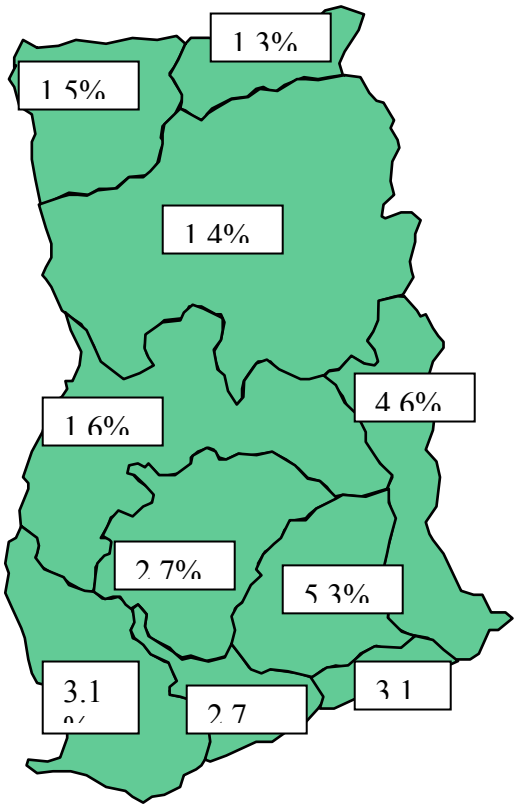
SITUATIONAL ANALYSIS OF HIV/AIDS in GHANA



Prepared for the Royal Danish Embassy/DANIDA

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CIDA	Canadian International Development Agency
CHRAJ	Commission on Human Rights and Administrative Justice
DANIDA	Danish International Development Agency
DFID	Department for International Development
DRI	District Response Initiative
EU	European Union
FHI	Family Health International
GAC	Ghana Aids Commission
GHANET	Ghana AIDS Network
GOG	Ghana Government
GSMF	Ghana Social Marketing Foundation
GTZ	German Development Cooperation
HIV	Human Immune-Deficiency Virus
IEC	Information Education and Communication
JICA	Japan International Corporation agency
LGA	Local Grant Authority
MDA's	Ministries, Departments and Agencies
MESW	Ministry of Employment and Social Welfare
MLG&RD	Ministry of Local Government and Rural Development
MOE	Ministry of Education
MOJ	Ministry of Justice
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NACP	National AIDS/STI Control Programme
NGO	Non Governmental Organisation
PLWHA	People Living with HIV/AIDS
PPAG	Planned Parenthood Association Ghana
RNE	Royal Netherlands Embassy
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNESCO	United Nations Education, Scientific and Cultural Organisation
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1.0 Introduction

The following situational analysis presents the most recent data on HIV/AIDS in Ghana. The situational analysis aims to provide information on the HIV/AIDS situation in Ghana in order to plan for future programming.

The report is divided into seven sections with the following information:

- Key HIV/AIDS indicators
- National AIDS Policy and Strategic organisation and finance
- The National Response: legal framework and political will
- HIV/AIDS programming across the Danish supported sectors
- Technical and Financial contributions by agencies in Ghana
- The UN system response
- The existing communication systems

Methodology

The research team used two main approaches in compiling the data: interviews with key stakeholders involved in HIV/AIDS programming, and a document review focussed on the latest data on HIV/AIDS in Ghana[2].

The National AIDS/STI Control Programme were instrumental in helping the research team access data from their sentinel surveillance and epidemiological reports. Interviews were held with the Ghana AIDS Commission, various donor agencies and NGOs active in the HIV/AIDS programming field. This report is based on the MOH/ NACP and GAC latest strategic and thematic documents, which form the basis of HIV/AIDS programming in the country. The research also builds on other studies conducted by this researcher (see Casely-Hayford/UNAIDS, 2001).

[2] Two researchers assisted in the situational analysis: Ms Vivian Sarpomaa Fiscian and Cromwell Awadey

2.0 The Key Indicators

This section briefly describes the key HIV/AIDS indicators in Ghana including the prevalence rate, demographic relationships, the country specific dimensions of the epidemic, and the impact. Box 1 presents a summary of some of the key indicators.

Box 1: Summary of HIV/AIDS Indicators

Prevalence:

Prevalence in adult population (NACP, 2001)	**3%**
Prevalence in young women under 20 (NACP, 2001)	4.6%
Prevalence in pregnant women (major urban areas)	2.5%
Prevalence in pregnant women (outside major urban areas)	2.4%
Prevalence among STD patients	17%
Prevalence among Blood donors	4%
Prevalence among Commercial Sex Workers	75.8%

Number of People living with HIV/AIDS

Adults and children (MOH/NACP, 2001)	400,000 (at 1999)
Adults (UNAIDS, 2000)	340,000 (at 2000)
Women (UNAIDS, 2000)	180,000 (at 2000)
Children (0-14)	14,000
Daily Infections (based on 3.0% prevalence)	120

AIDS Deaths

AIDS Deaths as at May 2001 (NACP)	47,444
Adults (15-49)	N/A
Children	N/A

Orphans

Cumulative number of HIV/AIDS orphans	170,000
Current living orphans	119,410

Life Expectancy at birth 2010

With AIDS	N/A
Without AIDS (2000, UNDP)	Male (58.7)
	Females (62.2)

Condom Availability

Per capita (GSMF, 2000)	13,302,414
(FHI, 1997)	2,126,171

STD Prevalence N/A
(17% of STD cases are HIV/AIDS)

(Based on HIV Sentinel Surveillance 2000, NACP, 2001 and UNAIDS epidemiological Fact Sheet, 2000)

2.1 HIV/AIDS Prevalence in Ghana

Adult HIV prevalence according to the Ghana AIDS Commission (GAC) and the Ghana National AIDS Control Programme (NACP) is **3%**[3]. This is lower than previous estimates causing some debate over the figures. The prevalence rate in 2000 was 4.6% based on projections using 1984 census data. The new prevalence rate (3%) is based on the most recent census data carried out in 2000. The actual 2000 census figures are lower than previously projected resulting in a lower prevalence rate.[4]

The Director of the National AIDS control programme explained that the 4.6% prevalence rate is based on projections. The UNAIDS epidemiological fact sheets are also based on estimates which found that Ghana had a 3.6% rate during the same period. Most of the projections have been based on 1984 census data. The new figures are based on an improved modelling approach using current population census data. There are also suggestions that new figures may also be due to underreporting[5]. Table 1 reveals the prevalence of HIV/AIDS over the last 10 years.

Table 1: HIV/AIDS prevalence and Number of reported AIDS cases between 1990 and 2001

	1990	**1992**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
HIV/AIDS prevalence[6]	.7	4.6	2.4	3.2	3.6	3.6	N/A	4.6	4.6	3%
Number of reported AIDS cases[7]	2013	2606	2330	2578	3295	3833	4854	6289	6289	5184

(Based on UNAIDS, 2000 Epidemiological Fact Sheet for Ghana and NACP data, 2001)

NACP has made two projections for the next 14 years. The low projection scenario estimates that HIV prevalence will be 3.3% in 2004 and 3.6% in 2009 and 4.0% by 2014. The high prevalence scenario estimates that HIV/AIDS prevalence rates will rise to 4.7% in 2004, 6.9 in 2009 and 9% by 2014 (NACP, 2001a).

HIV prevalence is lower in Ghana than in surrounding countries such as Cote D'Ivoire at (10.76%), Burkina Faso (7.17%), Liberia (8.2%), Sierra Leone (6%)

[3] Percentage of all persons between 15 to 49 in the country who are living with HIV/AIDS

[4] The population for 2000 projected from 1984 census data was about 1.7 million higher than the actual 2000 census count revealed.

[5] The sentinel surveillance survey does not cover testing of the general population (i.e. women who are not pregnant).

[6] HIV Prevalence in selected populations in percent; Data based on testing of pregnant women in major urban areas (maximum), UNAIDS Epidemiological Fact Sheet, 1997.

[7] Based on Epidemiological Fact Sheet.

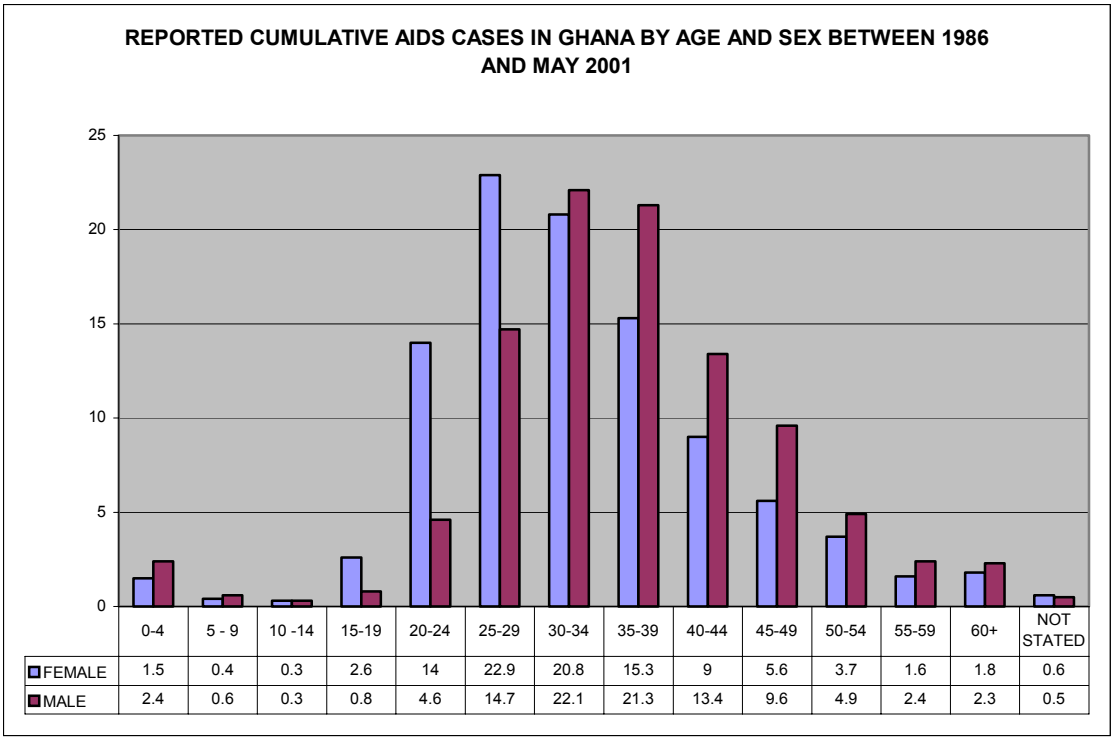
and Togo (5.98%). Ghana is experiencing a higher prevalence rate compared to countries such as Senegal (1.4%), Niger (2%) and Guinea (1.54).

2.2 Number of People Living with HIV

Ghana conducts sentinel surveillance in 22 selected sites across the country representing both urban and rural areas. The calculated prevalence of HIV is collected on pregnant women as part of the standard antenatal care. This provides regular and up to date data on the prevalence and number of people infected in the country. Several stakeholders interviewed mentioned that there may be underreporting. This could be attributed to the limited number of test kits available in the regions and other logistical problems such as transporting blood to the regional hospitals on a timely and regular basis.

The number of people living with AIDS as of October 2001 was 48,771 (National Aids Control Programme, 2001a). This is only the "tip of the pyramid" since there may be more people infected with HIV but have not yet developed full blown AIDS. The NACP estimated that the number of actual cases is closer to 185,000 (as at Dec. 2000) since only 30% of cases are reported suggesting that there are closer to 350,000 current HIV infections within the country.

Gender disagregated data reveals that over 54.55% of women and 4.07% of children are HIV/AIDS infected in Ghana (UNAIDS/ECA, 2000). The female to male ratio in 1987 was 6:1 and 2:1 in 1999 suggesting that the gender gap is closing. **More than two thirds of the reported AIDS cases are females.** This pattern may be due to the high proportion of commercial female sex workers returning from countries during the early stages of the epidemic (NACP, 2001a). Figure 1 presents the percentage of cumulative AIDS cases in Ghana by age and sex.



	0-4	5 - 9	10 -14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	NOT STATED
FEMALE	1.5	0.4	0.3	2.6	14	22.9	20.8	15.3	9	5.6	3.7	1.6	1.8	0.6
MALE	2.4	0.6	0.3	0.8	4.6	14.7	22.1	21.3	13.4	9.6	4.9	2.4	2.3	0.5

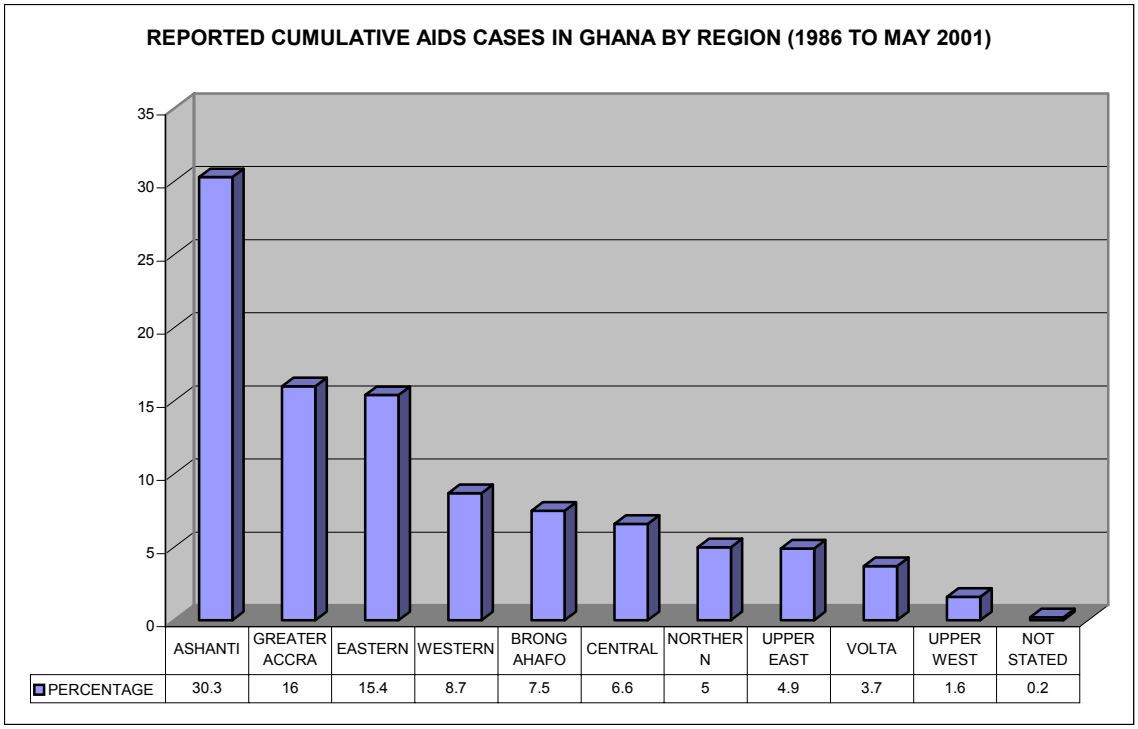
(NACP, Dec. 2001a)

The peak age groups of the epidemic are between 30 to 34--- the peak age groups for women are 25 to 34 and for men between 30 –39. " The number of reported AIDS cases for females in the 15 to 24 age group is much higher than for males in the same group due to the early sexual activity of young girls and the fact that many girls have older male partners (NACP, 2001a)." Children between the ages of 5 to 14 are considered by Government as the "window of hope" since this age group can be taught to protect themselves before they become sexually active.

2.3 Prevalence across regions

The HIV prevalence varies across the regions since there are several levels of infection in different parts of the country. According to NACP, Eastern region has consistently reported the highest levels of HIV infection followed by the Volta region, Greater Accra, Western, Ashanti and Central regions. The gap is narrowing between the regions as the epidemic progresses (NACP, 2001a).

The regional disparity is quite different across the 10 regions of the country with respect to the cumulative number of AIDS cases with the Ashanti, Greater Accra, Eastern and Western regions recording the highest number of AIDS cases. Figure 2.0 provides the latest figures related to the cumulative number of AIDS cases by region (NACP, 2001a).



(NACP, December 2001)

The 2000 Sentinel Surveillance Report (NACP) reveals that the median prevalence rate is 3.0% in Ghana's southern belt, 2.1% in the middle belt and 1.4% in the northern belts. Women in Agomanya in the Eastern region have an extremely high prevalence of 7.8 followed by Hohoe (5.0%) and Ho at 4.2% in the Volta regions. (MOH/NACP, 2001; Tadefa-Kubabom et al, 2001)

Factors affecting the spread

Several factors are identified as increasing the spread of HIV/AIDS in West Africa particularly:

- Mobility
- Migration
- Prevalence of sex worker activity
- Informal transactional sexual relations

These factors are all poverty related and caused by socio-economic status of people engaged in these activities. The Ashanti and Eastern regions are experiencing the highest levels of HIV/AIDS infection due to the migratory activities and economic trading activities, which bring people from around the sub region. The Ashanti region of Ghana is the centre of marketing and transmigration economic activities between Burkina Faso, Togo, Mali and other West African countries. Several "truckers" and sexual transactions take place in this area. Studies by this researcher suggest that the high prevalence of

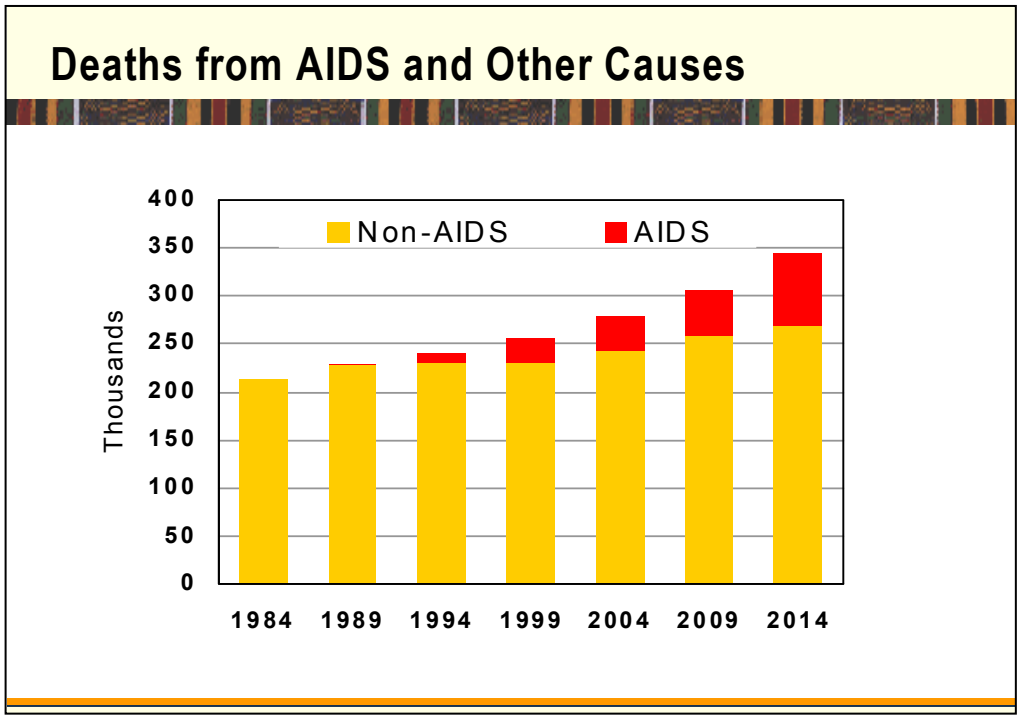
HIV/AIDS in Eastern region has been due to the historical migration of girls to Cote d'Ivoire as sex workers. The region has the highest rate of teenage pregnancy and several traditional practices, which expose girls to sexual activity at an early age (Casely-Hayford/UNAIDS, 2001).

The Volta region is bordering on Togo, which has one of the highest rates of infection in West Africa at 5.98%. There is a high level of cross border trading activities between Togo and Ghana.

The Greater Accra region has an increasingly high level of HIV/AIDS due to the presence of sex workers, which according to some studies 73% of Sex workers in urban areas are HIV/AIDS infected (Deceuninck, C., C.Asamoah-Adu et al, 2000) apart from the normal channels of MTCT, blood transfusion and other means.

2.4 AIDS Deaths and Orphans

Today AIDS in Ghana accounts for only 4% of all the deaths in the country. AIDS is expected to be the leading cause of death by 2014 accounting for 22% of all deaths. Table 2.0 reveals the increasing incidence of HIV/AIDS related deaths.



(NACP, December 2001)

The **low prevalence scenario** at an HIV prevalence rate of 4%, forecasts the annual number of deaths to reach 305,000 by 2014 an increase of 36,000 over the normal death rate. Under the low prevalence scenario the cumulative number of AIDS death will be 614,000 by 2014. The number of AIDS orphans would rise to 236,000 in 2014 from the current 170,000.

The **high prevalence scenario** with HIV prevalence at 9% by 2014 would mean that 344,000 people would die by 2014 an increase of 75,000 per year over the normal death rate. The cumulative number of AIDS deaths would reach 817,000 (NACP, 2001a). The number of AIDS orphans would rise to 390,00 under the higher prevalence scenario. The impact of the epidemic is particularly severe on the productive population between the ages of 15-49.

This situation requires at the very least a basic care and support programme be developed with particular attention on children and a comprehensive programme to mitigate the social and economic impact of the epidemic.

2.5 High risk groups

High-risk groups are highly mobile people often engaged in seasonal and yearly migration patterns within Ghana and neighbouring countries. HIV/AIDS prevalence among commercial sex workers is as high as 75.8% in Accra/Tema and 82% in Kumasi according to the latest sentinel surveillance survey. This is a high increase according to the historic figures, which revealed that in 1988 Ghana had less than 2% infection rate among sex workers and 30% in 1993. Deceunick, Asamoah et al (2000) found that out of a sample of 335 female sex workers in Accra, 76.6% were infected with HIV (HIV-1, 62.3% and HIV-2 at 4%; dual HIV1 and HIV2 profile included 10.3%).

The focus of most research over the last ten years has been on the professional and commercial sex worker. Studies are beginning to reveal that a much larger undocumented population of women are involved in informal, occasional or clandestine sexual activities, which are referred to as " transactional sex".

Studies at the tertiary level in Ghana reveal an alarming rate of transmission among university students (Anarfi, 2000). The "sugar daddy" syndrome has been stimulated by the pressing economic needs of girls inside and outside the formal schooling system. Recent studies conducted across the country revealed a high proportion of girls at Senior Secondary School level are forced to engage in transactional sex in order to feed and cloth themselves (Casely-Hayford and Wilson, 2000). More research is needed to determine the extent of this phenomenon where young girls sell themselves in return for economic favours from informal or casual relations with "boyfriends".

Truck drivers and mobile populations have also been identified as one of the most high-risk groups in Ghana according to the World Bank Study on Mobility (World Bank, 2000).

2.6 Modes of transmission in Ghana

Heterosexual contact accounts for most of the infections in Ghana followed by Mother to Child Transmission (MTCT) due to HIV/AIDS infection at the time of pregnancy, at the time of birth or through breast-feeding. Modes of transmission are important for analysis since programmes to slow the epidemic should focus on different approaches to prevention.

Table 2: Modes of Transmission in Ghana

Main mode of transmission	Percentage of HIV/AIIDS infections
Sexual transmission (Heterosexual)	75 to 80%
Mother to Child Transmission	15%
Contaminated Blood and Blood products	5%

(NACP, 2001)

Some modes are easier to arrest than others. For instance Mother to Child transmission has been eradicated in most of the developed world but remains a significant problem in Ghana as well as other African Countries. The contamination of blood is also a channel, which can be stopped if blood is properly screened. Currently, only 70% of blood is being screened for HIV/AIDS and other infectious diseases (NACP, 2001).

Most emphasis on preventive activities in Ghana is focussed on changing behaviour within the youth and adult population. Several media campaigns are currently running which use intensive communication strategies to reach youth and adults. These are presented in Section 7.0.

2.7 Availability of condoms

Studies in Ghana indicate that 95.3% of men and 90.5% of women know about condoms but only 20% have ever used a condom. Several large agencies are involved in the sale and promotion of condoms including the Ministry of Health, the Ghana Social Marketing Foundation (GSMF) and the Planned Parenthood Association of Ghana (PPAG).

Condom sales from Government sources decreased by 19% in 1999 from 2,126,171 in 1997 to 1,723,958 (FHI, 2001). Condom sales from private sources such as the Ghana Social Marketing Foundation increased by 70% between 1997/2000. The increased condom sales by the private sector are attributable to the communication strategies such as "Stop Aids Love Life" Campaign, which started in Feb. 2000.

There are wide inter regional variations in condom use ranging from 37% increases in the Upper West to a decline of 50% in the central region of the country (FHI, 2001). According to the Ghana Demographic and Health Survey

(1998) the private sector is the major provider of condoms (50%) while only 16% of men use brands marketed by the MOH/ GOG.

2.8 Vulnerability context in Ghana

The age groups, which are considered most vulnerable, are girls between the ages of 15 to 18 who are six times more susceptible to contracting HIV/AIDS than their male counterparts (Casely-Hayford/UNESCO, 2001). According to NACP, the "Window of Hope" is between 5 to 14 years of age. Children's moral values and behaviours can be easily influenced before they become sexually active.

Women are more vulnerable to HIV/AIDS for both biological and social reasons. Women are more economically vulnerable if the husband is infected since they are the main care givers in AIDS affected households and their subordinate position make them unable to protect themselves from HIV. "Gender differences in access to economic and educational opportunities reinforced by cultural practices and attitudes promote the transmission of HIV/AIDS" (NACP, 2001a). This is particularly the case for women and young girls in Ghana where we find increasing levels of poverty and HIV/AIDS transmission.

Approximately 42% of Ghanaians live under the poverty line. The majority of whom live in the three northern regions. Poverty in Ghana is predominantly a rural phenomenon affecting mainly food crop farmers and women. There is increasing migration patterns within the country particularly for women and girls children from the north who migrate to the south in search of economic opportunities. The "Kayayoo" or head carriers are one such group who often live on the streets at night, which makes them vulnerable to HIV/AIDS. Studies reveal that these girls migrate on a seasonal basis often exposed on the streets and in market places where they often get pregnant before returning to the north.

Ghana has embarked on an intensive analysis of its poverty situation over the last year culminating in the Poverty Reduction Strategy: 2002-2004. The document does place some emphasis on the need for HIV/AIDS across the sectors but more work is needed to ensure HIV/AIDS is mainstreamed in the strategy. This is elaborated in section 3.2 of this report.

Another dimension of Ghana's vulnerability context is the relationship of STDs to HIV infection. The prevalence rate for HIV among STD patients and blood donors is 17% and 4% respectively (UNAIDS, 2000). The FHI situational assessment reported that in Accra alone pharmacists treated between 50,000 to 90,000 cases of STD in a year (FHI, 2001). STD cases reported by Public health facilitates were only between 1,089 and 2,906. The FHI report suggests that there has been very poor treatment of STI's in Ghana. There is a high level of STD's in the country, which should be part of any strong prevention programme.

WHO's regional strategy clearly outlines the need to attack both STDs and HIV in a consistent and dual manner.

2.9 Socio-Economic Context

Ghana faces serious social and economic challenges due to the very low rate of literacy particularly among females in the country (59%). The country also has a very high rate of child mortality, poverty and poor health access. This scenario makes rural families highly vulnerable to HIV/AIDS and children and women susceptible victims. Table 3 outlines the latest key socio-economic indicators for Ghana.

Table 3: Key Socio-Economic Indicators for Ghana

Socio-Economic Indicators	Year	Estimate	Source
Population (thousands)	2000	18,412,529	Pop. Census
Annual Population Growth rate (%)	2000	2.9%	"
Life expectancy at birth (years)	2000	Male 58.7 Female 62.2	UNDP. HDR
Under 5 mortality rate (per 1000 live births)	1998	Urban76.8 Rural 122.0	DHS
Total Adult Literacy rate	2000	Male 78.5% Fem. 59.9%	UNDP.HDR
Primary School Enrolment rate	1998	Urban 85.4 Rural 70.7	Demographic & Health survey.
GDP per capita (US$)	1999	US$1,881.--	UNDP/HRD
Total Debt Service as a % of GDP	2000	6.7%	UNDP/HRD
Human Development index rank	1999	119	"
Health Expenditure per capita	1998	US$ 5.00	DHS
Physicians (per 100,000 people)	1999	6/100.000	UNDP/HDR

(UNDP (2001) The Human Development Report and the Ghana Demographic Health Survey, 2001)

HIV/AIDS threatens to erode some of the quality of life indicators, Ghana has been able to achieve over the last decade. For instance the gains made in overall life expectancy will not take place as expected due to the high death rates and declining age of death caused by the HIV/AIDS scourge. AIDS accounted for about 3.5% of deaths in 1994 and is projected to reach 18% by 2004 and 33% by 2014 (MOH, 2000).

Ghana experiences a high incidence of poverty particularly within the Northern regions, Central and Volta region. It is likely that children who lose their parents to HIV/AIDS will need support if they are to remain in school. Already there is a very fragile context in which children are undernourished, lack medical attention and often are deprived of their basic rights such as education. With the

onslaught of HIV/AIDS families and communities will find it increasingly difficult to provide for their children and special programmes (preferably Home-based) will have to be developed to cater to these groups.

Poverty assessments conducted in the country reveal that many of the productive labour force have migrated to urban centres leaving children and the elderly in rural deprived areas (Korboe, 1998). This vulnerable context will be further deepened if children are not given proper moral education and training at a young age in order to make the right choices and prevent the spread of the disease. Interviews with several civil society stakeholders indicate that youth groups, religious groups, and traditional leaders are playing a significant role in creating awareness among the youth. Educational Packages such as the "Journey of Hope" and other AIDS awareness packages will be essential for the young who are our "Window of Hope".

Ghana has also been going through a process of decentralisation, which places more emphasis on district-based development with the District Assembly as the key agency for development at the district level. The District Response Initiative (DRI) an HIV/AIDS capacity building programme assists district analyse their situation, build capacity and identify actions, which are timely and appropriate for their areas.

2.10 The Impact of HIV/AIDS in Ghana

There are very few impact studies available on HIV/AIDS in Ghana. The impact on the private sector appears to be the only research conducted to date on HIV/AIDS. The Futures Group and the Economic Commission on Africa have identified some of the economic and social impacts in Ghana these are highlighted in Table 4.

Table 4: Socio-Economic Impact of HIV/AIDS in Ghana

Sector	Socio-Economic Impacts
Health	➢ Recent estimates in Ghana reveal that the total cost for treating opportunistic infections for an AIDS patient ranges from 4.2 million cedis per year (US$ 595) or (US$54.34) per episode of illness. ➢ Health care expenditures are set to increase from about 59 billion cedis in 1999 to over 167 billion cedis in 2014. (NACP, 2001a)[8] ➢ The number of TB cases has also been rapidly increasing a study by NACP estimates about 30,000 people with TB in 2000 of which between 14 to 23% can be attributed to HIV/AIDS. ➢ AIDS bed occupancy at 50% in 2000. A large gap in funding is needed to scale up prevention programmes.
Education	➢ Not enough data has been collected on the impact that HIV/AIDS will make in the education sector ➢ Projections from UNICEF estimate that Ghana's enrolments in Basic Schools will decline as a result of HIV/AIDS. A large number of

[8] This does not include ART costs.

Sector	Socio-Economic Impacts
	teachers will also become infected by HIV/AIDS further eroding the valuable human resource base. ➢ A large number of orphans are also affected in their access to education. Currently 119,400 orphans in Ghana and over 170,000 children have been cumulative orphans.
Transport Sector	➢ Long distance Truck Drivers, which could affect the supply of food to major urban areas increasing food prices and compromise food security. ➢ Transport workers are highly vulnerable to the HIV/AIDS infection since they spend long periods of time away from their families. ➢ GOG is investing large amounts of funds into the improving transport sector. The GOG should also consider the protection of workers from HIV/AIDS transmission.
Agriculture	➢ This will have a negative impact on production of food crop farmers and food supply of the household and nation. ➢ The labour losses due to the HIV/AIDS infection also cause a shift from labour intensive export crops to food crops further eroding the gains made in the economy.
Private Sector	➢ Several studies in Ghana reveal the potential impact this will have on business particularly due to the high costs associates with Death Benefits (61%), training and productivity losses (22%) and labour turnover (7%) (Forsythe, 2001)
Macro economy	➢ GDP growth will decline by at least 1% once Ghana falls within the 5-10% infection rates. ➢ The economic impact is first felt by the individual and their families and then the ripple effects out to firms and the macro economy

(NACP, 2001a and Casely-Hayford, 2001)

There are particularly harsh impacts on children. Child mortality will increase instead of decline in Ghana due to the increases in MTCT. Child mortality rates were set to reduce from 110/1000 live births to 51/1000 live births by 2010. Current child mortality rates are projected to at 75/1000 live births.

The impact of HIV/AIDS is also being felt in most sectors of society particularly at the local level. Government is cautiously aware of the potential impact HIV/AIDS will have on the economy and has made several statements to alert the populace on the impact HIV/AIDS will have, if not controlled and abated.

3.0 National AIDS Policy, and Strategic Set up

"HIV/AIDS in Ghana was first managed as a disease rather than a developmental issue (GAC, 2000)".

The following section outlines the main agencies involved in the planning and mitigation efforts to control HIV/AIDS in Ghana. The establishment of the National Advisory Commission on AIDS (NACA) in 1985 was the first national response by government on HIV/AIDS issues. In 1987 the National AIDS Control Programme (NACP) was established under the Ministry of health for both the implementation and co-ordination of programmes. The NACP and the Public Health and Reference Laboratory are responsible for monitoring HIV/AIDS prevalence in Ghana. Sentinel surveys are conducted on a regular basis.

There have been several plans developed by the GOG/MOH and NACP and its stakeholders over the last 10 years including: the short-term plan, medium term plans1 and 2. In March 2000 the government and the technical working group on HIV/AIDS conducted a situational analysis. In June 2000 a response analysis was completed by the UN thematic group. The UN Thematic Working Group helped to spear head the strategic planning process out of which flowed the HIV/AIDS Ghana Strategic plan developed over an 18-month period. The National Draft policy on HIV/AIDS and STI was published in August 2000.

UNAIDS was instrumental in spear heading these planning processes along with the NACP. UNAIDS helped to set up the basic structures required for a multi sectoral approach to combating the epidemic. A UN thematic group was established in 1996 along with the establishment of a Ghana UNAIDS office. In 2000 the UN theme group was expanded and now includes the MOH, bilateral and multi-lateral agencies as well as NGOs.

The UN technical working group was established in 1996 comprises a larger set of stakeholders who are more focussed on implementation. These groups have helped to collect data and strategise on HIV/AIDS prevention, management and care programmes with the GAC/NACP and MOH.

In September 2000 the National AIDS Commission was launched by Ministerial decree as a supra agency to help co-ordinate the growing number of HIV/AIDS interventions in the country. This body forms the highest policy making body and comes directly under the Office of the President. The secretariat is still in the process of being fully established.

The GAC is mandated to direct and co-ordinate all HIV/AIDS activities. The membership includes:

- Representatives from all ministries, department and agencies (MDA's)
- Organised labour
- Ghana Employers Association
- National Population Council
- National Council on Women and Development
- PLWHA
- National House of Chiefs
- Selected individual and co-opted members

The Ghana AIDS Commission (GAC) is responsible for providing leadership in the national planning programmes, co-ordinate the national response and mobilise and manage resources and monitor their allocation and utilisation. It is also to foster linkages and networking among stakeholders.

3.1 Ghana HIV/AIDS Strategic Plan Objectives

The Ghana HIV/AIDS Strategic Framework (2001-2005) proposes a multi sectoral and multi disciplinary response to confront the disease. It provides broad guidelines for sector ministries, agencies, district assemblies, the private sector and NGOs in order to evolve programmes. Some of the main objectives and key strategies are outlined in table 5.

Table 5: Ghana's HIV/AIDS Strategic Plan (2001-2005)

Main Objective and some specific Objectives	Some of the Broad Strategies	Programme Target Group
Prevention of New infections ➢ Increase the median age of first sex from 17 to 18 years ➢ Achieve reduction in number of sexual partners ➢ Increase the use of condoms from 15% to 30%	➢ Promote safer sexual behaviour including condom use among the 15 to 49 age groups ➢ Improve the STD management ➢ Reduce the Mother to Child transmission ➢ Promote Voluntary Counselling and Testing	Youth, women commercial sex workers, mobile and migrant population and the general public
CARE and SUPPORT ➢ Improve the service delivery and mitigate the impact of HIV/AIDS ➢ Strengthen the capacity of Health care providers to care for PLWHA ➢ Provide good quality	➢ Promote Voluntary Counselling and testing of individuals especially the youth ➢ Improve the institution care including access to drugs for PLWHA ➢ Promote community and	PLWHA And their relatives All Health care providers Health care institutions Laboratory services Civil Society

Main Objective and some specific Objectives	Some of the Broad Strategies	Programme Target Group
home based care for PLWHA and AIDS orphans ➢ Promote positive attitudes and a supportive environment ➢ Promote self care and self reliance	social care and support including home based care ➢ Promote effective linkages between institutional and home based care providers	
ENABLING ENVIRONMENT: Create an enabling Environment for the implementation of the strategic framework To enact and enforce legislation to facilitate the provision for care and support for PLWHA	➢ Review existing clauses and engage policies to protect the rights of PLWHA ➢ Promote the stricter enforcement of HIV/AIDS related laws and policies ➢ Advocate for the elimination of negative socio-cultural practices that promote the spread of HIV/AIDS	CHRAJ, MOJ, Judiciary, Parliament, Ghana Prison Service, Ghana Health Service.
Decentralised implementation and institutional arrangement	➢ Formulate clear co-ordination and implementation data ➢ Strengthen the Human resources ➢ Mobilise resources to implement the framework	GAC, MESW, MLG&RD
Research monitoring and evaluation	➢ Build capacity to undertake HIV/AIDS related research ➢ Develop Objectively-verifiable indicators (OVI) ➢ Collect baseline data ➢ Follow the protocol developed by the National Population Council	Universities, Researchers, Ghana AIDS commission

(Based on Ghana HIV/AIDS Strategic Framework, 2001)

Key components of the strategic programme include:

- An expanded multi sectoral approach
- Supportive policies and laws that respect and promote the fundamental human rights
- Access to information and comprehensive services
- Decentralisation, community participation and individual responsibility in all HIV/AIDS programmes
- Adequate resource mobilisation
- Effective surveillance, evaluation and research

3.2 Poverty Reduction Strategy and HIV/AIDS

The Ghana Poverty Reduction Strategy (GPRS) also includes the integration of HIV/AIDS across the key areas and sets the following targets:

Table 6: Ghana's HIV/AIDS Targets

Key Targets based on PRSP and Ghana Strategic Framework	**2000**	**2004/2005**
Reduction of new HIV infections among the 15-49 age group.		25%
Improve the service delivery to 50% of PLHWA		50%
Promote condom use to avoid HIV/AIDS Women Men	 6% 14%	 15% 25%
Improve Health Facilities with adequate arrangement to care for PLWHA		30%
Establish a well managed institution arrangement for the control and co-ordination of HVI/AIDS		

The Government is planning to expand the response to HIV/AIDS at both local and national level through the involvement of all key stakeholders including religious groups, the media and community organisations. Emphasis is also being placed on high-risk groups to prevent the spread of HIV/AIDS and priority intervention areas are being given to the:

- Prevention of new transmissions including awareness creation direct service delivery and supporting high risk groups
- Providing support to people living with HIV/AIDS (PLWHA and their families)
- Laying an effective institutional foundation.

Other key areas identified will be the promotion of girls' education and job creation in rural areas to arrest the problem of out of school youth.

Finance and Budgeting: The HIV/AIDS National Action Plan has been costed at 303 million dollars over the next five years. Some funds have been pledged from donors such as the World Bank and DFID. The overall HIV/AIDS budget is much larger than the entire MOH budget, which is approximately 160 million dollars. Some stakeholders are questioning the costing rationale. This is further explored in section 6.4.

The Ghana HIV/AIDS Strategic Framework identifies several challenges, which have characterised HIV/AIDS financing including lack of funding and access to funds particularly for the NGO sector. This was confirmed in several interviews with the NGOs in the sector.

3.3 Ongoing Challenges and Risks in Response

Several stakeholders have commented on the need for a much more co-ordinated effort regarding HIV/AIDS interventions particularly at the regional and district levels. The District Response Initiative is a timely and effective approach to meeting these concerns. It provides the basic capacity needs of district agencies if HIV/AIDS is a menace and provides the skills to co-ordinate efforts.

There is growing institutional capacity being developed within the country due to the launching of the Ghana AIDS commission and the donor funds, which have been pledged to support for the agency. For instance, over 2 million pounds sterling has been allocated for institutional capacity building of the GAC through assistance from Action Aid as part of the DFID grant to the GOG. There will be a great need to ensure the most effective financial systems are put in place at National level in order to ensure that donor and GOG funds are properly channelled over the next ten years.

There is a risk that if Government does not lead a strong level of donor co-ordination there may be overlap of donor programming and assistance. Key to ensuring a general level of co-ordination will be the importance of continuing to focus on Ghana's HIV/AIDS strategic plan and using the existing channels for initiating programmes through the MOH and GAC. Most donors interviewed in the sector were quick to place the government ministries in the forefront of their programmes and referred to them as MOH programmes or Ministry programmes. This is a very encouraging sign and will ensure ownership and sustainability in the HIV/AIDS programming in future.

Despite the large amount of funding focussed on the NGO sector (i.e. 80% of the World Bank support will go to NGO's). There is need to monitor the mechanisms for quick and fast response to NGOs in the field with the least bureaucratic problems. The District Response Initiative (DRI) promises to be one effective channel for facilitating the easy distribution of these funds along with other networks such as the GHANET. The World Banks focus on NGO's with 80% of their funding going to the NGO sector will require a high level of capacity building and coordination.

4.0 National and Local Responses to HIV/AIDS

Ghana is one of the few countries within the sub region with all the necessary structures in place to combat the epidemic. Over the last 10 years Ghana has put in place several mechanisms to ensure a systematic and co-ordinated HIV/AIDS response. These include:

- National HIV/AIDS policy
- HIV/AIDS Policy across all the sectors
- High level structure to support the response to HIV/AIDS
- National Strategic Plan on HIV/AIDS
- Supported a budget for implementation of the Plan

Ghana ranks next to Senegal and Nigeria in leading the national response to HIV/AIDS in West Africa. These countries have all the necessary structures, processes and plans in place to combat the HIV/AIDS. Now is the time for action and reflection.

4.1 Leadership Commitment, Political Will and legal instruments

Leadership at the highest levels has been identified by several international agencies as the key to any successful national response. Over the last two years Ghana has witnessed an increasing level of political commitment towards the control and prevention of HIV/AIDS. Stakeholders interviewed revealed that the turning point for government was the visit by the "International Partnership for HIV/AIDS". Government officials recognised the need to put in place the Ghana AIDS commission and give it the necessary support after meetings with the highest political leaders.

The President and the Ministries, Departments and Agencies have been leading the way in the fight against AIDS. All MDA's have been tasked to ensure that a portion of their annual budgets includes activities for HIV/AIDS prevention. There have also been several funds committed to support these initiatives. Some of the key elements of the Ghana Government's commitment has been the establishment of the Ghana AIDS Commission under the office of the President and the inclusion of HIV/AIDS line items in all ministry budgets for the 2001 budget. Some ministries have allocated as much as 5-10% of their entire budgets to these activities.

Legal Instruments

The legal instruments for protecting people with HIV/AIDS, employees and the legal rights of PLWHA are yet to be passed by Parliament. There is still a tremendous stigma against those with HIV/AIDS. Stakeholders interviewed expressed the concern that the human rights PLWHAs are being marginalized.

There is a pressing need to ensure that the legal instruments to protect the rights of PLWHA and others are not affected by the epidemic. Employment and labour laws must also be adjusted to ensure fair testing of employees and their rights as citizens. The legal work will also help raise awareness of the status of PLWHA and most likely help reduce the stigma.

Some of the legal and regulatory issues, which were highlighted by the NACP, include:

- Employer and employee rights
- Protection of children who are infected and affected by HIV/AIDS
- Guidelines for insurance companies
- Codes for voluntary counselling and testing
- Regulations for drugs and drug trials
- Establish sanctions for those who knowingly infect others

4.2 Policy and Plans

Three broad policy documents guide the activities being undertaken by Government and donor agencies. These include the:

- Draft National HIV/AIDS/STI Policy Document
- National Strategic Framework on HIV/AIDS
- The Ghana HIV/AIDS Sectoral Plans

The Ghana HIV/AIDS Policy Document outlines a National Strategic Framework providing the basis for all sectors to get involved in the implementation. The Draft National Policy is premised on the 1992 constitution and ensures all the rights and responsibilities towards people with HIV/AIDs. It provides guidance on issues such as informed consent for HIV testing, counselling and confidentiality on HIV (NACP, 2001a).

The Strategic Framework proposes a multi-sectoral response to the disease and presents broad guidelines for MDA's, the private sector, NGOs and civil society to evolve programmes. The "Ghana HIV/AIDS Sectoral Action Plans 2001-2005" puts the framework into action outlining the key priorities within each MDA.

4.3 Current Information Campaigns

There have been several information campaigns over the last two years using radio and television to create awareness of the risk of HIV/AIDS. The most popular has been the "Stop AIDS Love Life Campaign" by John Hopkins University (JHU), which has focussed on youth (15 24) and adults. More recently JHU have launched another campaign called the "Journey of Hope" which is a multi media kit containing games which help people especially youth make choices and think about their future and the risks of HIV/AIDS.

Peer-to-Peer education is proving to be one of the most effective approaches used by NGOs and other agencies. UNICEF has recently initiated a programme called the SARA project, which is primarily focussed on girls between the ages of 10-15 years of age. It uses magazines, videos and posters to convey stories of young girls on reproductive health themes.

The USAID "Policy project" has also introduced advocacy and information packages to convey key messages to policy and decision-makers. The training package contains updated information, which is used by trainers in the country. FHI has also developed information/training packages for the private sector trainers.

4.4 Selected MOH/Government of Ghana programmes

There are several programmes, which are under way within Ghana some of which are outlined in the Strategic Framework and the Expanded theme group workplan. Below are highlights of two important programmes;

- **Pilot Programme on Prevention of Mother to Child Transmission (MTCT)**

Two programmes, which appear particularly important, are the Mother to Child Transmission pilot project currently being implemented through the MOH with the Assistance of UNICEF in one area of the country. The programme is run through two hospitals in the Manya Krobo area, in the Eastern region, which has the highest rate of HIV/AIDS. The MTCT pilot programme focuses on antenatal services, mothers' education, counselling and voluntary testing. The drug Nivaripine is provided to HIV/AIDS infected mothers during labour and after delivery.

There is a community component, which provides follow up to mothers in the programme but this is yet to be implemented. The programme only began in November 2001.

The HIV/AIDS Strategic Plan outlines the need to reduce the MTCT rates by 30% by 2005 as one of their main goals. Significant effort will be needed to implement policies and protocols related to MTCT. For instance, building capacity of the MOH and relevant stakeholders, creating awareness of the risk of MTCT and access to counselling services to mothers are all part of the necessary support.

- **District Response Programme**

The District Response Programme aims at building capacity of local institutions to plan and coordinate HIV/AIDS at District level. The programme is supported mainly by UNAIDS and has scaled up to reach approx. 42 out of 110 districts in the country.

The programme attempts to cover all the districts in one region before moving to the next region. The district response initiative has been running in 10 pilot districts and recently scaled up in two regions of the country. The Eastern (15 Districts) and Ashanti (18 districts) are now fully covered by the programme. Two districts in the Upper East, one in the Volta, two in Greater Accra and one district in Brong Ahafo are involved in the DRI programme. The programme is not yet active in the Upper West, Northern or Western Region where some Danish Assistance programmes are located.

The DRI approach uses a multi sectoral team at the district level to develop action plans and monitor ongoing activities. District focal people are trained to conduct a situational and response analysis. The programme was recently evaluated and shows signs of success particularly in engaging traditional leaders in the fight against HIV/AIDS. Several donors have channelled their programming through the DRI these include: DFID, UNICEF, UNDP, RNE and GTZ. It is expected that RNE will expand its support in this area in the future.

6.0 Technical and Financial contributions from donors and civil society

Higher levels of co-ordination were reported as one of the key areas for further support. Stakeholders reported that more coordination is needed to strengthen activities particularly in the light of the growing amount of funding and interventions by bi-lateral and multi-lateral agencies.

6.1 Multi-lateral Programming

Annex 2 outlines the main multi-lateral funds, activities and target groups. This information is based on interviews with donor agencies and the UNAIDS Ghana Country Report (July, 2001). Most of the programmes outlined are running over a three to five year period.

There has been a strong emphasis on the need for co-ordination in the HIV/AIDS programming sector. Several people interviewed during the assessment suggested that this co-ordination although it exists needs to be strengthened. The UN expanded thematic group meets on a quarterly basis while the UN technical team meets on a monthly basis.

6.2 Bilateral programming

All the donors support and pay into a common fund call the “Health Account” which covers all interventions including HIV/AIDS prevention and control. Most donors are supporting programming, which is focussed on the prevention of new transmissions. Only four agencies are involved in the care and support of HIV/AIDS. These are: The World Bank, UNAIDS, and CIDA. Seven Agencies are involved in "creating an enabling environment for HIV/AIDS prevention, management and control (UNDP, UNFPA, UNESCO, USAID, CIDA, RNE, DFID). Most donors are supporting initiatives through decentralised institutional arrangements such as the regional and district level agencies. Annex 3 reviews the main interventions and target groups according to the various bilateral agencies.

Analysis by Tadefa-Kubabom et al. (2001) on the current donor responses in Ghana's HIV/AIDS sector reveals that:

- Majority of donors are adopting approaches that target both the health and non-health sectors.

- MOH, MOE and MLGRD are the dominant donor partner agencies

- Some interventions are being directed through the Justice, Defence, Interior and Women's Affairs Ministries most likely due to their role in advocacy, human and legal rights.

- Only two agencies have incorporated HIV/AIDS initiatives within their various sectoral programmes (i.e. DANIDA and GTZ).

A growing number of interventions are being channelled through the Ghana Commission on AIDS.

6.3 Civil Society Programmes

Interviews with Civil society agencies revealed a high level of involvement in the current HIV/AIDS programming. Some agencies are represented on the UN technical working group and occupy active positions. Stakeholders interviewed expressed the need for more co-ordination and networking at district and regional level particularly due to the increasing levels of donor support to the sector. GHANET in particular sees itself establishing more regional and district-based programmes to support NGO networks and local responses to the HIV/AIDS epidemic. Annex 4 outlines some of the most active NGO programmes in the country.

Family Health International (FHI) has also a proven track record in administering small grants to NGO's within Ghana and has worked to support several NGOs with HIV/AIDS programming. FHI has set up a small rapid response fund for the NGO sector and can share many lessons with other agencies should they decide to set up similar mechanisms within the country.

With the current donor funding programmes the NGO sector is set to receive a large injection of funds in targeted areas of the country (Eastern and Ashanti region where the prevalence rates are the highest through the World Bank and RNE). Capacity building will also be a component of the funds for the GAC to administer the funds to the NGO sector. There still appears to be the need to encourage more NGO's to integrate HIV/AIDS in their programmes. UNICEF's HIV/AIDS strategy for Girls education may provide an important channel for reducing poverty and ensuring the protection of girls.

6.4 Financing and Budget Allocations

The latest budget figures for financing HIV/AIDS activities according to the latest "Ghana HIV/AIDS Sectoral Action Plan" compiled in the third quarter of 2001 is estimated at **US$ 303,000,000**. This is much higher than the original estimation based on the Ghana Strategic Framework, which estimated the financial requirements at **US $118,930,000**. Interviews with NACP suggest that this figure may be higher since the original was merely an estimate and that the ministries had not detailed out their activities. Some stakeholders believe that the Sectoral

Action Plan budget must be reassessed keeping in mind the need to coordinate and streamline activities.

Multi lateral and bilateral donors have committed **122,101,256** for 2001, which is based programmes and activities in the most recent 2001 Integrated Work Plan for members of the UN Expanded Theme group. Table 8 presents the most recent commitments. These figures do not include GTZ or JICA since they were not included in the report.

Table 8: Budget Allocation to HIV/AIDS Programmes by Donor Agency, 2001

UNICEF	UNDP	UNFPA	UNESCO	WHO	WORLD BANK	UNAIDS	CIDA	RNE	DFID	DANIDA	USAID	EU
3,020,000	2,350,000	3,704,118	100,000	1,240,000	25,000,000	1,413,500	2,100,000	33,400,000	22,031,000	13,641,000	10,091,638	4,010,000
2.5%	1.9%	3%	.08%	1.02%	20.5%	1.2%	1.7%	27.4%	18	11.2%	8.3%	3.3%

(Based on Integrated Work plan for Expanded Theme Group on HIV/AIDS, Aug.2001)

Figure 4 reveals that the key donors contributing the highest percentage of funding to the GOG HIV/AIDS strategic and sectoral programming are the: Royal Netherlands Embassy, the World Bank, the British Government, and the Danish Government. Some of the figures are not accurate since in some cases they reflect the total amount of funds, which are being allocated for funding the health sector and not only HIV/AIDS programming (i.e. RNE).

6.5 UN System Response to the Epidemic

UNAIDS along with other UN agencies have played a key coordination role in the areas of HIV/AIDS programming. UNAIDS initiated and facilitated several coordination activities before the Ghana AIDS Commission was established including:

- Establishment of the UN theme group (includes multi/ bilateral donors, MOH and some other government MDA) and technical working group on HIV/AIDS The UNAIDS Technical Working Group has various sub committees including: commercial sex workers, MTCT, VCT and advocacy and media.

- Spear heading the donor and multi-lateral co-ordination before the National AIDS commission was set up.

- Supporting the situational and response analysis, which was key to the development of the Ghana HIV/AIDS Strategic Framework, Draft Policy and the Sectoral Action Plans.

According to the most of the stakeholders interviewed UNAIDS has played an effective role in assisting agencies work towards collaborative interventions.

Now that the Ghana AIDS Commission is in place, the Government of Ghana is set to lead the fight against HIV /AIDS with support from donor agencies.

6.6 Effective Communication Strategies

There are two large campaigns currently running in the country aimed at different target groups. The "Stop AIDS Love Life " Campaign has been operational since February 2000 and is using popular media to reach youth (15 -25 years of age). The Journey of Hope is an educational tool on HIV/AIDS for training trainers, which can be used for all levels of society. This is a new campaign, which uses a tool kit of activities for social groupings.

Concerted action on a number of fronts is essential to the control of the epidemic. NACP recommends that not any one intervention can prove as effective as a multi- dimensional approach, which includes; blood screening, STD treatments, condom promotion and partner reduction. Behavioural change is needed to reverse the course of the epidemic in Ghana. This requires a range of communication strategies for different age groups. Table 9 describes some of the key communication strategies, which are already working in Ghana.

Table 9: Communication Strategies by Age Grouping in Ghana

Target Group	Agency	Approach
Children (0-15) (In school)	Ministry of Education UNESCO/GTZ	➢ Training of School Health Officers and Counsellors ➢ Integration of HIV/AIDS in school curriculum using the GES school health education programme (SHEP) ➢ Using school clubs to convey messages. ➢ National theatre drama group on HIV/AIDS awareness
Children (Out of School)	GHANET GSMF	➢ Church leaders, social groups and youth clubs, ➢ Moral Education ➢ Social groupings and identifiable groups to reach out.
Youth (15-25)	➢ Red Cross Network ➢ Family Health International ➢ John Hopkins University ➢ Ghana Social	➢ Peer Counselling ➢ Peer Counselling Tool which is a kit involves some games and magazines ➢ Radio/T.V adverts using peer role models ➢ "Edu-tainment" (magazines, condom dances, role-models or popular youth figures)

Target Group	Agency	Approach
	Marketing Foundation	
Adults	➢ Ghana Social Marketing Foundation ➢ GHANET	➢ Television, bill boards, easy accessible condom sales ➢ MPs, media personnel and district chief executives as channels for communication. ➢ Existing community and private sector structures. ➢ Workplace based programming is a very effective channel of communication particularly through training of human resource staff, associations, unions and umbrella organisations.
Girls	➢ UNICEF Education sector	➢ SARA is an educational media package for youth (10-15), which includes magazines and videos on reproductive health.
High risk groups (sex workers, truckers and market women)	➢ Ghana Social Marketing Foundation	➢ Promotion of condoms and safe sex.

(Based on Interviews with Key stakeholders, 2001)

Interviews revealed that the hard to reach populations are the youth out of school who are mobile and highly vulnerable to the infection. The GSMF attempts to reach out through edu-entertainment approaches by tracking the youth in areas where they can be found (i.e. clubs, discos, churches, beaches etc). They integrate HIV/AIDS awareness into the entertainment programmes when possible and use popular youth figures to promote messages.

According to the Ghana Social Marketing Foundation (GSMF) and the NACP the most effective media for conveying messages is radio; 84% of people obtain HIV/AIDS related information through the radio. Only 50% of the population obtain information through TV. Other sources include newspapers, and informal channels such as peers and faith based organisations. Interviews with FHI revealed that face-to-face peer education is the most effective communication strategy for behavioural change especially among youth.

The recent demographic and health survey pointed out that only 40% of the rural population use formal health systems since the cost is so high. This means that little information might by passed by health professionals stationed in hospitals.

The Government and its donor partners are sponsoring a large part of funding for media campaigns and radio programming. USAID in particular is supporting a number of agencies develop useful media campaigns including the: Ghana Social Marketing Foundation, FHI and John Hopkins University.

The Ghana HIV/AIDS Strategic Plan outlines several communication strategies needed to increase in condom usage through IEC strategies and promotion of appropriate changes in behaviour and safe sex. The reduction in MTCT will also require several communication strategies to create awareness among different target groups.

7.0 Key Conclusions and Recommendations

" It is more important than ever that Ghana mount an expanded response to the epidemic, especially to prevent the spread of HIV among vulnerable groups including adolescents and young adults" (NACP, 2001)

Youth particularly girls appear to be the most important target group for prevention and control of HIV/AIDS in short and long term. Stakeholders interviewed as part of this study stated consistently that the youth between the ages of 15-24 are the most vulnerable and most receptive to change. These groups and the younger pre youth should be targets for many of the activities since they will soon enter the world of work. The Window of Hope, which are children between 5-14, should also be a major target group using in school and out of school approaches described in section 6.0

Danish Development Assistance in Ghana should consider supporting the following initiatives over the next five years in order to strengthen existing programmes to combat HIV AID through:

- National and regional support to scaling up programmes for the prevention of Mother to Child transmission. This would involve scaling up support through UNICEF developed mechanisms within the regions DANIDA is active particularly the Volta, Western region and Upper West. It might also involve a national awareness campaign to educate mothers using radio and T.V. On the prevention of mother to child transmission (MTCT).

- The Danish Embassy should consider supporting the District Response Inititiatve (DRI) in DANIDA focal regions in order to ensure a co-ordinated and systematic response to the HIV/AIDS pandemic. Support should include DRI training and ongoing monitoring and support to the districts in order to build capacity for HIV/AIDS analysis and response.

- DANIDA should mainstream HIV/AIDS across all their programmes particularly private sector initiatives, transport and water and sanitation work. Training packages are available from the Family health International, John Hopkins University and GHANET. These agencies have developed packages for various sectors, agencies, and clients within Ghana and have experience in training trainers in HIV/AIDS awareness creation.

- Almost all stakeholders mentioned strengthening and expansion of Voluntary Counselling and Testing Services (VCT). This could be supported by DANIDA through their private sector or NGO linkages. Stronger out reach and counselling services for PLWHA are badly needed in the country. Promotion of training of trainers within this sector would also be considered.

- Support for the development of legal instruments to protect PLWHA and children affected by HIV are needed. Collaboration with existing agencies on Health and Human Rights should be explored.

- Laboratory support services, counselling and testing should be expanded and strengthened. Support to blood screening and safe blood transfusion to prevent new infection should also be explored.

Finally special emphasis should continue to focus on girls and young teens, which are the government "Window of Hope". Support, should be provided to the NGO sector to develop innovative programmes to reach children in and out of school. DANIDA's work in northern Ghana can go a long way to preventing the increases in HIV/AIDS through their Danish community programmes and other NGO activities through their local authority grants. More mechanisms for rapid financing of interventions by small NGO's engaged in education, gender empowerment, health and social development should be promoted with the integration of HIV/AIDS.

There is now consensus among many stakeholders that agencies should move from strategic planning to action and implementation. DANIDA appears well placed to activate an integrated HIV/AIDS programme across most of its sectors and focal regions in Ghana.

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Annex 1: Interviews Conducted for the Ghana Situational Analysis

	Designation	Agency
Charlotte Kanstrup Sigord Lawson	Counsellor Development Development Assistant	DANIDA, Royal Danish Embassy
Mrs Katsriku Dr Annie	Acting Co-ordinator Director of Policy Planning and Implementation	Ghana HIV/AIDS Commission
Dr A. Dzokoto	Regional AIDS Co-ordinator NACP focal person for STDs	Regional AIDS Co-ordination Unit
Dr Yeboah Dr Adu-Gyamfi	Director Deputy Director	National AIDS Control Programme
Mrs Alice Lamptey	Director	Ghana HIV/AIDS Network (GHANET)
Mr Bob Verbrugen	Advisor	GTZ regional HIV/AIDS programme
Mrs Jan Leno	Advisor	Action Aid Ghana (HIV Programme)
Dr Essah	Director	Family Health International (FHI)
Dr Ababio	Local Resident Advisor	The Policy Project , Ghana
Ms Froeks Kamminga	Junior Programme Officer (JPO)[9]	UNAIDS
Mr Andrew Osei	Programme Officer (AIDS)	UNICEF
Mr Morris Quaye	Programme Officer	John Hopkins University
Dr Victor Bampoe	Programme Officer	DFID Health Office HIV/AIDS
Mr Van der Horst Ms Patricia Kneepkens	1st Secretary (Development)	Royal Netherlands Embassy
Marian Tadefa-Kubabom	Socio-Economic Advisor	CIDA- Programme Support Unit
Mr Armah	Consultant, JSA Consultants (Implementing the DRI)	JSA Consultants

[9] Country Director is not yet in place

Annex 2: Multi lateral contributions

AGENCY	Total Funding for expanded theme group	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[10]
World Bank	US$ 25 million	Support activities of the civil society organisations to reduce the spread and impact of HIV/AIDS. The fund will complement the MOH programmes and ensure rapid response and multi sectoral scaling up in all regions. Focus on prevention, care and support activities to those affected 80% for the NGO sector (beginning in Ashanti, Eastern and Greater Accra regions) 20% to the ministry sectoral plans on HIV/AIDS	GARFUND through the Ghana AIDS Commission	2002 to 2005
UNAIDS	US $ 1,413,500	➢ Coordination and Facilitation role support to UN theme group and strategic planning ➢ Support to the GOG's prevention and control efforts (MTCT, VCT, and STD and commercial sex workers, female condom, advocacy and media) ➢ UNFPA workplace activities ➢ WHO blood safety and care and support ➢ UNDP strategic planning ➢ FAO capacity building for extension officers ➢ UNESCO for the AIDS education programming ➢ Support to the NGO sector and other initiatives ➢ District Response Initiative	UN partner Agencies: UNFPA. UNDP, UNICEF, UNESCO World Bank and WHO	
WHO	US $ 1,240,000	➢ Surveillance monitoring ➢ Support for local research on MTCT and HIV/AIDS transmission	MOH	

[10] These activities are outlined in several documents and reflect programming for the next few years although all the dates were not available.

AGENCY	Total Funding for expanded theme group	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[10]
		➢ Training in STD Management and Capacity building for Home based care ➢ Safe Blood Transfusion and VCT ➢ Support to Sentinel Surveillance (MOH)		
UNFPA	US $ 3,704,118	➢ Mainstreaming of HIV/AIDS into Safe mother hood programmes and projects and improved STD management ➢ Integration of Population and Family Life Education in schools and adult literacy programmes ➢ Peer education programmes through NGO capacity building ➢ Policy formulation support and chairs the UN theme group ➢ Workplace Programmes through the Ghana Employers Association	MOH Ministry of Education	
UNICEF	US $3,020,000	➢ Youth to youth Peer Education project (northern regions) in and out of school youth ➢ Prevention programmes for young people (street children) ➢ Safe Motherhood Programme and reduction of Mother to Child transmission Pilot (Eastern Region) ➢ Prevention activities in Western region with Commercial sex workers and the population	MOH and other partners at district and local level, NGOs	
UNESCO	US $ 100,000	➢ Support to the MOE strategic planning, HIV/AIDS in policy and programming. ➢ Convened Conference on the regional HIV/AIDS and Education conference	MOE	

AGENCY	Total Funding for expanded theme group	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[10]
		➢ Support to Dance theatre group on HIV/AIDS		
UNDP	US $ 2,350,000	➢ Technical Assistance to the GAC ➢ Capacity building for Health workers ➢ District Response Initiative	MES and MLG&RD	
World Food Programme	US $15.3 million	➢ Provided 482,000 Ghanaians with food AID. A special Aids component will target 3,000 PLWHA and their families (approx. 15,000 people).	Yet to be defined	2002-2005

(Based on interview with agencies and the UNAIDS integrated work plan, for the Expanded Theme Group August, 2001 and The Response to HIV/AIDS in Ghana, July 2001)

Annex 3: Bilateral Agency programmes

AGENCY	Amount allocated [11]	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[12]
DFID (British Gov.)	25 million Pounds	➢ Anti HIV/AIDS activities with the GAC ➢ Supports the UN theme group and technical working group ➢ Support the development of the strategic framework, sectoral implementation plans ➢ Two million pound to Action Aid Ghana for helping strengthen the GAC to administer the funds for the World Bank to NGOs ➢ Seven million for condom promotion through the GSMF ➢ Eleven million support the MOH programming and other activities[13] ➢ Supported evaluation of the District Response Initiative.	GAC Action Aid Ghana Social Marketing Foundation MOH	2002-2005
USAID	US $ 10,091,638	➢ Increase Demand for HIV/AIIDS Services (Behaviour change of uniformed services, miners and commercial drivers) Stop AIDS and Love Life and Journey of Hope Campaigns; Community based Activities ➢ Improve the quality of HIV/AIDS services (Training of Health professionals in STD management and prevention Counselling) Training of Pharmacists in client education ➢ Increase Access (Condom distribution, NGO Support activities, Rapid Response Facility (RRF) for NGO's (2	MOH, Family Health International (FHI), John Hopkins University (JHU/PCS), Planned Parenthood Association, IMPACT, CARE, GSMF	1998-2003 (renewable)

[11] Based on UNAIDS Response Analysis: Country Profile, July 2001.
[12] Timeframe taken from the Expanded UN Theme Group Work plans 2001
[13] Health funding in general goes to a common fund along with other donor funding

AGENCY	Amount allocated [11]	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[12]
		million per year) ➢ Improved Policies for HIV/AIDS services (Support to national surveillance, advocacy, and monitoring behavioural change and prevention impact)		
CIDA	US $ 2,100,000	➢ Commercial Sex workers project which includes capacity building IEC and STI management and support for PLWHA (Greater Accra, Eastern region and Kumasi) Target is Sex workers and high risk groups (STD clinics and capacity building for MOH personnel, STD surveillance and bulletin	MOH	2001-2005
GTZ	N/A	➢ Support to the DRI in Wenchi District, Brong Ahafo Region: integration of HVI/AIDS, Capacity building of health personnel in Sunyani ➢ Documentation centre ➢ Technical Support to the GAC ➢ Integration of HIV/AIDS across all bilateral programmes ➢ Supports inter-country initiatives on migration, prostitution and PLWHA ➢ Supports the District Response Initiative	Districts	
Royal Netherlands Embassy (RNE)	US $ 33,400,000	➢ Support to the MOH for prevention activities ➢ Three million dollar fund for three years to District Response Initiative (MLGRD) to support the care and support aspect of the DRI in all the districts in two regions: Ashanti and Eastern region. ➢ Integrated Community Programme (UNICEF) ➢ Support to the NGO sector in the Northern regions through Save	MOH	2001-2005

AGENCY	Amount allocated [11]	Areas of Focus Main activities	Mechanisms to channel Funds	Time frame[12]
		the Children's Fund Reproductive Health programme, which supports Community Based groups, youth and improves service deliver and advocacy work with HIV/AIDS as a component.		
EU	US $ 4,010,000	➢ Support to MOH/NACP for STD management in all health education in Ghana ➢ Supply of logistical support (i.e. drugs, basic equipment etc) ➢ Procures educational materials and lab equipment, training and supervision of staff at regional and district levels	MOH/NACP	2001-2005
DANIDA	US $ 13,641,000	➢ Poverty reduction and HIV/AIDS ➢ Incorporation of HIV/AIDS in bilateral programming particularly in Water, Transport, health and Energy ➢ Supports NGO's and CBO projects with particularly emphasis on youth, Street children, women and PLWHAs ➢ Multilateral support to HIV/AIDS through the UNAIDS and other UN agency.	Line ministerial, private sector UN agencies and NGOs	2001-2005
JICA	N/A	➢ Funding Support to MOH and Technical Support to Planned Parenthood Association of Ghana (PPAG)	MOH	2001-2005

(Based on Agency Interviews, Work plans for the Expanded Theme Group, August, 2001, UNAIDS Country Profile, July 2001 and CIDA-PSU Situation and Reponses through Development AID)

Annex 4: Civil Society Programme Focus, Target Groups and Future Plans

Name of NGO	Programme Focus	Target Groups	Future Plans
Ghana HIV/AIDS Network (GHANET)	➢ GHANET is an umbrella organisation for NGOs in Ghana ➢ Co-ordinates and strengthens the NGO response ➢ Information sharing with NGOs	200 registered NGOs	Plans to support regional and district levels networks.
Action Aid	➢ Peer Education in Northern and Upper East regions 1,500 peer educators ➢ Advocacy work to enlighten key government officials and policy development ➢ Support to the Ghana Red Cross-- peer education programme and other local NGOs ➢ PLWHA support through networks	Youth and adults Rural poor particularly in the northern regions and Brong Ahafo	Capacity building with the GAC
Family Health International	➢ Conducting training of trainers (peer counselling approach) in various sectors using behavioural change materials ➢ Capacity building within the NACP for STI management and strengthening of counselling and training. ➢ Work place programming for top management using advocacy. ➢ Rapid Response Fund for NGOs (max. is US $ 5000)	Private sector, Uniform services NGOs, traditional leaders and faith based organisations	Conducting research on the effectiveness of various approaches Starting a pilot project for treatment and ARV usage.
Ghana Social Marketing Foundation	➢ Peer educators reach commercial drivers at six transport hubs in five regions ➢ Condom promotion and sales ➢ Adolescent and reproductive health and HIV/AIDS education ➢ Audio visual vans and information officers reached out to over 3000 communities	Commercial Drivers Youth between 15 and 24 MPs to target people in their constituencie	To expand programming in rural areas They have initiated workplace programmes

Name of NGO	Programme Focus	Target Groups	Future Plans
		s	
Ghana Red Cross Society	➢ Implements HIV/AIDS education through first aid training ➢ Youth peer education programme "Action for Youth AIDS" is implemented in the northern regions and Kumasi area	Youth	
CARE International	➢ STI/AIDS prevention projects in mining areas of Western region	Miners and their families, youth and high risk groups	
Christian Health Association of Ghana (CHAG)	➢ Providing home based care for PLWHA through network of Volunteers in 4 regions	PLWHA, Mission hospitals	
African Commission on Health and Human Rights	➢ Reduce the levels of stigma and discrimination against PLWHAs ➢ Capacity building workshops ➢ Counselling services to PLWHA	PLWHA	
Wisdom Association	➢ Support Group for PLWHA in Greater Accra ➢ Training in Counselling	PLWHAs	

(Based on interviews, December, 2001)