
13. Train medical personnel, law enforcement agencies and traditional and religious leaders on issues of rape and PEP so as to improve reporting of exposure to HIV and rape, and referral system for PEP;
14. Strengthen blood donation, screening and transfusion services in public and private health institutions in line with the national Blood Transfusion Policy; and
15. Advocate for programmes to reduce preventable anaemia among women and children.
16. Engage civil society in community preparedness activities to embrace ART scale up.

Lead Agencies:

GAC, National Population Council, MOH/GHS

Key Actors:

MOH/GHS, NPC, NGO, CBO involved in BCC, Ministry of Education, Youth and Sports, Ministry of Women and Children's Affair, Traditional, religious and opinion leaders; FBO, MDA, Civil Society, organized labour, Nursing /Midwifery training institutions and medical schools, CHAG, Private Hospitals, WAJU, MOWCA**.**

Chapter 8: Treatment, Care and Support

Objectives

- To ensure an enabling environment for comprehensive treatment, care and support through reduced stigma and discrimination
- To strengthen infrastructure and human resource capacities necessary to rapidly scale-up provision of treatment, care and support for PLWHA, OVC and other vulnerable groups in public and private institutions at all levels
- To promote early diagnosis of HIV and AIDS through use of VCT and other services
- To ensure the availability of adequate laboratory support for clinical care services at all levels
- To develop strategies for ensuring universal access to ART
- To ensure the availability and standards for community and home based care for PLWHA, OVC and other vulnerable populations
- To ensure psychosocial support is an integral part of a comprehensive care and support package for PLWHA, caregivers, OVC and other vulnerable groups
- To strengthen referral mechanisms and other linkages between the community, preventive and clinical services in public and private institutions
- To promote adequate nutrition for PLWHA, mothers and children
- To promote public private partnerships for accelerated treatment, care and support
- To monitor, supervise and evaluate treatment, care and support programmes

8.1 Introduction

Programmes to provide treatment, care and support for PLWHA and affected persons at the institutional, community and home levels require vast expansion. Clinical care, defined as provision of services for opportunistic infections (OI), anti-retroviral therapy (ART and HAART), prevention of mother-to-child-transmission (PMTCT) and post-exposure prophylaxis (PEP) and laboratory services, were either introduced or expanded during the period of NSF I. Technological developments in anti-retroviral therapy, increased knowledge about the epidemic and a supportive social environment have combined to change the way HIV/AIDS is managed in the clinical setting in the country. With a drastic decline in the prices of drugs for highly active retroviral treatment (HAART), and the willingness of development partners and the government to support treatment, anti-retroviral therapy was introduced on an experimental basis in 2002/2003.

Introduced as a pilot programme between Family Health International and the Ghana Health Service to PLWHA in Manya and Yilo Krobo Districts in the Eastern Region, the success of the project has led to the expansion of the programme. Currently about 2,000 persons are receiving therapy. The success of the programme has given hope to many people and has transformed perspectives on treatment and care of PLWHA. These

developments are at the core of the quest for increased access to treatment, care and support for PLWHA. An important challenge is to develop strategies that will make access to ARV treatment progressively available to all those who need it. Associated with this expansion in ART will be increased motivation for VCT.

8.2 Care and Support at the Institutional and Community Levels

Care and support at the institutional level is in its infancy and is characterized by ignorance, fear, stigma, discrimination, inadequately trained and motivated staff, inadequate laboratory services for the management of HIV/AIDS, low coverage of ART, lack of post-hospital discharge policy and weak referral networks. Efforts therefore are needed to improve treatment, care and support for PLWHA at the institutional level. However, with increasing numbers of PLWHA, institutional care alone cannot provide the needed care and support. Therefore community and home-based care (and support CHBC) will become increasingly important.

CHBC services include physical, psychological, palliative, material and emotional assistance. Care provided to infected and affected individuals in their own environment form an important link in the continuum of health care for terminally and chronically ill persons. This care, delivered by trained (and in some cases untrained) nuclear and extended family members, neighbours, friends, independent volunteers, as well as organized volunteers working through religious and other organisations, has become an important element in HIV/AIDS treatment, care and support. Sometimes supported by skilled and motivated social welfare and health workers, HBC provides appropriate medical, social and nursing support for PLWHA, while at the same time reducing congestion in health facilities.

Community and home-based care are organized mainly by religious hospitals affiliated with the Christian Health Association of Ghana (CHAG). Lay counsellors and public health nurses provide outreach services to PLWHA who have been under their care in the health institutions through a discharge plan and referral system. Their experience will provide valuable insights to guide the scaling-up of community and home-based care in this second Strategic Framework. Implementing comprehensive community and home-based care services will also call for addressing issue associated with traditional home-based care strategies which rely mostly on females, irrespective of age, as primary care-givers.

Herbal and other traditional therapies have also emerged in the treatment of HIV/AIDS. Available evidence suggests that some infected persons depend on herbal and other treatments for various reasons including the belief that traditional medicine can cure HIV/AIDS (Acquaah, et al., 2004; Mensah et al., 2004). While the debate on the efficacy of herbal treatment and other therapies has not been conclusive, there is a growing interest in such therapies (Amoah and Acquaye, 2004). Therefore, it is necessary to explore the use of herbal medicines in treatment, care and support.

Programmes of care and support for vulnerable populations have so far targeted information and STI services to sex workers, long-distance truck drivers, and uniformed

service personnel. OVC have been identified for some targeting, as in the case of orphans in some areas in the country. Other vulnerable groups, such as clients of sex workers, men-having-sex with men and intravenous drug users, also require care and support services, as well as targeted BCC during the next five years.

Care of PLWHA at both the institutional and the community/home levels still remains one of the weakest components of the continuum of care for PLWHA in the country. In the 2003 review of programmes, care was the only programme component which was rated below 60 points in the AIDS Programme Effort Index (API) (Ghana AIDS Commission, 2004a). This is because ARV, PMTCT and VCT are not widely available to those who need them in various parts of the country. Therefore, scaling-up of treatment and care at both the institutional level and across geographic regions will present one of the biggest challenges. Within the period of NSF II, strategies will be developed towards ensuring universal access in the future.

8.3 Challenges in Promoting ARV

Promoting ARV and related services will generate new challenges. These will include the early diagnoses of HIV infection, especially among pregnant women, adequate nutrition for PLWHA on ARV, and issues of compliance. Another challenge is that some people on ARV may think that, given their improved health conditions, they can resume unprotected sexual activities. Others may be less concerned with HIV infection because they incorrectly think that a cure is available. BCC programmes under NSF II will be mindful of such challenges. Furthermore, the scaling-up of ARV and related services will generate the need for training and capacity building at all levels, including those providing home-based and institutional care.

Strategic Results

1. Developed strategies that will ensure progressive access to comprehensive and confidential ARV, PMTCT, VCT, PEP and other treatment, care, and support services;
2. Integrated long-term HIV/AIDS treatment, care and support with other chronic conditions within the health and social services;
3. Developed appropriate mix of institutional and home-based care and support which are affordable and feasible;
4. Implemented training programmes for comprehensive institutional and home-based care and support, and strengthened volunteer system for institutional and home-based care;
5. Advocated for standardized traditional and alternative medicine as part of long-term treatment, care, and support.
6. Developed and implemented workplace policies on treatment, care and support;
7. Strengthened involvement of PLHWA and affected persons in the planning and implementation of programmes and activities on treatment, care, and support; and

8. Implemented comprehensive programmes, including nutritional support, for orphans, and vulnerable children and adults, such as widows and other women not in a marital union.

Challenges

- Managing expanded ARV, PMTCT, PEP, and VCT services, and institutional and home-based care for increasing numbers of PLWHA, OVC and other vulnerable groups;
- Re-modelling the traditional system of care and support which relies mostly on women as primary care givers;
- Maintaining a functioning referral system;
- Providing support to institutional and home-based care givers;
- Ensuring the development and implementation of workplace policies on treatment, care and support; and
- Ensuring the promotion of adequate nutrition for PLWHA and OVC.

Strategies

1. Improve the relationship and linkages between providers of standard and traditional health systems for treatment, care and support;
2. Ensure the availability of human, financial and physical resources for scaling-up treatment, care, and support services;
3. Promote the utilization of good practices for managing opportunistic infections, as well as care and support strategies for PLWHA and OVC;
4. Develop training plans, operation manuals, tools and curricula covering the skills necessary to deliver institutional and home-based treatment, care and support for PLWHA, orphans and other vulnerable persons;
5. Strengthen the capacity of communities to mobilize and participate in the design and implementation of community and HBC for HIV and related illnesses, including TB;
6. Promote various forms of home-based care as a complement to institutional care, and encourage male members of the family to participate in home-based care in order to reduce the often overwhelming responsibilities placed on women and girls;
7. Promote community initiatives on psycho-social support for persons providing institutional and home based care for PLWHA, OVC and other vulnerable persons;
8. Strengthen and expand the delivery of quality laboratory services by developing standards for laboratory tests, providing training programmes for laboratory personnel, establishing and strengthening linkages between public and private sector laboratory services, and ensuring an adequate and uninterrupted supply of quality laboratory commodities and equipment for the diagnoses and management of HIV-related illness, including opportunistic infections;
9. Ensure ready access to confidential VCT services throughout the country by integrating them with STI and ANC services.

10. Promote the use of VCT among pregnant women, high risk, and vulnerable groups;
11. Develop appropriate policy guidelines and standards for the management of opportunistic infections and use of ARV;
12. Promote enabling, friendly, non-stigmatising, non-discriminatory and affordable services for early diagnosis and treatment of opportunistic infections and use of ARV;
13. Mobilize adequate financial resources to ensure uninterrupted supply of drugs for ARV, PMTCT and paediatric services;
14. Promote BCC programmes that address compliance and appropriate attitudes towards ARV, VCT, PEP, dual protection particularly for discordant couples, and PMTCT including appropriate breast feeding practices;
15. Promote effective referral systems to support institutional and home-based care at all levels; and
16. Develop programmes to build the capacity of both public and private sector providers to deliver efficient, effective and quality clinical services.

Lead Agencies:

Ministry of Health/Ghana Health Service; Ministry of Local Government; Department of Social Welfare.

Key Actors:

District Assemblies, Health institutions (public and private), NGO, FBO, GAC, NPC, CBO, PLWHA Associations, Communities and families, Centre for Plant Medicine, and Medical Schools in Ghana.

Chapter 9: Research, Surveillance, Monitoring and Evaluation

Objectives

- To enhance institutional and human capacity to generate and utilize high quality research data to inform policy and programming;
- To strengthen linkages among researchers and policy makers through the formation of research networks and partnerships
- To develop and implement a research agenda to strengthen coordination of HIV and AIDS related research and establish a better coordinated ethical review process
- To establish framework for documenting and sharing research findings which is centrally updated and accessible nationally both in print and electronic forms
- To achieve operational excellence in providing surveillance data on the national response
- To initiate, develop and implement a comprehensive surveillance framework in tandem with changing international standards .
- To ensure compliance of effective surveillance standards and protocols.
- To collaborate with professional bodies, other agencies and international organisations
- To develop and publish guidelines and protocols to guide the implementation of a second generation surveillance system
- To establish a system for linking the Second Generation Surveillance System to trends in prevalence/incidence of STI, HIV and individual and societal behaviour
- To ensure performance monitoring is factored into the design of interventions and that monitoring and evaluating programmes becomes part of the planning process.
- To provide technical and financial support to all levels to develop appropriate M/E processes including data collection and reporting systems
- To ensure that indicators link up with international requirements and emerging national priorities
- To enhance skills in monitoring and evaluation amongst HIV focal persons within the sector ministries, regional and district M/E focal persons etc
- To provide up to date information on national and international M/E indicators
- To establish mechanisms for networking and sharing experiences on monitoring systems
- To roll out PLACE in appropriate districts so as to inform better targeting of interventions

9.1 Introduction

Effective implementation of a national response to HIV/AIDS depends on the quality of information made available to all stakeholders implementing prevention, treatment, care and support activities aimed at reducing transmission and mitigating the impact of the epidemic. Information is said to be of good quality when it is accurate, relevant, adequate, systematic, timely, usable, and accessible and can be communicated to key audiences in terms that they can understand. Processes that make the response more efficient, such as geographical coverage, targeting, coordination, and rational distribution of resources will need to be information-based. Continuous monitoring of the national response is vital to ensure periodic assessment of status, trends and changes in research, outputs and outcomes that will help managers monitor programmes.

Evaluation builds on monitoring data and provides more in-depth analysis of HIV/AIDS interventions. It tries to answer questions of whether, how, and why specific programmes work. As part of the evaluation process, there will be an inventory of ongoing research and programmed evaluation, the coordination of evaluation studies and the dissemination and use of research findings. NSF II will be guided by strategic information obtained through research, surveillance, monitoring and evaluation.

9.2 Research

The determinants of the spread of the HIV/AIDS epidemic and the scale and types of responses required to avert new infections and mitigate the impacts of HIV/AIDS are complex. This complexity reinforces the critical importance of high quality research as a tool for filling gaps in knowledge, identifying intervention priorities, and improving the policy and legal environment. In order to maximise the advantages of an evidence-driven, expanded, multi-sectoral national response, accelerated research will be important for informing and supporting planning, management, coordination and evaluation of policies and programmes.

Research activities relating to identified areas will be developed and implemented within well-defined coordination mechanisms. The sharing of research results will be carried out at national, regional and district levels. Among the critical issues are documentation of research activities, dissemination and use of results to guide policy and programmes, and enhancing linkages among research institutions, policy makers, and programme managers.

Strategic Results

1. Co-ordinated research programme that will contribute to the identification of strategic information needs;
2. Identified national research agenda based on the dynamics of the epidemic in Ghana;
3. Developed knowledge management strategy which will be used for decision-making.
4. Built database on national capacity to carry out high quality research and utilise research data;

5. Undertaken evidence-based research to inform the national response;
6. Developed documentation system for the storage of research data and secondary information;
7. Developed a publication system for the dissemination of research results; and
8. Established ethical review process for HIV/AIDS research which protects the rights of PLWHA and other research participants, and ensures that research protocols and methods conform to international standards.

Challenges

- Coordinating various research efforts;
- Relating HIV/AIDS/STI research issues to the national framework; and
- Ensuring ethical review of all research on HIV/AIDS.
- Enhancing institutional and human capacity at all levels for conducting research, and mobilizing resources and funding for HIV/AIDS-related research.

Strategies

1. Establish a mechanism for periodic consultative meetings to develop and publish an HIV/AIDS research agenda and institutionalise a process to ensure that most research carried out in the country is in accord with the Strategic Framework;
2. Maintain a documentation system for findings from research on HIV/AIDS undertaken in the country and share data and research findings with stakeholders at all levels;
3. Develop a mobilization plan for enhanced funding of research.
4. Develop a capacity building plan to increase institutional and human capacity for conducting relevant research.
5. Enhance linkages between and among individuals and research institutions undertaking HIV/AIDS-related research; and
6. Ensure the development of structures for coordinated ethical review of research on HIV/AIDS.

9.3 Surveillance

Surveillance comprises periodic measurement of biological, behavioural and social impact indicators. The existing system HIV/AIDS surveillance relies on testing of antenatal patients, sex workers, and STI clinic attendees. For the first time, the 2003 GDHS also added biological markers. Through an appropriate expansion of such efforts to cover the entire population, adequate information on the magnitude and trends of the HIV/AIDS epidemic can be obtained. However, a prospective national population-based surveillance system is yet to be developed.

Incidence rather than prevalence is the best measure of the current force of the epidemic and the best tool for evaluating the impact of targeted interventions. The newly-developed detuned assay and other technologies provide better measures on trends in the

epidemic. NSF II will incorporate these new technologies as much as technically and financially feasible.

For policy and programme guidance, GAC will support the establishment of a comprehensive National Second Generation Surveillance System. This system will involve HIV, STI, and behavioural surveillance, as well as Integrated Disease Surveillance and Response (IDSR), Sentinel AIDS Case Surveillance, VCT, PMTCT, ART Records, Blood Donor Screening Records and Tuberculosis.

Strategic Results

1. Established a comprehensive national second generation surveillance system with various components to monitor trends in biological, behavioural and social factors;
2. Developed a population-based prospective HIV surveillance system capable of meeting diverse and specific needs of implementing agencies;
3. Instituted a mechanism for making periodic estimates the prevalence and in time, the incidence of HIV infection in specific populations and in specific geographic areas; and
4. Developed a system for utilizing surveillance data to monitor the epidemic and evaluate intervention programmes.

Challenges

- Collecting high quality data in a timely manner on the prevalence, incidence, and other indicators at the regional, district, and sub-district levels;
- Developing a comprehensive national surveillance system; and
- Instituting mechanism for obtaining regional level data for planning at that level.

Strategies

- To initiate, develop and implement a National Surveillance Plan in order to provide surveillance data on the national response and which is in tandem with changing international standards .
- To develop and publish guidelines and protocols to guide the implementation of a second generation surveillance system;
- To establish a system for linking the Second Generation Surveillance System to trends in prevalence/incidence of STI, HIV infection, and individual and societal behavioural responses
- To ensure compliance of effective surveillance standards and protocols.
- To collaborate with professional bodies, other agencies and international organisation..

9.4 Monitoring

Monitoring is the routine assessment of ongoing activities which helps to assess the progress of programmes. In the context of HIV/AIDS two broad monitoring systems are essential, financial management and programme activity monitoring. The former deals with the monitoring of the use of resources, and the latter is concerned with the progress in the implementation of activities identified in work plans.

To ensure a national and comprehensive monitoring system, the GAC developed a monitoring and evaluation plan as part of NSF I. The plan which has informed and guided activities has not been fully utilised to guide programmes as envisaged. Within the period of NSF II, GAC and other stakeholders will commit themselves to the development of a Country Response Information System (CRIS) for monitoring progress. The next generation monitoring system will include indicators on the allocation and use of resources.

Strategic Results

1. Instituted a national and comprehensive monitoring system for predicting, budgeting, allocating resources, and guiding programmes;
2. Developed a clear, precise, timely and understandable system for the collection, collation and regular dissemination of progress in the implementation of programmes;
3. Developed a unified reporting system using appropriate tools that incorporates key UNGASS and other relevant indicators; and
4. Enhanced human capacity for monitoring at all levels.

Challenges

- Strengthening the reporting of data by partner organisations;
- Improving analysis of data from blood donors/VCT/PMTCT;
- Integrating diverse approaches in the monitoring of programmes;
- Strengthening the standards of survey data analysis and reporting;
- Creating acceptable indicators which will be used by various agencies;
- Increasing resources; and
- Strengthening national data reporting structures.

Strategies

1. Update the Monitoring and Evaluation Plan in line with the One M & E principle, which incorporates key UNGASS indicators;
2. Develop monitoring operational manuals, which include standardised tools, formats, and instruments and a comprehensive national monitoring plan as part of the integrated National M&E Plan;

3. Strengthen the existing Research, Monitoring and Evaluation Technical Committee to support monitoring activities;
4. Enhance the capacity of national/regional/district focal persons in monitoring;
5. Develop national and local data collection systems;
6. Develop a national data base management system; and
7. Establish mechanisms for networking and sharing experiences on monitoring systems.

9.5 Evaluation

Evaluation is periodic assessment of accomplishments, achievements and impacts of projects and activities. Evaluation is expected to occur both during programme implementation (formative) and at the final stages of implementation (summative). The evaluation process will examine the quality of implementation (process), the plausible outcomes (outcome) and overall changes (impact). The intention is to assess programmes for their effect and lessons learnt which will then inform policy, programmes and activities. Evaluation in this context is viewed as part of the continuum for improving the quality of the national response. This approach implies the need for annual process evaluations, mid-term evaluations, and a final evaluation of NSF II.

Strategic Results

1. Instituted an effective evaluation system;
2. Developed indicators for the evaluation of programmes;
3. Developed capacity for evaluation at all levels;
4. Provided strategic information for planning and design of interventions; and
5. Improved documentation and application of lessons to subsequent activities.

Challenges

- Strengthening institutional capacity of key stakeholders to undertake evaluation;
- Improving documentation of information from evaluation exercises;
- Improving coordination of the evaluation and dissemination of data between and among national and sub-national levels; and
- Improving baseline information for future evaluation of programmes.

Strategies:

1. Enhance the capacity of key stakeholders to undertake evaluation of programmes and activities, to ensure adequate documentation and dissemination of evaluation reports, and to promote the utilisation evaluations for decision-making;
2. Design an operational manual for monitoring and evaluation of the response within the decentralised system;

3. Ensure the incorporation of baseline and evaluation into the design and implementation of all programmes, activities and interventions; and
4. Develop database on HIV/AIDS indicators, programmes/projects and research to inform M&E.

Lead Agency:

GAC

Key Actors:

Ghana Health Service and its allied agencies, Ministry of Education and Sports and its allied organisations, Research and academic institutions, Independent research organizations, and Development Partners.

Chapter 10: Resource Mobilisation and Funding Arrangements

Objectives

.

- To increase total resources from various sources committed to the national response
- To establish effective targeting and resource allocation process in consultation with partners;
- To strengthen financial management and monitoring systems through the strengthening of institutional and human capacity.
- To streamline budgeting process
- To establish a flexible funding arrangement for mobilizing and channelling HIV/AIDS resources for the national response

10.1 Introduction

Funding for HIV/AIDS activities from 1987, when the National AIDS/STD Control Programme (NACP) was established under the Disease Control Unit of the Ministry of Health (MOH), was mainly through the Sector-Wide Approach (SWAp) of the MOH. Since then, funding of the national response has gone through changes up to the current system that emerged with the development of the National HIV/AIDS Strategic Framework in 2000 and the establishment of the Ghana AIDS Commission in 2001.

In June 2002, the GAC set up a $25 million fund known as the Ghana AIDS Response Fund (GARFUND) with the support of the World Bank. This fund has ensured a multi-sector response to HIV/AIDS in Ghana by supporting activities of a broad spectrum on stakeholders including MDA, NGO (local and international), CBO, FBO, academic institutions, traditional authorities and religious bodies. Major new funding sources have emerged since the setting up of the GARFUND. These include a £20-million Ghana AIDS Partnership Programme (GAPP) from DFID to complement GARFUND, $4.5 million from the Dutch Government, $4.9 million from the Global Fund, and a commitment of $7 million per year for five years from USAID. The UN and its agencies have also contributed funds and technical support.

Since the implementation of NSF I, new dimension of the management of the epidemic and priorities have emerged in such diverse areas as ARV, care and support for PLWHA and OVC, prevention of MTCT, deepening of BCC activities and provision of more VCT centres. These emerging priorities have enormous resource implications for the national response, requiring significant increases in resources committed to HIV/AIDS activities. For instance, 750,000 women become pregnant each year. The annual cost of providing nevirapine to all pregnant women who are HIV-positive in order to prevent MTCT has been estimated at US $1.2 million (NACP/GHS, 2004). It is also estimated that about 71,000 PLWHA require ART yet only a small number of them are currently receiving treatment. The estimated annual cost of extending ART to all PLWHA who need

treatment is between $47 and $80 million (NACP/GHS, 2004). These, together with other priorities such as blood safety, BCC, infrastructural development, equipment, institutional development, training and capacity development, research and development, monitoring and evaluation have extremely large resource implications for the national response. To meet the above challenges, the estimated expenditure of $27.6 million for 2003 (GAC/UNAIDS, 2003) will have to be increased considerably.

Given the new realities of the national response and inherent resource implications, a proactive approach to resource planning, mobilisation and funding arrangements is required. This underscores the need to strengthen the resource mobilisation capacity of the national response to guarantee resource availability on a sustainable basis.

10.2 Funding arrangements

Arrangements for the funding of activities

The funding of HIV/AIDS in Ghana has received immense support from both multilateral and bilateral sources. But while the GARFUND and some of the support for the national response have been channelled through the Commission, some development partners and civil society organisations have tended to allocate funds directly to implementers without recourse to GAC. This situation has made it difficult to track and accurately estimate resources committed to the national HIV/AIDS response. The multiplicity of funding sources and channels also has implications for financial reporting. The major resource providers have complex reporting requirements which put serious strain on GAC and other recipients of financial support as they have to submit several different sets of financial reports concurrently.

One of the outcomes of the direct funding to implementing agencies without involvement of the GAC led to the implementation of programmes that were outside the National Framework. To focus the resource allocation process and the targeting of interventions to priority areas under NSF II, it is important to ensure that the funding of areas all activities are within the Framework.

This NSF II recognises the need for a holistic and flexible resource management mechanism that allows for pooling of resources earmarked for direct funding of HIV/AIDS activities under the national response. Under the pooled funding arrangement, contributions will be pledged annually by development partners and the Government of Ghana. The contributions and the commitments of resources will be based on consultations on annual work plans and budgets, to be facilitated by GAC, on priority programmes and budgetary requirements within the National Strategic Framework. This will help to improve the tracking and estimation of HIV/AIDS resources from all sources. As part of the process of pooled funding arrangements, the reporting requirements of the various providers of resource will be harmonised.

In addition to the pooled resources, other channels for funding such as the earmarked approach, direct funding and in-kind support will exist. Under the channel for earmarked funds, development partners interested in specific priorities in the national response will

provide resources for the specific interventions identified. With the direct funding arrangements and in-kind support, resource providers can fund selected activities under the national response but outside the pooled arrangement. The only requirement is that funding agencies will be requested to submit reports to GAC so that the Commission can facilitate the tracking of all resources committed to the national response.

Additionally, funds received through the Global fund for TB, malaria and HIV/AIDS will be channelled into the common basket.

Funding of the Ghana AIDS Commission

At the national level, GAC prepares and submits annual budgets in line with the Medium Term Expenditure Framework (MTEF). Given the competing interests for resources, the Commission may not always receive its full requirement of funds. In view of the high priority of HIV/AIDS in the country and the urgency of the national response, there is the need to guarantee resource flow to the Commission. Consequently, the budgeting process of GAC will be reviewed during the period of NSF II. The new realities will also require substantial funding from the Government of Ghana.

Management and Disbursement of funds

With the decentralization of the implementation of the national response, the allocation and disbursement processes will also be decentralised to strengthen community response to the epidemic using the existing district and sub-district structures. The challenge, however, is improving the low capacity to plan, implement, monitor, mobilize and disburse funds. In NSF II these will be the need to improve the processes and procedures for the disbursement of funds and the capacity of implementers in order to ensure the success of the decentralized response.

The resource requirement for scaling-up the national response has to be complemented by strong financial management and monitoring systems at both the Secretariat and district levels. Monitoring will focus on effective and efficient use of resources (based on outputs) rather than on inputs. This will necessitate cost-benefit analysis to evaluate the extent to which results being achieved are consistent with resources used. Among others, it will require the development of national benchmarks and performance measures to guide resource use by both resource providers and implementers. To achieve these, it will be necessary to integrate the financial systems of the Secretariat with those of the districts, and improve the capacity of the latter to facilitate accurate and timely financial reporting. This calls for training in financial management, monitoring and evaluation of resource flows.

The success of the national response is dependent on the existence of capacity to undertake critical tasks and activities. This includes addressing institutional capacity in financial management as part of the process to improve resource mobilisation, allocation, use, accountability and reporting to cover GAC, NGO (local and international), district assemblies, CBO, FBO, MDA, corporate bodies and other organisations involved in implementation activities. Civil society organizations operating in the districts and

communities also constitute 'social capital' that can be harnessed to strengthen the monitoring of effective and efficient resource use by implementers. To achieve this, the capacity of civil society organizations will be developed their representation on the RAC and DAC will strengthen the monitoring roles that these units are expected to play (Appendix 1).

Strategic Results

1. Mobilized adequate resources to the requirements of NSF II;
2. Streamlined budgeting process;
3. Established effective targeting and resource allocation process;
4. Strengthened financial management and monitoring systems; and
5. Strengthened institutional and human capacity for resource mobilisation and management.

Challenges

- Raising sufficient funds;
- Gaining commitment from multiple funding sources;
- Coordinating funding channels and sources;
- Improving the budgeting process;
- Improving targeting of available resources;
- Strengthening financial management and monitoring;
- Reporting promptly on financial activities by collaborating agencies; and
- Building capacity for mobilizing and managing resources.

Strategies

1. Ensure an increase in the resource commitment of the Government of Ghana to HIV/AIDS activities under NSF II through:
    a. Improved direct funding from the consolidated fund through the MTEF budget;
    b. Improved allocation of funds from MDA to HIV/AIDS activities in their annual MTEF budgets;
    c. Developed criteria and formula for allocating resources to HIV/AIDS from the district common fund;
    d. Ensured disbursement of the minimum 1% of the district assembly common fund allocated to HIV/AIDS activities.
2. Ensure that all resources committed for HIV/AIDS activities by the government, MDA and District Assemblies are disbursed in full and released on time;
3. Ensure the establishment of a joint country appraisal of Development Partners to be facilitated by GAC to undertake and develop one project document for funding HIV/AIDS activities under a pooled funding arrangement;

4. Institute regular HIV/AIDS round table meetings with resource providers and key stakeholders to provide update and review programmes, resource availability, funding gaps, resource requirements and disbursements;
5. Identify and streamline the roles and contributions of NGO involved in resource mobilisation and funding through dialogue and consultations to ensure that their activities are consistent with, and integrated into, the national response;
6. Identify and acknowledge the roles and contributions of the private sector and corporate organisations in resource mobilisation and funding to the national response;
7. Create a unit/desk within GAC to be responsible for exploring new sources of funding (both locally and externally) for the national response;
8. Establish a funding arrangement that is flexible and attractive to development partners and other resource providers through:
    a. Pooled funds (government and development partners) based on agreed annual work plan and corresponding budget;
    b. Earmarked funds (development partners);
    c. Developed strategies for direct funding of HIV/AIDS activities by development partners, NGO, FBO, CBO, private sector/corporate entities;
    d. Identified and developed strategies for other forms of funding arrangements such technical support and in-kind contributions.
9. Develop guidelines in consultation with all implementers and organisations involved in HIV/AIDS activities detailing priority intervention areas at agreed periods;
10. Develop strategies for information sharing on national HIV/AIDS priorities among stakeholders to help improve the targeting of intervention;
11. Decentralise the allocation and disbursement of funds for HIV/AIDS activities to the district levels;
12. Enhance the capacity of GAC, implementers and other stakeholders, including INGO, on financial management, monitoring and evaluation, tracking and other financial issues within the context of HIV/AIDS priorities areas;
13. Strengthen the financial and fiduciary arrangements at the GAC and the district levels to improve resource tracking, monitoring and accountability;
14. Harmonise financial reporting requirements of Development Partners contributing to the pooled funding and strengthen mechanisms for reporting by GAC and other implementers;
15. Establish a mechanism for tracking resource flow outside the pooled funding arrangement and ensure that the disbursements of earmarked and direct funds are reported to GAC;
16. Develop key indicators for measuring and evaluating use of resources to assess results achieved vis-à-vis resources used;
17. Improve the auditing of activities of implementers to ensure that resources are effectively and efficiently utilised;

Lead Agency

Ghana AIDS Commission

Key Actors

Ministry of Finance and Economic Planning, Ministry of Health, Municipal/District Assemblies and Ministry of Local Government & Rural Development, Development Partners, NGO, Private sector/corporate bodies, FBO, CSO, and CBO

Chapter 11: Conclusion

This Framework indicates the scope of work required to strengthen the national response to the epidemic as well as the work required to prevent new infections, and provide treatment care and support for PLWHA and OVC and affected persons. Meeting these goals will involve responding to a number of challenges. First, it will require changing attitudes and behaviour towards HIV/AIDS, and sexual and reproductive health among the general population, people at high risk and care givers. Second, it will require expanding programmes based on recent developments in knowledge and new technologies, such as VCT, PMTCT, HAART and PEP. All these require substantial human capacity building for large numbers of personnel, including volunteers, and a huge effort to mobilize resources, develop detailed plans for programmes and activities, allocate budgets through a rational process, and develop and implement a comprehensive monitoring and evaluation system.

As the epidemic presents challenges to individual rights and liberties, especially for infected and affected persons, the success of programmes will also require changes in basic cultural beliefs, elements of traditional social organization that have implications for transmission and management and legal systems to deal with stigma, discrimination and marginalization of vulnerable groups. Increased HIV/AIDS infection is likely to affect social institutions and the economy of the country since the epidemic disproportionately affects the more productive population. It is, therefore, imperative to develop strategies to mitigate the social, economic and cultural impact of the epidemic. Given the multi-sectoral and multi-faceted nature of the epidemic, the integrated approach within the context of the "Three Ones" Principle provides the focus for achieving maximum output from the objectives set in the Framework. Donor co-ordination will be all important also in order to co-ordinate resources used for the national response.

Political commitment is key to the success of the fight against HIV/AIDS. So are the collective will, commitment and responsibility of all partners. Therefore, the success of NSF II will also depend upon the level of socio-political commitment to all activities in the Framework. This should be demonstrated by all political leaders in their public speeches, and other behaviour such as commitment to financial support for HIV/AIDS programmes, non-discrimination and willingness to provide for the requirements of PLWHA and affected persons. Achieving the objectives of NSF II will demand strong partnership among government, non-governmental organisations, and the private sector and development partners.

One of the first steps in the implementation process of NSF II will be MDA and M/M/DA either reviewing or developing new HIV/AIDS strategic frameworks that incorporate the priority areas identified under NSF II. This will involve developing a 5-year programme and a rolling annual plan of work (POW), with budgets. It will also involve mainstreaming HIV/AIDS activities into the Ghana National Poverty Reduction Strategy which provides Government's blueprint for national development. Incorporating HIV/AIDS into the national development strategy recognizes the epidemic as a developmental challenge.

Mobilisation of both financial and human resources is crucial for the successful implementation of NSF II. It is estimated that, to effectively implement the framework, an equivalent amount of three hundred million dollars will be needed through 2007. While the Government of Ghana will continue to work closely with development partners on the M-SHAP strategy to leverage resources, each sector and district will have to continue to make budgetary allocations in their Medium Term Expenditure Framework (MTEF) for HIV/AIDS activities. Achieving the objectives set out will also depend on qualified and motivated personnel at GAC, and at all levels of the decentralized system.

The framework also recognizes the emergence of a number of cross-cutting issues which will need to be addressed. Among them are research, information sharing, social and resource mobilization, capacity building and behavioural change communication. For instance, there will be the need for capacity building in all the thematic areas and strategies for achieving behavioural change will also be needed across the whole spectrum. PLWHA receiving ARV will have to adopt behavioural change in the same way as community members, care givers and service providers. Implementing these cross-cutting issues will need concerted efforts on the part of all stakeholders.

The epidemic poses many challenges to the nation's development that affect the happiness and wellbeing of millions. NSF II is designed to guide us in meeting these challenges.

References

Acquaah, S. O., I. L. Sawer, O. Denso, B. L. Lawson, K. Ter-Larbi, and K. Ansah. 2004. **Traditional Medicine and HIV/AIDS in Ashanti Region**. Abstract No. 8 presented at the National HIV/AIDS Research Conference, Accra. Ghana AIDS Commission, Accra.

African Union. 2003. **AU Declarations: Assembly of the African Union Second Ordinary Session**. AU Meeting of10-12 July, 2003, at Maputo, Mozambique. African Union, Addis Ababa.

Amoah, J. and G. Acquaye. 2004. **Effect of Herbal Product of Ghanaian Origin in Improving the Declining Immunity Status of Persons Living with AIDS (the Asante Mampang Experience: 2000 – 2003)**. Abstract No. 9 presented at the National HIV/AIDS Research Conference, Accra. Ghana AIDS Commission, Accra.

Anarfi, J. K. 1999. *Vulnerability to Sexually-transmitted Disease: Street Children in Accra*, In Caldwell, J. C., P. Caldwell, J. Anarfi, K. Awusabo-Asare, J. Ntozi, I. O. Orubuloye, J. Marck, W. Cosford, R. Colombo and E. Hollings (eds)**. Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries.** Health Transition Centre, The Australian National University, Canberra. Pp. 281-306.

Anarfi, J. K. and P. Antwi. 1995. *Street Youth in Accra City: Sexual Networking in a High Risk Environment and its Implications for the Spread of HIV/AIDS.* In Caldwell, J. C. et al. (eds.), **The Third World AIDS Epidemic.** [Supplement to *Health Transition Review*, Vol. 5] The Australian National University, Canberra. Pp. 131-152.

Ankomah, A. 1998. *Condom Use in Sexual Exchange Relationships Among Young Adults in Ghana.* **AIDS Education and Prevention.** Vol. 10(4): 303-316.

Anie, S. J. et al 2004. *Global Advances in HIV/AIDS Monitoring and Evaluation.* Deborah Rugg, Greet Peersman, Michel Carael (eds). A publication of Jossey-Bass and the American Evaluation Association. **New Directions for Evaluation.** No. 103.

Appiah, E.N., S. Afrane, and M.P. Price. 1999. **Infringements of the Rights of People Living with HIV/AIDS (PLWHA): Any Evidence in Ghana?** The African Commission for Health and Human Rights Providers, Accra.

Awusabo-Asare, K., A. M, Abane, D. M. Badasu, and J. K. Anarfi. 1999. *"All die be die:" Obstacles to Change in the Face of HIV Infection in Ghana.* In Caldwell, J. C., P. Caldwell, J. Anarfi, K. Awusabo-Asare, J. Ntozi, I. O. Orubuloye, J. Marck, W. Cosford, R. Colombo and E. Hollings (eds.). **Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries.** Health Transition Centre, The Australian National University, Canberra. Pp. 125-132.

Awusabo-Asare, K., A. M. Abane, and A. Kumi-Kyereme. 2004. **HIV: Review of Evidence.** Alan Guttmacher Institute, New York.

Bellinger, L, K. Cooper-Arnold, and J. Stover. 2004. *Where Are the Gaps? The Effects of HIV-Prevention Interventions on Behavioral Change.* **Studies in Family Planning,** 35:1, 27-38.

Center for Health and Gender Equity. 2004. **Gender, AIDS, and ARV Therapies: Ensuring that Women Gain Equitable Access to Drugs within U.S. Funded Treatment Initiatives.** Center for Health and Gender Equity, Takoma Park, Maryland.

Claypoole, C., and A. Nazzar. 2004. **Baseline Research Among Ghanaian Teacher Trainees on Knowledge, Attitude and Practices towards HIV/AIDS**. Abstract No. 15 presented at the National HIV/AIDS Research Conference, Accra. Ghana AIDS Commission, Accra.

Anie. S. J., Larbi E. T. 2003. **Cromhout, P. B.** Small Projects Foundation, 5 St. James Road, Southernwood, East London, South Africa in conjunction with the Measure: Evaluation, University of North Carolina, The Ghana AIDS Commission and USAID, Ghana.

Fayorsey, C. 2002. **Knowledge Attitude and Practice (KAP) on HIV/AIDS among Students, Teachers and Parents in Selected Schools in Ghana.** SHAPE Project, World Education/Ghana, Accra.

Forsythe, S. 2001. **An Economic Evaluation of the Impact of HIV/AIDS on Ghana Breweries**. The Futures Group International, Washington DC.

Ghana AIDS Commission. 2000a. **The National Monitoring and Evaluation Plan for HIV/AIDS in Ghana, 2001-2005.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission. 2000b. **Ghana/AIDS Strategic Framework: 2001-2005.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission. 2002. **Organisational Manual of Secretariat.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission. 2003. **2002 Annual Report.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission. 2004a. **National HIV/AIDS Policy and STI Policy.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission. 2004b. **The Joint Review of Ghana's National HIV/AIDS Response.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission/USAID. 2001. **The National Monitoring and Evaluation Plan for HIV/AIDS, 2001-2005.** Ghana AIDS Commission, Accra.

Ghana AIDS Commission/UNAIDS. 2003. **HIV/AIDS Accounts: Ghana, 2002-2003**. GAC, UNAIDS, Mexican Health Foundation (FUNSALUD).

Ghana Statistical Service, and MacroInternational. 2004. **2003 Demographic and Health Survey.** Ghana Statistical Service/MacroInternational, Accra.

Government of Ghana. 2003. **Ghana Poverty Reduction Strategy: 2003-2005: An Agenda for Growth and Prosperity, Vol. I. Analysis and Policy Statement.** Government of Ghana, Accra.

Government of Ghana. 2004. **Implementation of the Ghana Poverty Reduction Strategy: 2003 Annual Report.** Government of Ghana, Accra.

Health and Development Africa. 2004. **Guidelines for Research on High Risk Groups in Ghana.** Jacana Media, Johannesburg.

Health Development Africa, and Social Surveys Africa. 2004. **Formative Research Amongst Teachers and National Service Personnel on HIV/AIDS in Ghana.** Social Surveys Africa, Johannesburg.

Hearst, N. and S. Chen. 2004. *Condom Promotion for AIDS Prevention in the Developing World: Is it Working?* **Studies in Family Planning,** 35:1, 39-47.

Hochbaum G. M. (1958). **Public Participation in Medical Screening Programs: A Socio-Psychological Study.** US Public Health Service. PHS No. 572, Washington, D.C.

Hogle, J. A. (ed.). 2002. **What Happened in Uganda? Declining HIV Prevalence, Behaviour Change, and the National Response.** USAID, Washington, D.C.

http://www.unaids.org/en/about+unaids/what/+is+unaids/unaids/unaids+at+country+level/the+three +ones asp.

Measure Project and Ghana AIDS Commission. 2003. **AIDS in Africa During the Nineties: Ghana. A Review and Analysis of Survey Research Results.** North Carolina Population Center, University of North Carolina, Chapel Hill.

Mensah, M. L. X., T. C. Fleischer, K. Sorpong, T. C. Anlara, Y. Adusi Poku, and S. E. Owusu. 2004. **A Case Study of an Herbal Treatment of Cinical Diagnosed Cases of HIV/AIDS of Adom Herbal Clinic, Jena**. Abstract No. 6 presented at the National HIV/AIDS Research Conference, Accra. Ghana AIDS Commission, Accra.

National AIDS/STI Control Programme of the National Health Service, and the Ghana AIDS Commission. 2003. **AIDS Surveillance Report: Reported AIDS Cases in Ghana.** NACP, Accra.

National AIDS/STI Control Programme of the Ghana Health Service, and the Ghana AIDS Commission. 2004. **HIV/AIDS in Ghana: Current Situation, Projections, Impacts, and Interventions**. NACP, Accra.

National HIV/AIDS/STI Control Programme, Ghana Health Service, World Health Organization, and DFID. 2004. **AIDS Surveillance Report 2003: Reported AIDS Cases in Ghana**. National AIDS/HIV/STI Control Programme, Accra

Organisation of African Unity. 2001. **Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases**, African Union, Addis Ababa.

Tanle, A. 2003. **Rural-Urban Migration of Females from the Wa District to Kumasi and Accra: A Case Study of the *Kaya Yei* Phenomenon**. Unpublished MPhil thesis submitted to the University of Cape Coast.

UNAIDS. 1998. **Guide to the Strategic Planning Process for a National Response to HIV/AIDS. Situation Analysis, Response Analysis, Strategic Plan Formulation, Response Mobilization. UNAIDS Best Practice Collection.** UNAIDS, Geneva.

UNAIDS. 2002. **Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators.** UNAIDS, Geneva.

UNAIDS. 2003a. **Planning, Costing and Budgeting Framework. User's Manual.** UNAIDS, Geneva.

UNAIDS. 2003b. **Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS. Progress Report on the Global Response to the HIV/AIDS Epidemic.** UNAIDS, Geneva.

UNAIDS. 2003c. **Treatment – 3 Million by 2005. Making it Happen. The Whole Strategy.** UNAIDS, Geneva.

UNAIDS. 2004a. **Fourth Global Report on the Global AIDS Epidemic.** UNAIDS, Geneva.

UNAIDS. 2004b. **Emergency Scale-up of Antiretroviral Therapy in Resource-limited Settings: Technical and Operational Recommendations to Achieve 3 by 5.** UNAIDS, Geneva.

UNAIDS. 2004c. **Stepping Back from the Edge: The Pursuit of Anti-retroviral Therapy in Botswana, South Africa and Uganda.** UNAIDS, Geneva.

UNAIDS. 2004d. **National AIDS Programmes. A guide to Monitoring and Evaluation.** UNAIDS, Geneva.

UNAIDS (ND). **Coordination of National Responses to HIV/AIDS. Guiding Principles for National Authorities and Their Partners.** UNAIDS, Geneva.

UNAIDS (ND). **Monitoring and Evaluation Modules**. UNAIDS, Geneva.

UNAIDS/World Bank. 2002. **National AIDS Councils. Monitoring and Evaluation Operations Manual.** UNAIDS, Geneva.

UNAIDS/WHO. 2002. **Initiating Second Generation HIV Surveillance Systems: Practical Guidelines.** UNAIDS, Geneva.

United Nations. 2000. **Millennium Declaration. Resolution Adopted by the General Assembly at its 55th Session.** United Nations, New York.
United Nations. 2001. **Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS**. United Nations, New York.

World Health Organization. 2000. **Community-based Care: Family Care-giving. Caring for Family Members with HIV/AIDS and the Other Chronic Illnesses. The impact on Older Women and Girls. A Botswana Case Study.** World Health Organization, Geneva.

World Health Organization. 2003. **A Public Health Approach for Scaling-up Antiretroviral (ARV) Treatment. A Toolkit for Programme Managers.** World Health Organization, Geneva.

World Health Organization. 2004a. **An approach to Rapid Scale-up. Using HIV/AIDS Treatment and Care as an Example.** World Health Organization, Geneva.

World Health Organization. 2004b. **Lessons for Long-term Care Policy. The Cross-cluster Initiative on Long-term Care.** World Health Organization, Geneva.

World Health Organization Regional Office for Africa. 2002. **Strategic Framework: Strengthening HIV/AIDS & STI Surveillance in the WHO African Region 2002-2005.** World Health Organization, AFRO-Region, Harare, Zimbabwe.

Appendix 1:

ROLES AND RESPONSIBILITIES OF REGIONAL AND DISTRICT AIDS COMMITTEES

Regional AIDS Committee (RAC)

A Regional AIDS Committee (RAC) is a multisectoral group consisting of 15–20 members and composed of heads/representatives of key decentralized MDAs, representatives of religious and traditional leaders, NGO, CBO, women's groups, PLWHA groups, staff of the RCC, and the regional monitoring and evaluation focal person. All members should be of senior rank with decision making responsibilities. The RAC will:

- Maintain oversight responsibility for the regions local level responses to HIV/AIDS;
- Approve quarterly reports from the DAC;
- approve of semi-annual regional HIV/AIDS reports prior to forwarding them to GAC
- Establish mechanisms for inter- and intra-regional exchange of community-based best practices and innovations;
- Participate actively in the decision making process during the evaluation of NGO, FBO, and CBO proposals at the district level;
- Establish regional HIV/AIDS resource centres;
- Facilitate district capacity building initiatives;
- Engage in resource mobilization and advocacy for regional activities; and
- Advise the Regional Minister on resource mobilization opportunities for regional HIV/AIDS activities.

Regional Monitoring and Evaluation Focal Person

The Regional Monitoring and Evaluation Focal Person shall report to the Regional Minister and will be responsible for the following:

- Compile an inventory on all HIV/AIDS implementers in the region i.e. NGO, CBO, MDA, FBO, Private Organisations and Development Partners working within the Region;
- Supervise the District Monitoring and Evaluation Focal Persons and provide guidance on policy and programme issues;
- Develop and disseminate semi-annual reports on Regional HIV/AIDS activities to the Ghana AIDS Commission;
- Arrange information sharing on HIV/AIDS within the Region and act as a resource point for information on HIV/AIDS relevant to the Region;
- Prepare and operationalise a Regional monitoring plan in order to assess the progress of the regional response to HIV/AIDS;

- Organise fora of Monitoring and Evaluation Focal Persons as and when applicable to encourage the sharing of best practice.
- Facilitate the work of the Regional AIDS Committee as member/secretary by performing tasks such as organizing meetings, keeping records and undertaking and other activity that may be recommended by the RAC;
- Play an active role in the screening the proposals of NGO, FBO and CBO and to ensure fair play and transparency in the administration and implementation of programmes, activities and the use of resources;
- Facilitate resource mobilization which will be used to expand the region's responses to HIV/AIDS.
- Monitor activities and ensure proper utilization of funds within the districts.

Metropolitan/ Municipal / District AIDS Committee

A District AIDS Committee (DAC) is a crucial link in the implementation of the decentralised national HIV/AIDS strategy. It is a multi-sectoral group consisting of 8–12 members comprising heads/representatives of key decentralised MDA in the district, district assembly staff including the district monitoring and evaluation focal person, private sector, traditional and religious leaders, women's groups, and representatives of PLWHA groups working in the district. The DAC will:

- Receive recommendations from DRMT on the selection and funding of NGO, FBO, CBO and approve good proposals that are in line with district's strategy for HIV/AIDS. The approved proposals will be forwarded to administrative head of the Assembly i.e. DCE;
- Be responsible to GAC for the accounts (i.e. the DA/MMA own Account and NGO/FBO/CBO Account) into which funds supporting the implementation of the district strategic HIV/AIDS will be lodged;
- Ensure the effective and efficient implementation of the programs at the sub-district levels;
- Receive and review quarterly district reports from the district focal person;
- Promote inter- and intra-district information sharing; and
- Facilitate the signing of all grant agreement with implementing entities in the district by the DCE on behalf of GAC.

Metropolitan/Municipal/District Response Management Team

The Metropolitan/Municipal/District Response Management Team, which will be part of the DAC, is an important link for the successful implementation of local level interventions to HIV/AIDS. It shall consist of five (5) members namely district monitoring and evaluation focal person, District Directors/representatives of Education, Health, Social Welfare and one other person who shall be a staff of the district assembly. The DRMT will:

- Provide technical support on HIV/AIDS issues and advise on the district HIV/AIDS programme implementation;
- Evaluate and select sub-projects submitted by NGO, FBO and CBO and make recommendations for funding to the District AIDS Committees;
- Collate, document and maintain a stock of HIV/AIDS related material for dissemination within the district; and
- Establish district HIV/AIDS documentation centre for use by Assembly Persons, district level HIV/AIDS practitioners and the general public.

Metropolitan/Municipal/District Monitoring and Evaluation Focal Person

The Monitoring and Evaluation Focal Person shall report to the District Chief Executive and will be responsible for the following:

- Collaborate with members of the District Assembly, Unit Committees, Chiefs and Opinion Leaders to identify and prepare an inventory of NGO, CBO, FBO, and other institutions working on the HIV/AIDS related activities in the District;
- Be responsible for the formulation and operationalisation of district strategic HIV/AIDS plans through participatory mechanisms with key stakeholders;
- Receive and document the proposals and programme of activities of NGO, FBO and CBO working in the district;
- Prepare monitoring and evaluation plans for HIV/AIDS activities within the district through the selection of appropriate indicators;
- Coordinate, monitor and evaluate activities of NGO, CBO, FBO and institutions working on HIV/AIDS related activities in the district;
- Receive and collate quarterly progress reports on activities of NGO, CBO, FBO, and other institutions working on HIV/AIDS-related activities in the district, and forward them to the Regional M&E Focal Persons with copies to the GAC.
- Facilitate the work of the District AIDS Committee and management teams as member/secretary.
- Act as resource point for district level information on HIV/AIDS.
- Assist all NGO, CBO, FBO and other institutions working on HIV/AIDS-related activities to identify sources of funding for their activities;
- Ensure that funds allocated to NGO, FBO and CBO and other institutions in the district are utilized as intended.
- Disseminate best practices amongst district stakeholders;

Appendix 2:

Consultants and Members of Working Groups

PROJECT STAFF

Supervising Director: Dr Sylvia Josephine Anie, GAC
Task Manager: Mr Kyeremeh Atuahene, GAC
Coordinator: Mr Evans Degboe, Connect Consult
Secretary: Ms Olivia Graham, GAC

STEERING COMMITTEE MEMBERS

Prof Fred T. Sai, GAC	Chairman
Prof Sakyi Awuku Amoa, GAC	Member
Mr Alfred Salia Fawundu , UNDP	Member
Dr. Kwame Essah, AED	Member
Dr. Warren Naamara, UNAIDS	Member
Dr. Sylvia J. Anie, GAC	Member
Mrs. Yaa Preprah Preprah Amekudzi, HACI	Member
Ms. Emma Spicer, DFID	Member
Ms. Anna Bossman, CHRAJ	Member
Mr. Kyeremeh Atuahene, GAC	Member
Mr. Elvis Addai, PACT	Member
Mr. Philbert Kankye, CHAG	Member
Mr. Andrew Osei, UNCEF	Member
Mr. Kuwornu, MLGRD	Member
Prof John K. Anarfi, ISSER	Member
Dr. Nii Akwei Addo, NACP	Member
Ms Kathlyn Ababio, GRMA	Member
Mrs. Rose Karikari Anang, GEA	Member
Mr. Maxwell Addo, GAC	Member
Mrs. Virginia Ofosu Armah, NPC	Member
Ms. Evelyn Awittor, World Bank	Member
Dr. Joana Nerquaye-Tetteh, PPAG	Member

LEAD CONSULTANTS

- **Kofi Awusabo-Asare, University of Cape Coast**
- **Robert A. Miller, Population Council**

MEMBERSHIP OF THEMATIC GROUPS

1. **POLICY, ADVOCACY AND ENABLING ENVIRONMENT**

- Mr. Stephen Ayidiya, University of Ghana – *Team Leader*
- Dr. Clement Ahiadeke, ISSER
- Mrs. Esther Apewokin, National Population Council
- Mr. Charles Aikins, PLWHA
- Dr. Sylvia Anie, GAC
- Nana Oye Lithur, FIDA
- James Aryeetey
- Dr. John David Dupree, AED/SHARP Project

2. **PREVENTION AND BEHAVIOURAL CHANGE COMMUNICATION**
   - Mr. Maurice Ocquaye, FHI – *Team Leader*
   - Mr. Peter Wondergem, USAID
   - Mr. Kojo Lokko, GSMF
   - Dr. Joana Nerquaye-Tetteh, PPAG
   - Mr. Eric Pwadura, GAC
   - Mr. Azara Ali Mamshie, FAO
   - Mr. Robert Mensah. AYA
   - Mr. Mohammed A. K Addo, Federation of Muslim Councils
   - Ms. Angela Bannerman, FHI
   - Mr. Kyeremeh Atuahene, GAC
   - Bernice Herloo, Prolink
   - Mr. Haruna Ibn Hassan, AIDS Activists Foundation
   - Ms. Hilda Eghan, MOEYS
   - Mr. Frimpong Addo, PEF
   - Dr. Khonde Nzambi, WAPCAS
   - Mrs. Esther Cobbah, Stratcomm
   - Dr. Agnes Dzokoto, NACP

3. **TREATMENT, CARE AND SUPPORT**
   - Dr. Yao Yeboah, PENTSOS – *Team Leader*
   - Dr. Agnes Dzokoto, NACP
   - Dr. Kwesi Torpey, FHI
   - Dr. Peter Preko, AED/SHARP
   - Mr. Adu Samson, GES
   - Ms. Kathlyn Ababio, GRMA
   - Mr. Placide Tapsoba,
   - Mr. S. K. Kumah, Department of Social Welfare
   - Dr. Aboagy Sampson, Chest Clinic – Korle-Bu
   - Dr. Morkor Newman, WHO
   - Dr. Richard Amenyah, FHI
   - Regina Akai-Nettey, FHI
   - Ms. Mavis Ama Frimpong, AED/CRS

4. **MITIGATION OF SOCIAL, CULTURAL AND ECONOMIC IMPACTS**
   - Mrs. Esther Baah Amoako, AIDS Alert – *Team*
   - Ms. Estelle Appiah, Attorney General's Department
   - Ms. Yaa Amekudzi, HACI

- Mrs. Akua Asumadu, ILO
- Mr. John Yanulis, World Education
- Ms. Gloria Ofori-Boadu, Women's Assistance & Business Association
- Ms. Beatrix Allah Mensah, World Bank
- Dr. Kwame Essah, AED/SHARP Project
- Mr. David Logan, Policy Project
- Mr. Ampadu, Ghana Employers Association
- Mr. Kyeremeh Atuahene, GAC

5. **COORDINATION AND MANAGEMENT OF DECENTRALIZATION MULTI-SECTORAL RESPONSE**

- Mr. Ben Treveh, Partneris Consult – *Team Leader*
- Mr. Steve Gray, NPC – *Team Leader*
- Mr. Francis Collins, MOEYS
- Mrs. Mercy Osei-Konadu, UNFPA
- Mrs. Juliana Dennis, MOFA
- Dr. Mokowa Adu-Gyamfi, MOH
- Mrs. Jemima Amanor, World Vision
- Mr. Stephen Kpormegbe, Ministry of Manpower Development & Employment
- Mrs. Bridget Kastriku, Ministry of Tourism
- Mr. Samuel Ayimadu-Amaning, GHANET
- Mr. Louis Agbe, MLGRD
- Ms. Golda Asante, RCC Focal Person, Eastern Region
- Dr. Gilbert Buckle, National Catholic Secretariat
- Dr. Kwabena A. Poku, University of Ghana
- Mr Andrew Osei, UNICEF
- Mr. Philibert Kankye, CHAG
- Dr. Sylvia Anie, GAC
- Mr. Kyeremeh Atuahene, GAC
- Mr. Napoleon Graham,
- Mr. Robert Djangmah, UNDP
- Mr. Isaac Offei, UNAIDS
- Mr. Felix Tsameye, JSA
- Ms. Irene Kpodo, UNDP Intern

6. **RESEARCH, SURVEILLANCE, MONITORING AND EVALUATION**

- Dr. Raphael Avornyo — AED/SHARP Project – *Team Leader*
- Dr. Sylvia Anie — GAC
- Mr. Bright Drah, — FHI

- Dr. Grace Bediako, Ghana Statistical Service
- Mr Kyeremeh Atuahene GAC
- Mr. Emmanuel Larbi, GAC
- Mr. Taavi Erkkola UNAIDS
- Mr. Silas Quaye WHO/NACP
- Derek Aryee FHI
- Dr. Amanua Chinbuah, HRU
- Mr. Joseph Mwangi, AED

7. RESOURCE MOBILIZATION AND FUNDING ARRANGEMENT

- Mr. Bennet Kpentey, Sync Consult – *Team Leader*
- Mr. Maxwell Addo, GAC
- Ms. Philomena Johnson, National Catholic Secretariat
- Mr. Abu Fusieni, GAC
- Dr. Eddie Addae, MOH
- Ms. Evelyn Awittor, World Bank
- Mr. Michael Ayensu, World Bank Desk-MOF
- Mr. Anthony Boateng, GAC
- Mr. Ishmael Ogyefo, RCC, Central Region
- Mr. Lawrence Aduonum-Darko, Private Consultant
- Mr. Kyeremeh Atuahene, GAC