GHANA COUNTRY AIDS PROGRESS REPORT

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GHANA AIDS COMMISSION

TABLE OF CONTENTS

Contents

LIST OF TABLES

TABLE OF FIGURES

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APOW	Annual Programme of Work
ART	Anti-retroviral Therapy
BSS	Behaviour Surveillance Survey
CCM	Country Coordinating Mechanism
CD 4	Cluster of differentiation Four
CEPEHRG	Centre of Popular Education and Human Rights
CRIS	Country Response Information System
CSO	Civil Society Organisations
CSW	Commercial Sex Workers
CT	Counselling and Testing
DA	District Assembly
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHMT	District Health Management Team
DOTS	Direct Observed Strategy Short course
DP	Development Partners
EKN	Embassy of the Kingdom of Netherlands
FHI	Family Health International
FSW	Female Sex Workers
GAC	Ghana AIDS Commission
GBCA	Ghana Business Coalition against HIV & AIDS
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GFATM	Global Fund for AIDS TB and Malaria
GHANET	Ghana HIV/AIDS Network
GHS	Ghana Health Service
GRMA	Ghana Registered Midwives Association

GRSP	Ghana Poverty Reduction Strategy
GIZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HRAC	Human Rights Advocacy Centre
IDU	Injecting Drug Users
ILO	International Labour Organization
JPR	Joint Programme Review
JUTA	Joint UN Team on HIV and AIDS
LEAP	Livelihood empowerment against Poverty
MARPS	Most At Risk Groups
MDG	Millennium Development Goals
MICS	Multi Indicator Cluster Survey
MLGRD	Ministry of Local Government and Rural Development
MOT	Modes of Transmission
MOWAC	Ministry of Women and Children Affairs
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACP	National AIDS/ STI Control Programmes
NAP+	Network of Persons Living with HIV
NCPI	National Composite Policy Index
NHIS	National Health Insurance Scheme
NSF	National Strategic Framework
NSPS	National Social Protection Strategy
PMTCT	Prevention of Mother to Child Transmission
POW	Programme of Work
PPP	Public Private Partnerships
RCC	Regional Coordinating Council
RCH	Reproductive and Child Health Services
RH	Reproductive Health
STI	Sexually Transmitted Infections
SWAA	Society of Women against AIDS

TAP	Treatment Acceleration Project
TB	Tuberculosis
TWG	Technical Working Group
UA	Universal Access
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAPCAS	West African Program to Combat AIDS and STI
WB	World Bank
WHO	World Health Organisation

I STATUS AT A GLANCE

1.1 Introduction

In 2001, one hundred and eighty-nine (189) Member States of the United Nations adopted the Declaration of Commitment on HIV/AIDS at a UN Special General Assembly Session on HIV and AIDS (UNGASS). The Declaration of Commitment represents a global consensus on a comprehensive framework to achieve the Millennium Development Goal (MDG) of halting and beginning to reverse the HIV epidemic by 2015. To facilitate the tracking of progress of implementation of the commitments, the UNAIDS developed core indicators to measure country and global level responses to the HIV epidemic. The UNAIDS has since 2001, collated and compiled country level reports into a global report of the HIV epidemic and response every other year.

This report is a national progress report. An interim review of advancement towards the UNGASS targets took place in 2003, 2005, 2007 and 2009. Ten years after the landmark UN General Assembly Special Session on HIV/AIDS (UNGASS), progress was reviewed at the 2011 UN General Assembly High Level Meeting on AIDS. A new Political Declaration on HIV/AIDS with new commitments and bold new targets was adopted.

The 2011 declaration builds on two previous political declarations: the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. At UNGASS, in 2001, Member States unanimously adopted the Declaration of Commitment on HIV/AIDS. This declaration reflected global consensus on a comprehensive framework to achieve Millennium Development Goal Six-: halting and beginning to reverse the HIV epidemic by 2015. It recognized the need for multisectoral action on a range of fronts and addressed global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The 2006 Political Declaration recognized the urgent need to achieve universal access to HIV treatment, prevention, care and support.

While these three declarations have been adopted only by governments, their vision extends far beyond the governmental sector to private industry and labour groups, faith-based organizations, nongovernmental organizations and other civil society entities, including organizations representing people living with HIV.

This report covers the period of 2010 and 2011 and represents a comprehensive set of standardized data on the status of the epidemic and progress in the response. This exercise is underpinned by Ghana's National Monitoring and Evaluation framework indicators which encompass most of the indicators utilised in this Country AIDS Response Progress Report.

The Objective of this document is to provide key constituents involved in the national response to HIV with essential information on core indicators that measure the effectiveness of the national response.

1.2 Methodology

The following methodologies were used in the compilation of this report

1. **Desk review**: Background documents on the HIV epidemic and response in Ghana and relevant international documents were reviewed. Documents included:
    a. Strategic documents; National Strategic Framework 2011 – 2015. Annual Programme of Work 2009 and 2010
    b. Programmatic Reports: Ghana AIDS Commission's Monitoring and Evaluation Report, 2008, National AIDS Control Programme, Annual reports,
    c. Population based survey reports: Ghana Demographic and Health Survey 2003 and 2008,
    d. Sub-populations survey reports; HIV Sentinel Surveillance Report 2007, 2008 and 2009, Multiple Indicator Cluster Survey (MICS) 2006, Modes of Transmission Study Report. Behavior Surveillance Survey 2006,
    e. Specialized surveys in specific population groups, programmatic data, National AIDS Spending Assessment 2007, 2008 and 2010.
    f. Programme Reviews: the National Composite Policy Index, Joint Programme Review (JPR) 2007 report,[i] and Ghana Country UNGASS Report, 2003, 2005 2007 and 2009,
    g. Epidemic and response synthesis, programme data and other relevant data sources.

2. Key Informant Interviews were conducted with Ghana AIDS Commission (GAC), National AIDS Control Programme (NACP), Key Ministries Departments and Agencies, NGOs, UN agencies, Bilateral Partners, development partners, CCM, private sector among others.
3. Stakeholder consultations and validation of the National Composite Index: A stakeholder workshop was organized with participants from the UN agencies, bilateral and multilateral development partners and the civil society organizations to complete the NCPI questionnaire. Thematic groups reviewed the various aspects of the HIV response and completed relevant sections of the questionnaire. Each thematic group worked in syndicate sessions and reconvened at plenary session to present and discuss results to obtain a final score for each section.
4. Data collection was facilitated by relevant data collection tools including the guidelines on construction of core indicators.
5. A draft Country AIDS Response Progress report was prepared and presented at a stakeholder forum on 29th March 2012 for validation and consensus building under the leadership of the GAC Research, Monitoring and Evaluation (RM&E) Committee. Feedback from the consultative forum was used to finalize the report.

1.3 Status of the Epidemic

The HIV epidemic in Ghana continues to be a generalised epidemic with a prevalence of more than 1% in the general population. (WHO definition for a generalised epidemic is when the prevalence is 1% or greater in the general population). According to the annual HIV sentinel surveys conducted among antenatal attendants, the HIV prevalence in the country seemed to be on a downward trend from 3.6% in 2003, to 2.7% in 2005, increased to 3.2% in 2006, reduced to 2.2% in 2008 (95% CI 2.18-2.22) and increased to 2.9% (95% CI 2.49 -3.31) in 2009 1-3. The HIV prevalence from the sentinel survey was 2.0% (CI 1.6-2.4) and 2.1% (CI 1.48 – 2.72) in 2010 and 2011 respectively. Using the EPP modelling for HIV the National HIV prevalence in 2009 was 1.9%, this dropped further to 1.5% in 2010 and also for 2011.

The HIV prevalence in Ghana varies with geographic areas, gender, age and residence. In 2010, in the 40 sentinel sites, HIV prevalence ranged from 0.4% in Krachi and Adibo (Rural) to 7.8% in Agomanya (Urban). In 2011 the lowest was Adibo0.0%, and the highest was Cape Coast with 9.6%. Two sites had a prevalence rate above 5.0% in 2011 as compared with one site in 2010. The prevalence in the urban sites was higher than in rural sites

In 2011 five regions, namely, Central, Easter, Greater Accra, Ashanti and Volta recorded an increase in HIV prevalence, the Brong Ahafo prevalence stayed the same and the remaining four regains recorded a decrease from their 2010 figures. The Regional prevalence ranged from 0.3% in the Northern Region to 4.7% in the Central Region.

In 2010, the prevalence was highest in 30 – 39 year age groups (2.8%) and lowest in 15 – 24 year age group, (1.5%). The prevalence in the young people aged 15 – 24 years dropped from 2.1% in 2009. In 2011 the prevalence was highest in the 30 - 34 year age group (2.9%) and lowest in the 20 - 24 year age group. The prevalence in the 15 – 24 year age group rose marginally to 1.7%, whiles that in the 15 – 19 year age group rose sharply to 1.9%.

HIV prevalence in most at risk group (MARPS) has been consistently higher than the general population. In 2009, the HIV prevalence among sex workers was 25.1% which is a decline from the 34% in 2006. (The modes of transmission study has indicated that low risk heterosexual sexual activity (30.2%), Casual heterosexual sex, (15.5%) and sex with partners of clients of sex workers (23.0%) contributed to most of HIV incidence in 2008[5]). The recent MARPs studies show that prevalence among FSW is 11.1% overall and for MSM 17.5%.

Knowledge and behaviour affect an individual's risk of acquiring HIV infection. HIV transmission is dependent on a number of behavioural and physical factors these include the number and nature of unprotected sex acts, and the number of sexual partners. Individuals who have multiple partners concurrently or sequentially have a higher risk of HIV transmission than individuals who have fewer links to a wider sexual network.

In the general population, though awareness of HIV is almost universal (98% for women and 99% for men) (DHS 2008), this has not translated into comprehensive knowledge and safe sexual behaviour. During this reporting period, there has been little change in the overall comprehensive knowledge of HIV. In 2006, 25% of females and 33% of males aged 15 - 24

years had comprehensive knowledge of HIV compared with 28.3% of females and 34.2% of males in 2008.

A major goal is to delay the age of sexual debut and premarital sexual activity because it reduces their potential exposure to HIV. From the DHS 2008 7.8% and 4.3% of young women and men aged 15-24 respectively had sexual intercourse before the age of 15.

The number of individuals with more than one partner in the past 12 months is monitored as a proxy to a reduction in sexual partners. In 2008, 11.3% of male and 1% of female respondents aged 15 – 49 years had more than one sexual partner in the past 12 months. Thus the males are more likely to have more than one sexual partner than the females. This indicator increased with age; 3.1% for males 15- 19 years, 9.6% for 20 -24 years and 44.6% in respondents 25 - 49 years.

Condom use is an important measure of protection against HIV. The extent to which condoms are used by people who are likely to have high risk sex is a measure of risk reduction measures being taken by such persons. In 2008, 26.2% of male respondents aged 15–49 who had more than one sexual partner in the past 12 months reported the use of a condom during their last intercourse. The same indicator was not measured for females, but was measured for high risk sex (defined as sexual intercourse with a non-marital, non-cohabiting partner). This showed 25.4% of females using a condom at their last sexual intercourse of risk. This indicator for men shows a gradual increase till age 25 and drops dramatically thereafter.

Though data on comprehensive knowledge for sex workers was not available, compared to the general population, female sex workers had a greater knowledge of HIV prevention and had fewer misconceptions. A greater proportion of FSW used condoms than the general population [8].

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. The proportion of persons aged 15 – 49 who received an HIV test in the past 12 months and know the results were 6.8% and 4.1% for females and males respectively.

In 2008 it was estimated that there were 236,151 adult and children were living with HIV (20,808 children) and there were a total of 22,541 new infections [9], while in 2009, there were 267,069 adults and children living with HIV (25,666 children). It was estimated that in 2008 63,137 adults and 6,086 children needed ART and in 2009 64,978 adults and 6,010 children were in need of ART. The estimated annual AIDS deaths for 2008 and 2009 were 18,082 and 17,058 respectively [9].

In 2010 it was estimated that there were 230,348 adults and children living with HIV(32,057) and there were a total of 14,165 new infections, while in 2011 there were 225,478 adults and children living with HIV((30,401 children) and there were 12,077 new infections. The estimated annual AIDS deaths for 2010 and 2011 were 17,230 and 15,263 respectively and for children in the same period 2,472 and 2080 respectively.

In 2011 ANC Prevalence has risen to 2.1% from 2.0% in 2010. It is estimated that of the 225,478 people were living with HIV in 2011 100,336 were males and 125,141 were females.

1.4. The policy and programmatic response

Ghana has a positive policy, advocacy and enabling socio-political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic. Ghana subscribes to the "three ones principles". The Ghana AIDS Commission was established by an ACT of Parliament as a supra-Ministerial Body with multi-sectoral representation [10]. It coordinates the national response with the involvement of key Ministries, the private sector, traditional and religious leaders and civil society in the design, planning, implementation, monitoring and evaluation of programmes.

Through various institutional arrangements such as the Partnership Forum, Technical Working Groups and decentralised structures such as the Regional and District AIDS Committees, and District Response Management Teams, the GAC interacts with all stakeholders and receives input and feedback towards the HIV and AIDS response and modifies priorities and interventions. The oversight and support function at the sub-national levels has been enhanced with the introduction of technical support units in all ten regions.

The National Response continues to benefit from improved strategic planning. In the period under review the National Strategic Plan for 2011 – 2015 was developed. In line with efforts to continue and sustain this progress, Ghana in collaboration with key partners and stakeholders has developed a National Strategic Plan on HIV and AIDS 2011-2015 (NSP 2011-2015) to direct the implementation of the national HIV and AIDS response over the next 5 years. The NSP was assessed through a Joint Assessment of National Strategies (JANS) Process which involved the participation if a wide range of stakeholders. The process was successful and the emerging gaps in the plan have since been effectively addressed.

The GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation and research as well as coordination of HIV/AIDS interventions. Since the development and implementation of the National HIV and AIDS Strategic Framework 2001-2005 (NSF I) and National HIV and AIDS Strategic Framework 2006-2010 (NSF II), Ghana has enjoyed improved strategic planning. The NSF II benefitted from the development of Annual Programmes of Work (APOWs) from 2006 – 2010 which served as the operational plans of the NSFII.

The NSP 2011-2015 is the result of over a year of preparatory work, starting with the development of Ghana United Nations General Assembly Special Session (UNGASS) Report 2010; reviews of the 2008 Ghana Demographic and Health Survey (GDHS) 2008, HIV Sentinel Surveillance (HSS) Surveys covering seven years, Estimation Projection Package (EPP) and SPECTRUM modeling; a Joint Review of the National HIV&AIDS Strategic Framework 2006-2010 and an epidemic synthesis and response analysis in order to anchor the NSP on evidence.

The NSP 2011-2015 emphasizes intensification of HIV prevention to reduce new HIV infections by 50% and also provides a broad framework towards virtual elimination of Mother-to-Child-Transmission (MTCT) of HIV in Ghana.

These plans have been operationalised with stakeholder involvement and through various mechanisms such as:

- Technical Working Groups: TWG on MARPs, ART, Research, Monitoring and Evaluation, Expanded TWG and Communication
- Task teams such on Gender and HIV, Stigma Reduction, PMTCT, Task, Universal Access, Decentralised Response, APOW task teams and the NSP 2011-2015 steering committee, World AIDS Day Planning Committees.
- The Partnership Forum
- Technical review meetings with implementing partners and stakeholders

These working groups, task teams have been institutionalised and hold regular planned meetings and provide a platform from which GAC engages its stakeholders from all sectors to provide input and disseminate information for the national response. A broad stakeholder base is involved in these groups and it is ensured that all key areas from the public, private and civil society (including religious, traditional leaders and PLHIV) are involved in all areas of planning and decision making. Furthermore other opportunities to engage stakeholder have been utilized such as the partnership framework with which the GAC and its advisory committee made up of the GAC, NACP, NAP+, Ghana Business Coalition, GHANET, UNAIDS and Ministry of Finance engages the USG and its implementing agencies [12].

The Government of Ghana through institutions such as GAC, National Development Planning Commission (NDPC)[13], Ministries, Departments and Agencies (MDAs), in collaboration with Civil Society including the Private Sector, UN Agencies, Multi–lateral and Bi-lateral Development Partners developed a number of Policies ,Guidelines, Strategic frameworks, Acts and related legal instruments to create an enabling environment to fight the HIV/AIDS epidemic in Ghana.

Within this reporting period, key guidelines and polices were developed or updated to guide implementation and other already developed policies or were made operational for implementation of the national response. Significant among these were:

1. Guidelines for antiretroviral therapy in Ghana by the NACP in 2011 and
2. Youth policy of Ghana by the ministry of youth and sports in 2010
3. National HIV testing and counseling manual 2010
4. PMTCT trainers manual 2010
5. Chronic care manual 2010
6. Acute care manual2010
7. PMTCT guidelines 2010

Due to availability of funds and immense effort of implementers in 2010 and 2011, prevention, care, treatment and support were scaled-up and the number of persons with access to services increased. In 2011, 51% of HIV positive pregnant women and 51.6% of adults and children with advanced HIV received ART services. Care services still lag behind the needs and the targets the country set for itself.

1.5. GARP Indicators

Table 1 Indicator Data

Name of Indicator	Indicator value 2008/ 2009	Indicator value 2010	Indicator value 2011	Comments (Data Source for 2010 and 2011)
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015				
Indicators for the general population				
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Males 15- 24 yrs 34.2% 15 -19 yrs 30.4% 20 – 24 yrs 39.1% Females 15- 24 yrs 28.3% 15 -19 yrs 27.2% 20 -24 yrs 29.0%	Data collected every five years	Data collected every five years	Ghana Demographic and Health Survey 2008
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before age of 15	Males 15- 24 yrs 4.3% 15–19 yrs 3.6% 20–24 yrs 5.2% Females 15- 24 yrs 7.8% 15 – 19 yrs 8.2% 20 – 24 yrs 7.2%	Data collected every five years	Data collected every five years	Ghana Demographic and Health Survey 2008
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Females 15- 49 yrs 1.0% 15 - 19 yrs 1.2% 20 - 24 yrs 1.6% 25 - 49 yrs 2.4% Males 15- 49 yrs 11.3% 15 - 19 yrs 3.1% 20 - 24 yrs 9.6% 25 - 49 yrs 44.6%	Data collected every five years	Data collected every five years	

Name of Indicator	Indicator value 2008/ 2009	Indicator value 2010	Indicator value 2011	Comments (Data Source for 2010 and 2011)
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse*	Females Males 15 - 49 yrs 26.2% 15 - 19 yrs 24.4% 20 - 24 yrs 49.2% 25 -29 yrs 42.8% 30 -39 yrs 19.6% 40 -49 yrs 3.5% 25 -49 yrs 22.07%	Data collected every five years	Data collected every five years	Data not available for females. Only higher risk sex is available Ghana Demographic and Health Survey 2008
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	Females 15 – 49 yrs 6.8% 15-19 yrs 2.6% 20-24 yrs 7.6% 25-49 yrs 24.2% Males 15 – 49 yrs 4.1% 15-19 yrs 1.6% 20-24 yrs 5.7% 25-49 yrs 13.3%	Data collected every five years	Data collected every five years	
1.6 Percentage of young people aged 15-24 who are living with HIV	1.9% (HSS 2008) 2.1% (HSS 2009)	1.5%		HIV sentinel surveillance 2009 & 2010
Indicators for sex workers				
1.7 Percentage of sex-workers reached with HIV prevention programmes	N/A	N/A	56.3%	Source IBBSS 2011
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	N/A	N/A	92.0%	Source IBBSS 2011
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	N/A	N/A	66.7%	The result does not indicate whether those tested knew their results. Source IBBSS 2011

Name of Indicator	Indicator value 2008/ 2009	Indicator value 2010	Indicator value 2011	Comments (Data Source for 2010 and 2011)
1.10 Percentage of sex workers who are living with HIV	N/A	N/A	Overall 11.1% Roamers 6.6% Seaters 21.4%	Only 77% consented to the test. Source IBBSS 2011
Indicators for men who have sex with men				
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	N/A	N/A	95.70%	These are preliminary figures
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A	60%	These are preliminary figures
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	N/A	N/A	26.30%	These are preliminary figures
1.14 Percentage of men who have sex with men who are living with HIV	N/A	N/A	17.50%	These are preliminary figures
Target 2.Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015				
Indicators				
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	N/A	N/A	Study yet to be commissioned
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	N/A	N/A	Study yet to be commissioned
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A	Study yet to be commissioned
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	Study yet to be commissioned
2.5 Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A	Study yet to be commissioned
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
Indicators				

Name of Indicator	Indicator value 2008/ 2009	Indicator value 2010	Indicator value 2011	Comments (Data Source for 2010 and 2011)
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	82.9% (2008) 54.9% (2009)	53.20%	74%	NACP Annual report 2010 & 2011 Annual Health Statistics
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		N/A	18%	Ghana AIDS Report 2011
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months		N/A	9%	Ghana AIDS Report 2011
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015				
Indicators				
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	2009 Adults 30.5% Children 14.8%	36%	52%	Ghana AIDS Report 2011
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		N/A	71%	Ghana AIDS Report 2011
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015				
Indicators				
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	24% (2009)		Total 18.6% Male 17.6% Female 19.5%	NSP 2011 - 2015 Ghana AIDS Report 2011 NTP Annual Statistics
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries				
Indicators				
6.1 Domestic and international AIDS spending by categories and financing sources				
Target 7. Critical enablers and synergies with development sectors				
Indicators				

Name of Indicator	Indicator value 2008/ 2009	Indicator value 2010	Indicator value 2011	Comments (Data Source for 2010 and 2011)
7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)				
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	5.2			%
7.3 Current school attendance among orphans and non-orphans aged 10–14	Orphans 67% Non-Orphans 86%			DHS
7.4 Proportion of the poorest households who received external economic support in the past 3 months				

II OVERVIEW OF THE HIV AND AIDS EPIDEMIC

The first case of HIV in Ghana was reported in March 1986. Since then HIV has been endemic in the country and has been classified as a generalized epidemic. (WHO definition of a generalized epidemic is when the prevalence is greater than 1% in the general population) By definition, the HIV prevalence among pregnant women has been consistently above 1% but has not exceeded 4%.

The last population-based survey on HIV prevalence carried out in Ghana was through the Ghana Demographic Health Survey (GDHS) of 2003. Results of the DHS 2003 indicated that 2% of adults age 15-49 were HIV positive (2.7% women and 1.5% men)[1]. Since then, HIV Prevalence in Ghana has been estimated based on sentinel surveillance of pregnant women attending in ANC and most recently through the Estimation and Projection Package (EPP) Modeling.

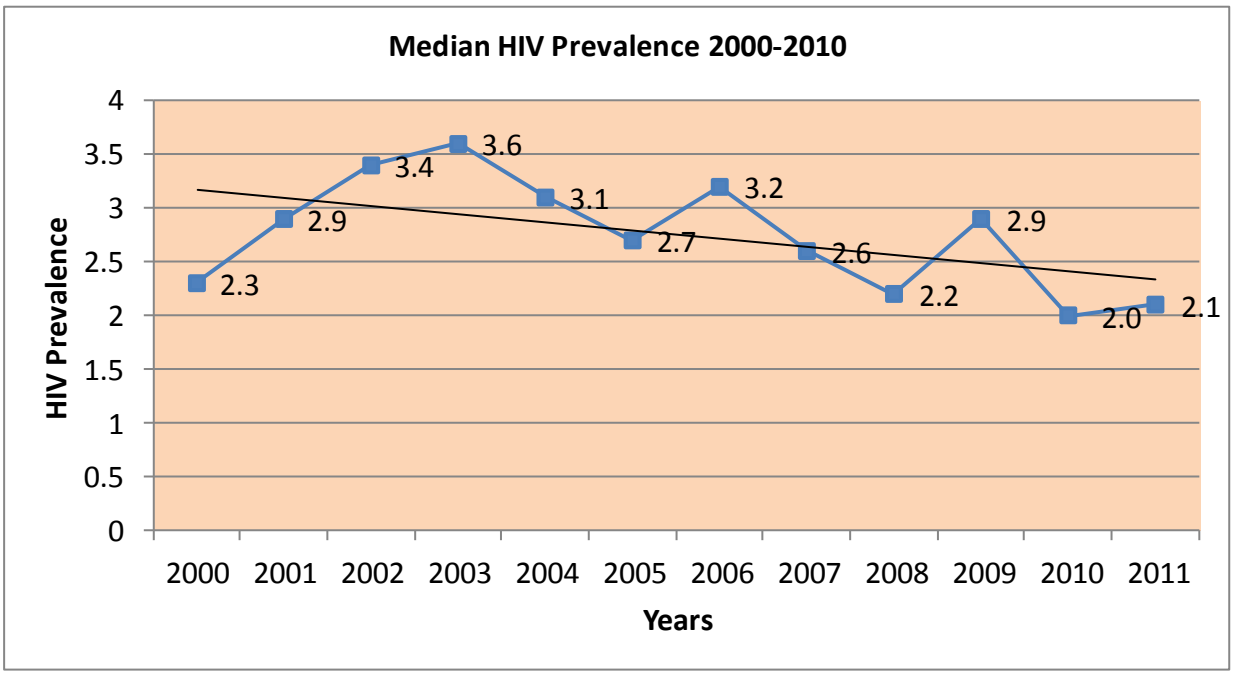
The EPP modeling (2008) estimated the national HIV prevalence among adults for 2007 to be 1.9% (range 1.7% - 2.2%) and urban and rural prevalence estimated at 2.3% and 1.7% respectively. In 2008, the estimated adult national prevalence was 1.7%. This rose to 1.9% in 2009 and dropped to 1.5% in 2010.

Data on the HIV prevalence among pregnant women is obtained from the HIV Sentinel Surveillance Survey (HSS). HSS data has been collected from antenatal clinic attendants at sentinel sites across regions of Ghana since 1992. The sentinel sites increased from 8 sites in 1992 to 40 sites in 2005, which have been maintained since then [1]. In all, 21 surveys have been conducted to monitor the trend and provide information on the HIV prevalence in Ghana. Over the last decade the median prevalence has stabilized.

The sentinel surveillance at ANC sites in 2011 indicated a median HIV prevalence of 2.1% (Confidence Interval 1.48-2.72). The trend in the median HIV prevalence from sentinel sites since 2003 shows three peaks: 2003 (3.6%), 2006 (3.2%) and 2009 (2.9%). Despite the increase of HIV prevalence from 2007 to 2009, a linear trend analysis shows that prevalence since 2000 is on a downward trend.

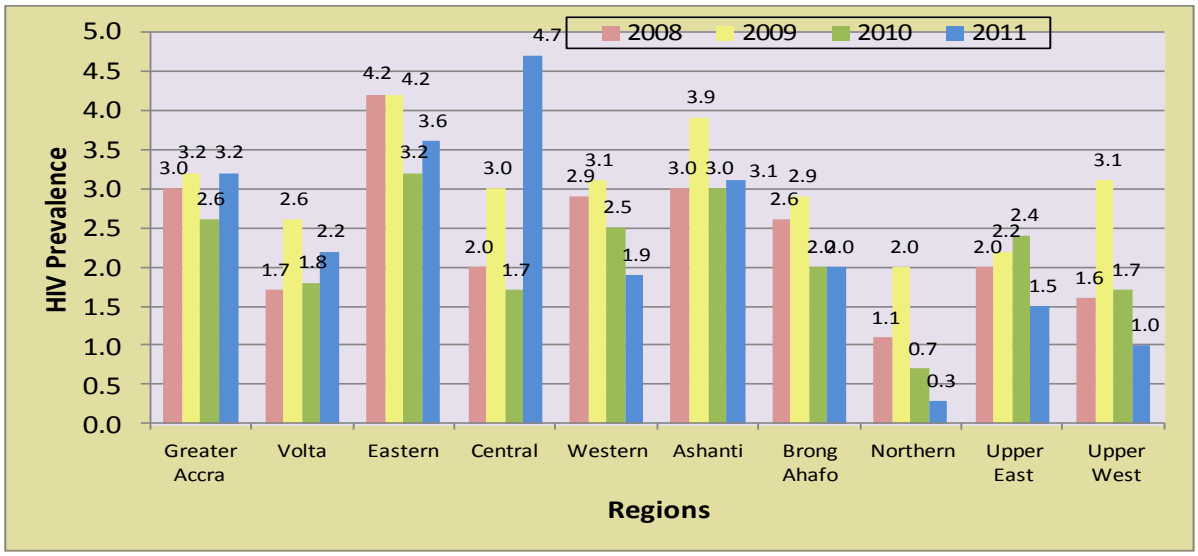
[1] GSS and ORC Macro, 2004

Figure 1 Median HIV prevalence 2000-2011, with linear trend



Source: HIV Sentinel Surveillance Report, 2011

Figure 2 Regional HIV Prevalence

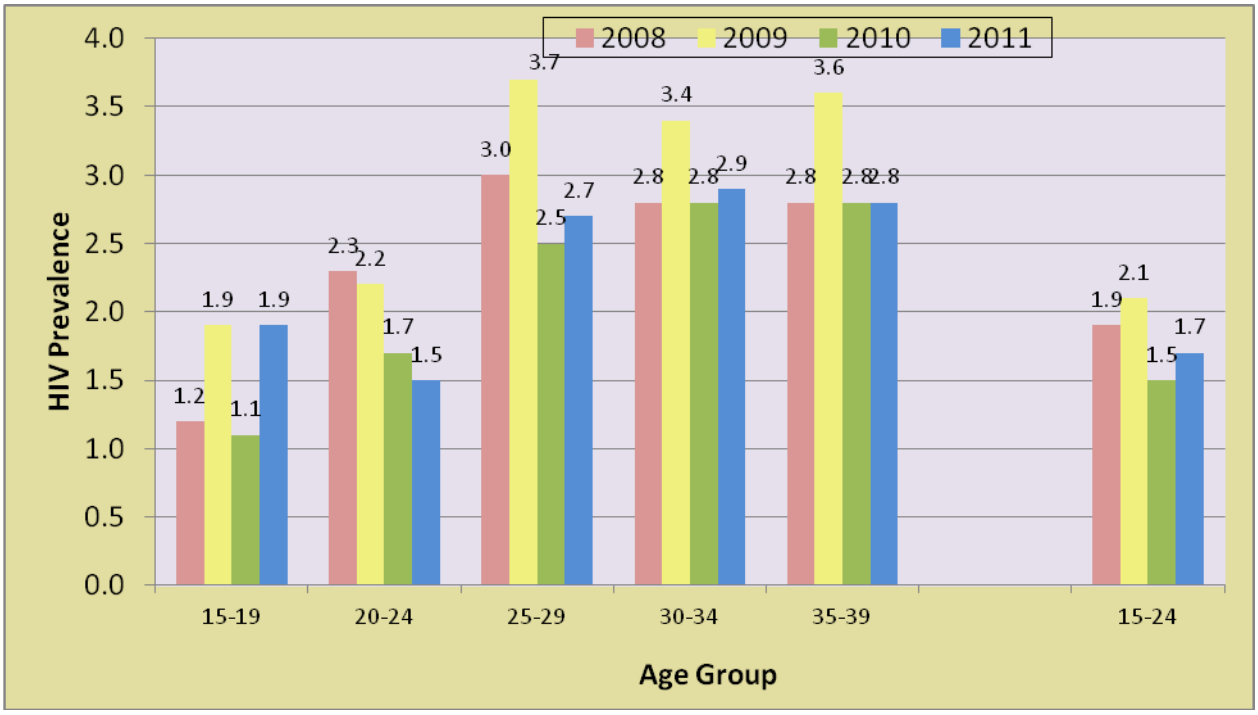


Source: HIV Sentinel Surveillance Report, 2011

In 2011 five regions, namely, Central, Easter, Greater Accra, Ashanti and Volta recorded an increase in HIV prevalence, the Brong Ahafo prevalence stayed the same and the remaining four regains recorded a decrease from their 2010 figures. The Regional prevalence ranged from 0.3%

in the Northern Region to 4.7% in the Central Region.. According to the HIV sentinel surveillance (2011), urban sites had higher prevalence (2.6%) than rural sites (1.4%).
HIV prevalence increased in all age groups except the 20 to 24 and 35 to 39 year groups. Only age group 20-24 years has witnessed consecutive declines over a four year period (2008-2011). The 15-19 year group has consistently remained the age group with the lowest mean prevalence prior to 2011.

Figure 3 HIV Prevalence by Age Group and Year 2008 - 2011



Source: 2011 HIV Sentinel Survey Report

HIV prevalence varies across age groups. In 2011, the prevalence was highest (2.9%) in 30 – 34 age group and lowest (1.5%) in the 20 - 24 age group. The prevalence in youth aged 15 – 24 years which is an indicator of new infections was 1.7% in 2011. The HIV prevalence in this age group has also seems to be stable. The prevalence increased from 1.9% in 2008 to 2.1% in 2009 dropped to 1.5% in 2010 and rose again to 1.7% in 2011 [3].

It is estimated that 230,348 people were living with HIV in 2010 (102,713 males and 127,635 females) and 32,057 were children. In 2010 there were 14,165 new infections and 17,230 annual AIDS deaths, 2,472 of whom were children. In 2011 225,478 were living with HIV (100,336 males and 125,141emales) and there were 12,077 new HIV infections (10,373 adults and 1,707 children) new infections with 15,263 deaths.

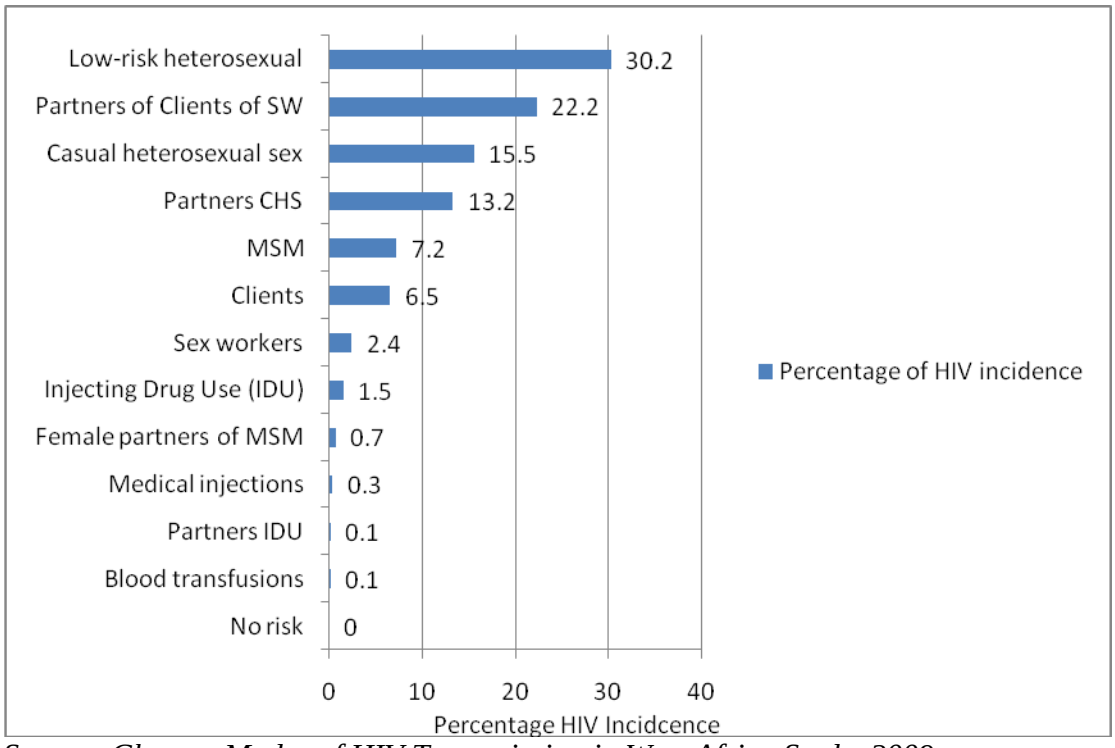
HIV epidemic among Most at Risk Populations (MARPs)
In Ghana, it is estimated that 80% of HIV infections are through sexual transmission[5]. A debate on the contribution of FSW and other most at risk populations (MARPs) to HIV incidence occurred after a study conducted by Cote *et al*. which estimated that 84% of infections were

attributable to sexual intercourse with FSWs [34]. The most at risk populations in Ghana include Sex Workers, clients of Sex Workers, Men Who Have Sex with Men (MSM) and Injecting Drug Users (IDUs). These populations are highly exposed to HIV infection due to their risky sexual behaviour and tend to contribute a significant proportion of new HIV infections[2].

A Modes of Transmission (MOT) study was undertaken in 2008 to determine the contributions of various population groups (aged 15 – 49 years) to HIV transmission. The findings suggest that HIV transmission occurs both among MARPs and High risk groups as well as within the general population. According to this study 13,437 new infections occurred in 2008 (i.e. an incidence rate of 125 per 100,000.)[5] The highest proportion of these infections occurred among the low-risk general population (30.2%), and individuals involved in casual heterosexual sex with non-regular partners (15.5%) and partners of clients of sex workers (22.2%). Sex workers and MSM contributed 2.4% and 7.2% to all new infections and respectively. The regular partners of high risk groups (IDU, FSW clients and MSM) together accounted for the second largest number of new infections (23.0%)[5].

Fig 2.4 gives an overview of the estimated proportion of new infections and their sources..

Figure 4 Distribution of new infections by modes of exposures[3]



Source: Ghana - Modes of HIV Transmission in West Africa Study, 2009

[2] HIV Epidemic Analysis report, 2010 Page8

[3] Clients refer to persons engaged in sex with female and male sex workers. Partners of clients are the spouses of clients of female or male sex workers.

Female Sex Workers (FSWs)

FSWs remain a key most at risk population with HIV prevalence several times higher than the national average. The contribution of sex workers to new HIV infections is 2.4%, whiles the contribution of clients of sex workers is 6.5%. Partners of clients of sex workers contribute 22.2%. (see Figure 4 above). The clients of sex workers constitute a bridging population spreading HIV to the general population.

Studies on sex work have been limited in geographical coverage until a recent Integrated Biological and Behavioural Surveillance Survey was conducted. This is the first national survey whose main objective was to collect data among the female sex workers and male populations who patronize female sex worker services. In this study mapping and size estimation of sex workers was undertaken.

The population of sex workers was estimated at 51,934 (47,786 – 58,920). The mean age of all FSWs in the study was 27.2 years with Seater sex workers on average, 9 years older than Roamers. More than thirty per cent (31.5%) of FSWs have ever been married. They have low levels of education; 13.6% have never been to school and 23% have only attended primary school education. Many of them (42%) reported to have engaged in commercial sexual intercourse before the age of 20.

The proportion of respondents who reported to having at least one non-paying partner was 60%. Over half of the respondents had between one and two non-paying partners. Condom use with commercial partners was general high. Over three-quarters (79.2%) of FSWs said that they used condoms every time they had sex (consistently) with a paying client whiles condom use with non-paying partners was low. Almost 40% of the respondents reported to have never used a condom with their husband/boyfriend(s) or pimp, while about one-third (35.3%) claimed they used it sometimes. Use of lubricants was low. Over two in five (42.6%) of the FSWs reported to have used a lubricant once in the last month before the study while 18.8% reported to have used a lubricant more than once. Majority of these used oil-based lubricants. About seven percent (7.1%) of FSWs reported to have ever engaged in anal sex.

Overall, over one-quarter of the respondents had been forced by a client (paying or non-paying) to have sex without a condom in the last 3 months before the study.

60% of FSWs have ever had an HIV test. Testing was more common among seaters (70.7%) than with roamers (55.0%).

The HIV prevalence among FSWs is currently 11.1%, down from 25% in 2009. The seater female sex workers had a higher prevalence of HIV. About one in five (21.4%) of the seaters are living with HIV compared to 6.6% of the roamers.

Overall, 73.6% of the respondents have HSV-2 with more Seaters infected (86.7%) as against 66.9% Roamers. In addition, respondents were HIV positive were more likely to have HSV-2. The data shows that 70.1% of HIV negative respondents had HSV-2 compared 95.1% of HIV infected respondents. HSV-2 is the most common cause of genital ulcer disease. In this study, high levels of HSV-2 consistent with results in other studies within the Sub-Saharan region were

observed. Low (1.7%) prevalence of *Chlamydia Trachomatis* (CT) and *Neisseria Gonorrhea* (NG) (2.0%) was observed across all regions. More than six percent (6.3%) of the female sex workers had syphilis.

Men Who Have Sex with Men (MSM):

In the past there is limited data on MSM in Ghana. The first bio-behavioural study conducted among MSM was in 2006. The study found a high HIV prevalence of 25.3% among this group with 62% being bi-sexual, 66% reporting paying for sex with men and 48% using condoms. However, the study oversampled young men who engaged in transactional sex and were HIV positive. The findings showed that MSM, though perceived to constitute a small proportion of the male population in Ghana, contributed significantly to the spread of HIV. The estimation of sources of new HIV infection (shown in Figure 4), indicate that MSM account for about 7.2% of new infections.

Results from a recent Integrated Bio-behavioural survey known as the Ghana Men's Study (2011) showed that 17.5% of MSM in Ghana are living with HIV. The survey established that 95.7% of MSM had been reached with HIV prevention programmes 12 months prior to the survey. 60% of Men who have sex with men reported using a condom the last time they had anal sex with a male partner. The study also found that 26.3% of men who have sex with men have received an HIV test in the past 12 months and knew their results.[4]

Injecting Drug Users (IDUs)

Data available on IDUs in Ghana is from prisons. A survey carried out among prison inmates in 2008 found that 11.4% of IDUs among prisoners were HIV positive[5]. However, the inmates are also exposed to other risks such as tattooing and MSM. The modelling of sources of HIV infections shown in Figure 4 estimates IDUs contribute about 0.1% of new HIV infections.

Men and women engaging in casual heterosexual sex

Men and women engaging in casual heterosexual sex are characterized by having sex with a non-marital and non-cohabiting partner. The DHS 2008 and 2003 show the percentage of males and female respondents who had more than one sexual partner in the last year, as well as the lifetime number of partners (Table 2). The Eastern, Ashanti, Greater Accra regions have higher proportions of men and women with more than one partner and higher numbers of lifetime partners. In both regions, more than one fifth of men report having multiple partners, and the proportion with multiple wives is lower than the national average. While it is possible that some men who report more than one partner, are not mutually exclusive from those who had a paid sex partner, the much higher levels of multiple sex partners compared to paid partners suggests a large portion of men actually have "casual heterosexual sex" with more than one partner.

[4] These results are preliminary and should not be quoted.

[5] Correlates of HIV, HBC, HCV and Syphilis infections among prison inmates and officers in Ghana: a national multicenter study, Adjei, AA Et al, 2008

Table 2 Percentage of women & men with more than one sex partner in last 12 months & mean lifetime sex partners

	% women with 2 or more partners in last 12 months (all women)		% men with 2 or more partners in last 12 months (all men)		% men with 2+ wives	Women: Mean # of lifetime partners	Men: Mean # of lifetime partners
Region	**2008 DHS**	**2003 DHS**	**2008 DHS**	**2003 DHS**	**2008 DHS**	**2008 DHS**	**2008 DHS**
Western	0.9	0.9	11.6	7.3	4.1	1.9	5.7
Central	0.5	1.5	7.1	10.7	2.9	2.1	5.6
Greater Accra	0.8	2.1	15.1	13.5	0.4	2.2	5.3
Volta	0.5	0.2	10.9	12.3	18.2	2	5.3
Eastern	2.4	1.4	11.7	10.3	5.2	2.3	6.7
Ashanti	0.2	0.8	15	8.7	8.6	2.3	5.9
Brong Ahafo	0.7	1.2	8.3	11.4	3.9	1.9	5
Northern	0.5	0.3	6.6	9.7	23.3	1.3	3
Upper East	1.1	0.6	9.1	4.7	13.4	1.2	3.7
Upper West	1.5	0.5	6.7	4.1	17.5	1.4	4
National	1.0	1.1	11.4	9.9	9.8	2.0	5.6

The table also shows an increase in the proportion of men with multiple partners between 2003 and 2008 across most regions except in Central, Brong-Ahafo and Northern Regions.

High-risk sexual behaviour

Table 3 shows data on levels of sexual activity across regions. These include the DHS reports on persons who had first sex before age 18.

Table 3 Percentage of men and women who have had sex disaggregated by age

	% who had sex in the last 4 weeks		Sex before aged 18 years (18-24 yrs)		% never married youth (15-24) sex in past 12 months	% never married youth (15-24) sex in past 12 months
Region	**2008 DHS (Men)**	**2008 DHS (Women)**	**2008 DHS (Men)**	**2008 DHS (Women)**	**2008 DHS (Men)**	**2008 DHS (Women)**
Western	41.1	42.8	26	39.4	22.3	24.3
Central	44.1	37	24.5	45.4	28.4	41.3
Greater Accra	44.2	37.6	26.7	32.1	31.7	33.1
Volta	32.9	41.6	31.6	44.7	20.4	22
Eastern	41.8	41.2	32.8	55.1	35.8	43.3
Ashanti	43.5	44.2	35.2	45.8	33.4	42.9
Brong Ahafo	46.1	46.4	46.9	51.7	47.9	39.9
Northern	26.9	29.9	7.2	41.8	16.8	19.7
Upper East	28.2	36.7	10.7	50.8	28.9	20.3
Upper West	27.4	32.2	18.2	51.1	19.8	32.6
National	41.4	39.9	27.7	43.9	29.5	34.2

Extent of HIV infection and its impact on various populations

The total estimated number of people living with HIV in Ghana by 2011 is estimated at 225,478, comprising about 100,336 men and 125,141 women. This figure is projected to decrease to 221,884 by 2015. It is also estimated that about 12,077 new infections occurred in 2011 with a projected decrease in annual new infections to 9,022 in 2015. The estimated number of AIDS related deaths in 2011 is 15,263 with a projected decrease to about 6,350 deaths in 2015. It was also estimated that 1,707 children were infected with HIV in 2011. The number of children

infected by HIV annually is expected to decrease to 824 in 2015[6]. Table 4 shows the summary of the projected estimates of new HIV estimates up to 2015 based on the SPECTRUM modeling.

Table 4 Summary of HIV estimates up to 2015

Summary of HIV population						
HIV/AIDS Summary						
	2010	**2011**	**2012**	**2013**	**2010**	**2011**
HIV population						
Total	230,348	225,478	222,124	220,659	220,684	221,884
Male	102,713	100,336	98,639	97,802	97,635	97,995
Female	127,635	125,141	123,485	122,857	123,049	123,890
Prevalence (15-49)	1.53	1.46	1.41	1.37	1.34	1.32
New HIV infections						
Total	14,165	12,077	10,961	10,292	9,630	9,022
Male	6,725	5,675	5,127	4,812	4,502	4,217
Female	7,440	6,402	5,834	5,480	5,128	4,805
Children 0-14	3,359	1,707	1,083	970	895	824
Annual AIDS deaths						
Total	17,230	15,263	12,658	10,131	8,047	6,350
Male	8,099	7,165	5,951	4,789	3,841	3,072
Female	9,131	8,098	6,707	5,342	4,205	3,278
Children 0-14	2,472	2,080	1,636	1,298	1,053	816

According to the DHS 2008, less than 1% of children under 18 years have both parents dead while 8% have one or both parents dead. AIDS contributes about 12% of the total orphans. Table 5 shows the projected number of orphans due to AIDS in the next five years based on SPECTRUM modeling.

Table 5 Projected number of orphans due to AIDS

	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Maternal orphans							
AIDS	96,259	101,440	104,512	106,070	106,432	105,885	104,723
Non-AIDS	401,568	406,668	411,071	414,743	417,693	420,027	421,821
Total	497,827	508,109	515,583	520,812	524,125	525,912	526,543
Paternal orphans							
AIDS	93,132	98,586	102,147	104,302	105,383	105,599	105,158
Non-AIDS	692,059	701,882	710,958	719,229	726,647	733,294	739,309
Total	785,192	800,468	813,105	823,531	832,030	838,894	844,466
Double Orphans							
AIDS	58,434	60,605	61,230	60,855	59,772	58,333	56,783
Non-AIDS	88,699	89,964	91,128	92,100	92,832	93,362	93,729
Total	145,053	150,123	153,268	154,864	155,336	155,010	154,240
Total Orphans	1,137,965	1,158,453	1,175,420	1,189,480	1,200,819	1,209,795	1,216,770
All AIDS Orphans	140,547	149,543	155,862	160,097	162,638	163,660	163,450
% of AIDS Orphans	12.4	12.9	13.3	14.5	13.5	13.5	13.4

[6] National HIV Prevalence and AIDS Estimates Report 2011-2015. NACP, 2010

Orphaned children are at a greater risk of dropping out of school due to lack of money or the need to take care of a sick relative. DHS 2008 found out that the proportion of children 0-14 attending school who have lost both parents is 67%. The ratio of orphans to non-orphans attending school is 0.76.

Determinants of spread of HIV in Ghana

The studies that have informed the identification of key determinants of HIV in Ghana include the Ghana DHS 2008, Modes of Transmission Study (2009) and the HIV epidemic analysis of 2010. The key determinants of HIV include the following:

1. ***Marginalisation of Most at Risk Populations***

MARPs (FSWs, MSM, and IDUs) have difficulties accessing HIV prevention services due to stigma and discrimination, social hostility, fear of losing jobs and families and even verbal and physical violence. Legal barriers also hinder service providers from reaching these groups given the criminalization of MARPs activities. The size of these populations is also not known and services may not be reaching a significant number of them. As a result the MARPs continue to contribute a significant proportion of new HIV infections.

2. ***Low condom use***

Although the awareness of HIV prevention among the general and most at risk populations is high, this knowledge has not adequately been translated to behaviour change. The DHS 2008 indicated that only 25% and 45% of females and males respectively reported using condoms during high risk sex behaviour.

3. ***Multiple concurrent partners***

DHS 2008 data shows that men tend to have more multiple sexual partners than women. 1% of women reported having more than 2 partners in the last 12 months during DHS 2008 compared to 1.1% during DHS 2003. On the other hand, the percentage of men reporting having more than 2 partners increased from 9.9% (DHS 2003) to 11.4% (DHS 2008). Secondly, the average lifetime partners among men are significantly higher among men (5.6) than women (2). This is partly attributed to the polygamous culture among some of the communities in Ghana. However, the practice exposes the partners, including older people who are more likely to be in polygamous relationship, to HIV infection.

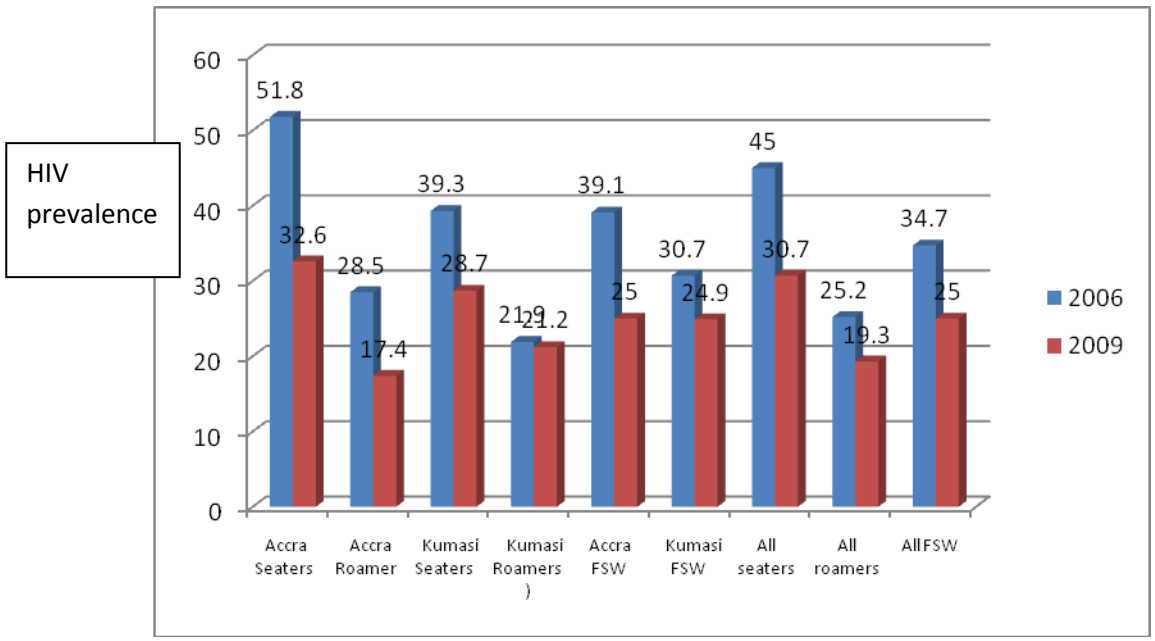
4. ***Stigma and discrimination***

HIV stigma and discrimination can be a hindrance to access to HIV prevention services resulting in exposure to HIV infection. HIV stigma and discrimination is a significant factor in Ghana. DHS 2008 shows that only 32% of women and 43% of men would buy fresh food from a shopkeeper living with HIV while 62% of women and 66% of men reported that an HIV positive teacher should be allowed to continue teaching. The percentage expressing accepting attitudes on all four measures of stigma and discrimination is just 11% of women and 19% of men aged 15-49. HIV related stigma hinders access to HIV services and consequently contributes to further new HIV infections.

5. ***Gender***

Women are disproportionately affected by HIV. Men who are clients of sex workers and those with multiple sex partners act as a bridge populations spreading HIV infection to their female partners. Men involvement in critical interventions such as consistent condom use and prevention of mother to child transmission of HIV is also limited. There is need to empower among women.

Figure 5 Trend of HIV prevalence in FSW in Ghana in 2006 and 2009



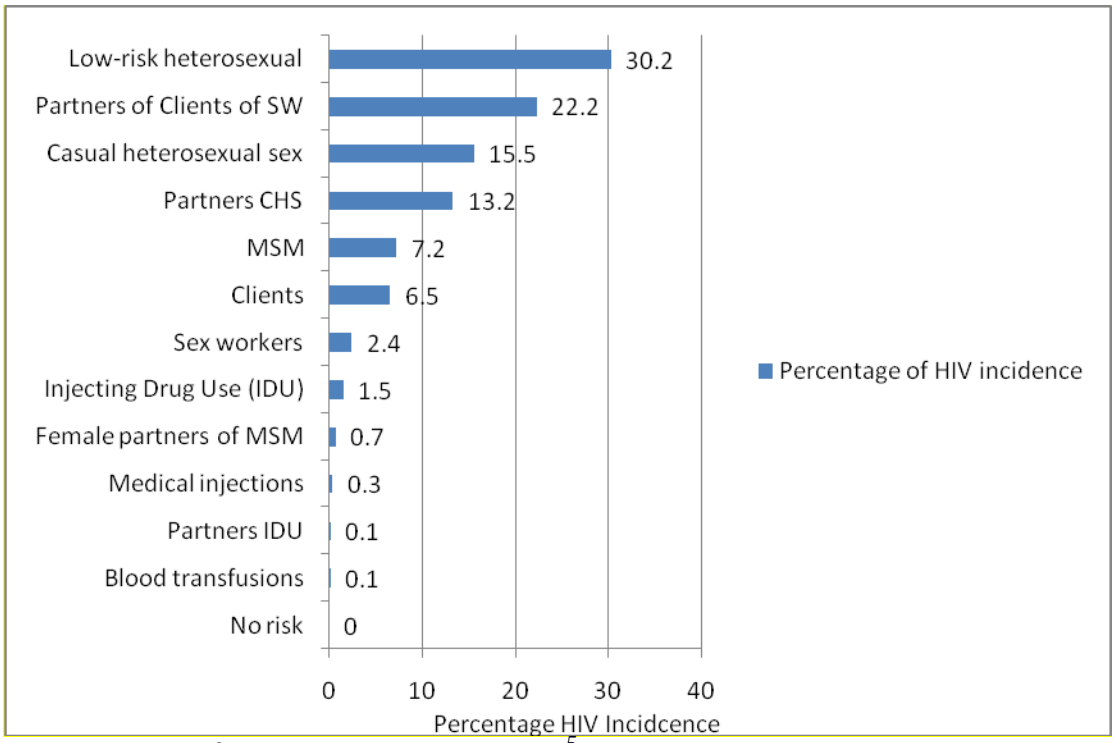
Source: Bio-behavioural Surveillance Survey 2008 [8]

In Ghana, most of HIV transmission is through sexual transmission [5]. A debate on the contribution of CSW and other MARP to HIV incidence occurred after a study conducted by Cote et al. which estimated 84% of infections were attributable to sexual intercourse with FSWs [34]. A Modes of Transmission (MOT) study was undertaken in 2008 to determine the contributions of various population groups (aged 15 – 49 years) to HIV transmission. The findings suggest that HIV transmission occurs both among MARPs and High risk groups as well as within the general population. According to this study 13,437 new infections occurred in 2008 (i.e. an incidence rate of 125 per 100,000.)[5] The highest proportion of these infections occurred among the low-risk general population (30.2%), and individuals involved in casual heterosexual sex with non-regular partners (15.5%) and partners of clients of sex workers (22.2%). Sex workers and MSM contributed 2.4% and 7.2% to all new infections and respectively The regular partners of high risk groups (IDU, FSW clients and MSM) together accounted for the second largest number of new infections (23.0%)[5].

The results are in line with the core group phenomenon which suggests a diffusion of HIV from a population of high HIV prevalence with numerous sexual partners through bridging population to the general population [34, 35]. As indicated in the MOT study, in the current stage of Ghana's epidemic, sexual networks within the general population also contribute considerably to HIV

transmission and are adequate to maintain a considerable level of prevalence within the Ghana's population.

Figure 6: Contribution of different population groups (aged 15 – 49) to HIV incidence in 2008



Source Modes of Transmission Study, 2009 [5]

The National Prevalence Estimates and Projections for 2008 to 2015 are based on the prevalence of HIV in the country. With the declining HIV prevalence the total number requiring ART is slightly reduced with each ensuing year.

III NATIONAL RESPONSE TO THE HIV AND AIDS EPIDEMIC

The national response to HIV and AIDS commenced with the formation of a Technical Committee on AIDS in 1985, a year before the first case was recorded. This Committee developed a short-term plan for AIDS prevention and control and set up the National AIDS/STI Control Programme (NACP) in 1987. The NACP under the Ministry of Health was responsible for prevention, management, and coordination of HIV and AIDS activities in the country and led the country through a medium term plan.

In 2000, the establishment of the Ghana AIDS Commission (GAC) and its enactment into law in 2002, marked the era of multi-sectoral response to HIV and AIDS. GAC, a supra-ministerial body was mandated to formulate a national comprehensive HIV/AIDS policy, provide high level advocacy, effective leadership, direct and co-ordinate the national response to HIV and AIDS response [10]. Since its inception, the GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation and research as well as coordination of HIV/AIDS interventions.

National Strategic Plan

Ghana subscribes to the "three ones principles" (One National Coordinating Authority, (the GAC (established through the enactment of law-ACT 613, 2002)), One National HIV and AIDS Framework, (NSF) and One National level monitoring and evaluation system coordinated by the GAC.

The National Strategic Framework 2001-2005 (NSF I) was developed and used to guide the implementation of the HIV and AIDS response. The NSF was developed within the context of the Ghana Growth and Poverty Reduction Strategy I, The NSF I focused on five intervention areas a) prevention of new transmission, b) care and support, c) creating and enabling environment d) decentralisation implementation and institutional arrangements and e) research monitoring and evaluation. Several policies, guidelines and strategic documents were developed to direct the implementation of a coordinated response [36].

Following a Joint Programme Review (JPR) of the National Response in 2004 and other reviews, which indicated that, the implementation of the NSF I (2001-2005) focused mainly on prevention as against the other components, the NSF II (2006-2010) was designed to focus on wider areas of interventions. The NSF II was developed within the context of the Ghana Growth and Poverty Reduction Strategy 2006 – 2010, Universal Access to Prevention, Treatment, Care and Support by 2010 and the achievements of the Millennium Development Goals by 2015.

Ghana's national response to HIV is spelt out in the National Strategic Framework 2006 – 2010 (NSFII), which was based on the national HIV/AIDS and STI Policy 2004. The framework is premised on the 1992 Constitution of Ghana, Ghana Government's Medium term Strategy document, Ghana Poverty Reduction Strategy, the revised Population Policy and the Millennium Development Goals.

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

The NSF II's seven areas of intervention were:

1. Policy Advocacy and Enabling Environment
2. Coordination and Management of the Decentralised Response
3. Mitigating the Social, Cultural, Legal and Economic Impacts
4. Prevention and Behavioural Change Communication
5. Treatment Care and Support
6. Research, Surveillance, Monitoring and Evaluation
7. Mobilisation of resources and Funding Arrangements [37, 38]

The strategic planning process has improved with wider stakeholder involvement and improved planning processes at the national level. The GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation and research as well as coordination of HIV/AIDS interventions. The NSF II benefitted from the development of APOWs from 2006 – 2010 which served as annual operational plans of the NSFII. These are costed operational plans for which specific interventions and expected output are provided to implementing partners to ensure the strategic framework is fully implemented [11]. This has been done with increased stakeholder involvement and through various coordination mechanisms such as:

- Technical Working Groups: TWG on MARPs, ART, Research, Monitoring and Evaluation, Expanded TWG and Communication
- A number of task teams such as Gender and HIV, Stigma Reduction, PMTCT, Task, Universal Access, Decentralised Response, APOW task teams and the NSF III steering committee, World AIDS Day Planning Committees.
- Partnership Forum and Business Meeting
- Technical review meeting with implementing partners and stakeholders

These working groups and task teams have been institutionalised and hold regular meetings and provide a platform by which GAC engages its stakeholders from all sectors to provide inputs and disseminate information for the national response. A broad stakeholder base is involved in these groups and it is ensured that all key areas from the public, private and civil society (including religious, traditional leaders and PLHIV) are involved in all areas of planning and decision making. Furthermore other opportunities to engage stakeholders have been utilized such as the partnership framework with which the GAC and its advisory committee made up of the GAC, NACP, NAP+, GBCA, GHANET, UNAIDS and Ministry of Finance engages the USG and its implementing agencies [12].

A number of Ministries Department and Agencies have had sectoral plan with specific budgets provided with funds for HIV activities since the implementation of the multi-sectoral strategy. These are Ministries of Health, Education, Manpower and Employment, Transportation, Interior (Police, Fire, Immigration, Customs, Prisons), Women and Children, Ministry of Youth and Sport, Ministry of Defence, Ministry of Justice, Ministry of Finance, Ministry of Trade and

Industry and Ministry of Agriculture. Each of the above named Ministries and their implementing agencies were provided with funds for HIV activities.

The National Development Planning Commission (NDPC) also requires that all sector ministries integrate HIV into their annual programmes and budgets before their plans are approved and funded. All aspects of HIV intervention areas are integrated into the sectoral plans, each MDA however intervenes in areas that it has comparative advantage (e.g. Ministry of Health: care and treatment), Ministry of Education; HIV prevention for the youth etc.)

On the strategic planning level the country continues in its quest towards Universal access to prevention, treatment, care and support services and the attainment of the Millennium development Goals by 2015. Using information from Estimates and Projections of National HIV prevalence and Impact in Ghana, the National Universal Access plan was developed for 2006 to 2010. This document defined strategies and target to be achieved by 2010 [42]. This scale-up plan is being supported with funds from the Global Fund to fight AIDS TB and Malaria, other multilateral and bilateral partners. The plan describes capacity gaps and the strategies for strengthening the health system through provision of equipment, infrastructure and monitoring systems for Health information and logistics management especially for the ART programme. The progress of the scale up is monitored programmatically by the National AIDS Control Programme at health facility, district, regional and national levels and by the Universal Access task team set up for that purpose.

The NSF I, and II benefited from programme reviews (Joint Programme Review I, and II) in 2004 and 2007 to evaluate the level of implementation of the NSF and to inform the interventions for subsequent years. The two reviews determined progress towards achievements towards NSF I and II objectives and informed programmatic decisions. Additionally an assessment of the Universal Access targets was conducted and indicated Ghana achieved and exceeded the targets for eight out of the thirteen targets. Four indicators were lagging behind and were not on track to being achieved at the level of implementation. These were indicators on the comprehensive knowledge of HIV and AIDS, PMTCT, ART treatment for adults and children and HIV prevalence in the 15–24 age group. The report "concluded that concerted and coordinated effort should be harnessed to enhance available human, technical and financial resources to achieve the Universal Access targets for 2010" [43].

Based on the new evidence on the epidemic and information on the coverage of services, Ghana's Multi-sectoral strategy has included a wider range of target populations and settings for prevention, treatment care and support. The target populations include women, young people, orphans and vulnerable children, MSM, FSW and their partners, uniformed service personnel and their families, STI and TB patients, persons living with HIV and AIDS, prison inmates and other vulnerable groups such as refugees, market porters etc. The settings in which interventions are provided include communities, workplace, schools and prisons. Various cross cutting issues have been mainstreamed into interventions. These include HIV and Poverty, Human rights and social protection, greater involvement of PLHIV, addressing stigma, gender empowerment and gender equality.

In line with efforts to continue and sustain this progress, the Ghana AIDS Commission (GAC) in collaboration with key partners and stakeholders has developed a new National Strategic Plan on HIV and AIDS 2011-2015 (NSP 2011-2015) to direct the implementation of the national HIV and AIDS response.

In the period under review the National Strategic Plan for 2011 – 2015 was developed. The NSP 2011-2015 is the result of over a year of preparatory work, starting with the development of Ghana United Nations General Assembly Special Session (UNGASS) Report 2010; reviews of the 2008 Ghana Demographic and Health Survey (GDHS) 2008, HIV Sentinel Surveillance (HSS) over the last 7 years, Estimation Projection Package (EPP) and SPECTRUM modelling; a Joint Review of the National HIV&AIDS Strategic Framework 2006-2010 and an epidemic synthesis and response analysis in order to anchor the NSP on evidence.

The development of the NSP 2011-2015 itself, which was carried out between June and November 2010, has been based on the broad participation of all partners and stakeholders involved in the national HIV and AIDS response. This Strategic Plan emphasizes intensification of HIV prevention to reduce new HIV infections by 50% and also provides a broad framework towards virtual elimination of Mother-to-Child-Transmission (MTCT) of HIV in Ghana.

The NSP has been subjected to a Joint Assessment of National Strategy (JANS) process with local and external experts and involved the participation if a wide range of stakeholders undertaking a critical review of the document. The process was successful and the emerging challenges have since been effectively addressed and the Plan revised accordingly.

The process of joint assessment, analysis and consultative nature of the development of the NSF II and NSP (2011-2015) has resulted in better planning, budgeting and funding and direction for implementation of prioritized activities over the reporting period.

The average NCPI score for strategic planning was at 8 for 2007, 7.25 for 2009 and 9 for 2011. Achievements over the period of 2010 to 2011 were:

- Government pledge of $100m for five years
- Costed strategy with Operational Plan using broad based processes at all levels
- Development of Medium Term Plan for decentralized structures
- Partnership Forum looking at annual program of work for the year

The remaining challenges in strategic planning for 2010 and 2011 were:

- High human resource turn over
- Coordination within each sector as well as supra-ministerial coordination
- Weak health systems
- Weak community systems
- Inadequate resource contribution by the central Government to enable the country move forward on its own agenda
- Weak M& E system in some sectors

Political Support And Leadership

National AIDS Spending Assessment

As the national response to HIV and AIDS continues to scale up, it is important to track how funds are spent at the national level and where funds originate. This is a measure of national commitment and action to the response. Such data can assist national decision makers to monitor the scope and effectiveness of their programmes.

To date, five National AIDS Spending Assessments (NASA) have been conducted and the results are systematically fed into the Country's Country AIDS Response report. The overall objective of the NASA assessment is to track transactions of total public, private and foreign (international) spending on HIV and AIDS across different sectors. The assessment tracks expenditure across eight programmatic areas namely: Prevention; Treatment and care; Orphans and vulnerable children; Programme management and administrative strengthening; Incentives for human resources; Social protections and social services; Enablement of environment and community programmes; and Research.

In this report data is taken from the National AIDS Spending Assessment (NASA) draft report of 2010.
HIV and AIDS funding has three main mechanisms which the Government of Ghana (GOG) and the development partners utilise to channel funds for the implementation of APOW of the NSF.

These are:

- Pooled funds: funds are pooled by development partners and given directly to GAC for implementation of the response,
- Earmarked; funds earmarked for special government institutions and NGOs
- Direct funding; funding provided directly to the implementing agencies by DPs

In 2010, US$158,764,061 was provided for in the HIV and AIDS budget. Funds from international organisations formed 77% of total spending on HIV and AIDS; public funds formed 13 percent of the total expenditure.

International organisations are mainly the UN agencies, Global Fund, the World Bank, USAID, DANIDA, GIZ and other international for-profit and not-for-profit organisations active in HIV and AIDS programmes in Ghana. Of the contribution by International Organizations, Multilateral funds formed 65% of the total followed by 19% from International not-for-profit organizations and foundations and 16% from direct bilateral partners. Funds from GFATM formed 88% of the total funds from multilaterals in Ghana. Out of the total funding by international organisations only 21% (US$10,263,810) was sent to the pooled or earmarked fund overseen by the GAC, the remaining 79% of funds was sent directly to implementing agencies.

There was overall increase in spending (of about US$ 13,594,151) from US$54,228,388 in 2009 to $62,147,564 in 2010. In 2010 significant reductions in spending was noted in OVC programs, Human Resources, social protection and social services as well as HIV related research. (Table 6)

Table 6 Spending Priorities, 2009- 2010

Key areas of Expenditure	2009 (US$)	2010 (US$)	Increase in spending (%)
Prevention	9,231,209	12,051,631	30.6%
Care and treatment	17,046,501	21,467,922	25.9%
Orphans and vulnerable children	621,251	261,175	-58.0%
Programme management and administration	17,315,220	20,108,990	16.1%
Human resources	5,813,156	4,807,684	-17.3%
Social protection and social services (excluding OVC)	724,284	282,872	-60.9%
Enabling environment	2,283,057	2,252,151	-1.4%
HIV and AIDS-related research (excluding operations research)	1,193,710	915,139	-23.3%
Grand Total	**54,228,388**	**62,147,564**	14.6%

NASA 2009, 2010 draft

Table 6 shows a significant increase in spending on prevention activities between 2009 and 2010. It can be argued that this was in reaction to the worsening HIV prevalence situation in 2009, when it was suggested that too much of resources had been taken from prevention in favour of treatment and care. In 2010 the NACP supervised and supported the establishment of 251 HTC centres across the country as a key strategy to in preventing new infections and re-infection among the general population. For the first time in the history of the program, over one million people were tested for HIV within one calendar year through the HTC centres and the "Know Your Status Campaigns". More than 100,000 additional clients were reached for PMTCT in 2010 with more than 1,200 clients over and above the 2009 figure being put on ARV prophylaxis. There was modest increase in the number of blood units screened from approximately 160,000 units to 192,000 units.

By far the greatest expenditure for Prevention activities is in the area of communication for social and behavioural change and BCC as part of programmes for vulnerable and accessible populations, (36% and 18% respectively of the prevention expenditure).

Table 7 shows the amounts funding agents spent on key intervention areas in 2010. The majority of the funds, US$48,015,481 (77.3%) was sourced from international organisations, US$8,087,144 (13.0%) was provided through public funds and private sources (private individuals/households) of funding was US$6,044,939 (9.7%). The GFATM, The World Bank and Bilateral agencies were the key sources of funding in 2010 and 2011.

Table 8 shows the contribution of funding agents to each of the key priority intervention areas.

Table 7 Relative spending on key priorities by each funding agent

Key Priority Areas	Public sector	%	Private sources	%	International Organisations	%
Prevention Programmes	2,233,421	20	167,968	3	9,650,242	20
Treatment and care components	2,271,952	28	5,731,690	95	13,464,280	28
Orphans and Vulnerable Children	1,398	0	0	0	259,777	1
Programme Management & Administrative Strengthening	1,610,745	20	114,748	2	18,383,497	38
Incentives for Recruitment & Retention of Human Resources	1,200,785	15	30,533	1	3,576,366	7
Social Protection and Social Services(excluding OVC)	0	0	0	0	282,872	1
Enabling Environment and Community Development	512,017	6	0	0	1,740,134	4
HIV- and AIDS-Related Research (excluding operations research)	256,826	3	0	0	658,313	1
Grand Total	**8,087,144**	**100**	**6,044,939**	**100**	**48,015,481**	**100**

Table 8 Contributions to spending on each key priority area by Funding agent

Key Priority Areas	Prevention Programmes	Treatment and care components	Orphans and Vulnerable Children	Programme Management & Administrative Strengthening	Incentives for Recruitment & Retention of Human Resources	Social Protection and Social Services(excluding OVC)	Enabling Environment and Community Development	HIV- and AIDS-Related Research (excluding operations research)
Public sector	2,233,421	2,271,952	1,398	1,610,745	1,200,785	0	512,017	256,826
Public sector %	19%	11%	1%	8%	25%	0%	23%	28%
Private sources	167,968	5,731,690	0	114,748	30,533	0	0	0
Private sources %	1%	27%	0%	1%	1%	0%	0%	0%
International Organisations	9,650,242	13,464,280	259,777	18,383,497	3,576,366	282,872	1,740,134	658,313
International Organisations %	80%	63%	99%	91%	74%	100%	77%	72%
Grand Total	**12,051,631**	**21,467,922**	**261,175**	**20,108,990**	**4,807,684**	**282,872**	**2,252,151**	**915,139**
%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

It should be noted that the public spending does not include salary of public health and non-health personnel in HIV and AIDS related activities and cost of the use of public health facilities.

Table 9 shows the relative spending on key intervention areas in 2009 and 2010. According to the report a greater proportion of funds spent on prevention in 2010 compared with 2009. A marginal increase on spending on Treatment, care and support was noted from 31.4% of funds in 2009 to 34.5% of the finds in 2010. Overall however, treatment care and support still receives most of program implementation funding probably because of the cost of the intervention. A marginal increase in relative spending was also noted in the programme management and administrative strengthening.

Table 9 Trend in Relative spending on key intervention areas, 2009 and 2010

	2009 US$	Percentage of total spending (%)	2010 US$	Percentage of total spending (%)
Prevention	9,231,209	17.0%	12,051,631	19.4%
Care and treatment	17,046,501	31.4%	21,467,922	34.5%
Orphans and vulnerable children	621,251	1.1%	261,175	0.4%
Programme management and administration	17,315,220	31.9%	20,108,990	32.4%
Human resources	5,813,156	10.7%	4,807,684	7.7%
Social protection and social services (excluding OVC)	724,284	1.3%	282,872	0.5%
Enabling environment	2,283,057	4.2%	2,252,151	3.6%
HIV and AIDS-related research (excluding operations research)	1,193,710	2.2%	915,139	1.5%
Grand Total	**54,228,388**	**100.0%**	**62,147,564**	**100.0%**

Table 9 also shows that in 2009 the total amount spent on prevention was US$9,231,209 which fell short of the of total of US$12,329,108 by approximately $3 million required for the programme implementation in that year . The total amount spent on prevention activities in 2009 compared with 2010 saw an increase from US$9,231,209 to US$12,051,631. This expenditure also fell short of the requirement of US$40,931,837[7] projected for that year. Out of the total amount, funds provided for HIV and AIDS, prevention increased from 17%% to the 19.4% of the total expenditure.

In the same period, the amount spent on treatment care and treatment increased from US$17,046,501 to US$21,467,922, increasing from 31.4 % to 34.5 % of the total expenditure. In 2010, a substantial investment was made in putting an additional 12,920 PLHIV on HAART as compared to a similar increase on 9,409 in 2009, representing an additional annual scale-up of

[7] HIV and AIDS Program of Work 2010

3,511 clients. This was accompanied by substantial investments in marinating infrastructure in 62% of Metropolises, Municipalities and Districts as well capacity building of service providers. The current investments are mainly for the Anti-retroviral drugs (37.2% of the treatment and care expenditure in 2010)

Targeted cost-effective interventions are critical in the response to HIV and AIDS. The Modes of Transmission study indicated the contribution of various population groups to HIV transmission in Ghana. Although low risk heterosexual contact contributes considerably (30%) to HIV transmission, partners of clients of sex workers (15.5%), Casual heterosexual sex (13.2%), MSM (7.2%) and clients of sex workers (6.5%) also contribute considerably to HIV transmission [5]. Targeting these populations with effective HIV intervention would result in reduction in HIV transmission.

The NASA 2010 report also indicates that spending on activities/services excluding ART for PLHIV and MARPS was 25% and 2% respectively of the total spending.

Figure 7 Overview of Spending by Beneficiary Group, 2010

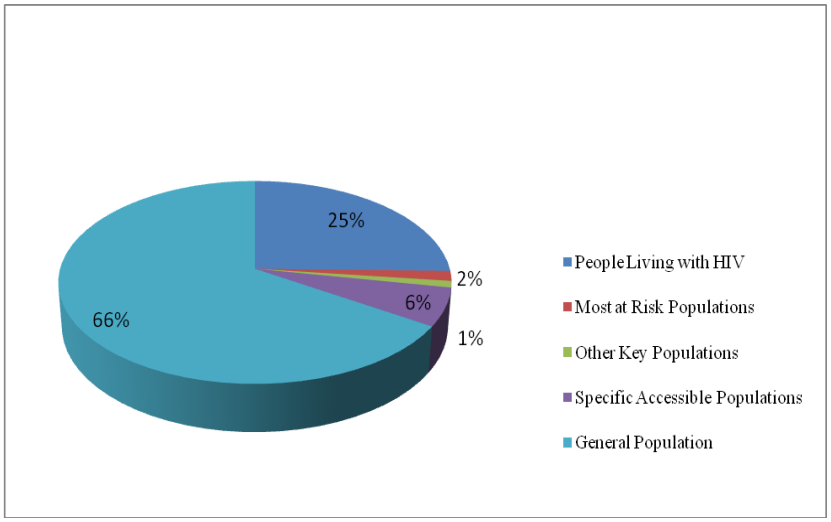


Table 10 HIV and AIDS related Spending by Beneficiary Groups, 2010 (US$)

BENEFICIARY GROUPS	Amount	% Within Beneficiary Group	% Within Total Expenditure
PLHIV			
People living with HIV not disaggregated by age or gender	15,747,863		
Sub Total	**15,747,863**	**100.00**	**25.3**
Most at Risk Populations			
Female sex workers and their clients	872,077	88.94	
Men who have sex with men (MSM)	31,211	3.18	
Most at risk population not disaggregated by tpe	77,201	7.87	
Sub Total	**980,489**	100.00	**1.6**
Other Key Populations			
Orphans and vulnerable children (OVC)	455,325	70.88	
Refugees (externally displaced)	100,000	15.57	
Children and youth out of school	87,102	13.56	
Sub Total	**642,427**	**100.00**	**1.0**
Specific "Accessible " Populations			
Junior high/high school students	585,211	15.48	
University students	20,226	0.53	
Health care workers	70,150	1.86	
Factory workers	136,483	3.61	
Specific "accessible " populations not disaggregated by type	2,947,714	77.95	
Specific "accessible " populations not elsewhere classified	21,672	0.57	
Sub Total	**3,781,456**	100.00	**6.1**
General Population			
Female adult population	61,507	0.15	
Youth (age 15 to 24 years) not disaggregated by gender	1,295,947	3.16	
General adult population (older than 24 years) not disaggregated by age or gender	289,389	0.71	
General population not disaggregated by age or gender.	39,348,486	95.98	
Sub Total	**40,995,329**	100.00	**66.0**
TOTAL	**62,147,564**		

The Policy And Coordination Environment

The Ghana AIDS Commission was established by an Act of Parliament as a supra–ministerial body with multi-sectoral representation [44]. It is a national coordination body with well defined terms of reference and has active Government participation. It is chaired by the President of the Republic of Ghana. It has a defined membership with the Ministers of State from the Ministry of Finance and Economic Planning, Health, Education, Manpower and Employment, Local Government and Rural Development, Youth and Sports, Tourism, Roads and Transport, Food and Agriculture, Defence, Women and Children's Affairs, Interior, Justice, Trade and Industry and Information, Ministry of Employment and Social Welfare and other MDAs. It also has representation from, Parliament, The Trade Union Congress, Christian Council, Christian Health Association of Ghana, Ghana Medical Association and other health profession organisations, Ghana HIV/AIDS Network and the National AIDS Control Programme, Ghana Employers Association and the civil society representatives including people living with HIV Associations, The Ghana HIV/AIDS Networks and the private sector. The Commission has four technical committees including the steering committee, programme committee resource mobilization and Research Monitoring and Evaluation committees and each of these committees have broad representation from MDAs, private sector, development partners, civil society including PLHIV [36]

The GAC has a functional secretariat responsible for the day-to-day coordination, management of funds and supervision of HIV and AIDS related activities. During the period government provided office space for the secretariat, moved staff from Donor to government payroll, increased staff strength from 27 to 60.

Through various institutional arrangements such as the Partnership forum, Technical Working Groups and decentralised structures such as the regional and District AIDS Committees the GAC interacts with all stakeholders and receives inputs and feedback towards the HIV and AIDS response and modifies priorities and interventions. A Partnership forum is organized annually with MDAs, Bi-laterals and Multi-lateral institution as well as the civil society organizations including PLHIV. These meetings review progress of implementation each year and reviewed the annual program of work for the ensuing year. In 2010 and 2011 these partnership fora created the avenue for partners to pledge their commitment to support the national response and the Annual Programme of work of the ensuing year. In 2011 the funding challenges facing the program were prominent in discussions.

HIV and AIDS activities have over the years received strong political support. This includes government and political leaders who include HIV and AIDS messages in their public speeches.

The President, Vice President and Ministers spoke publicly about HIV and AIDS on a number of occasions. In June 2011, the Vice President, H.E. John Dramani Mahama led a government delegation to the UN General Assembly High Level Meeting on AIDS. The session, which marked thirty years into the fight against the AIDS epidemic, reviewed progress and chart the future course of the global AIDS response. At the meeting the Vice President said that in Ghana, HIV/AIDS is a visible and key component of Ghana's Shared Growth and Development Agenda and is therefore accorded a high level of political commitment, with leadership of the Ghana AIDS Commission placed directly under the Office of the President.

The Vice President also launched the World AIDS Day activities at a durbar in Takoradi in 2010, and also launched the NSP 2011-1015. He also addressed a durbar in Obuasi on December 1st 2011 to mark that year's World AIDS Day, which focused on the role of the youth in preventing new infections and discrimination against infected persons.

The main challenges identified in the area of political support are:

- insufficient financial commitment for activities,

Respondents rated political support efforts in HIV and AIDS programmes in 2009 at 7.3. In the 2011 political support was rated at 8.

Human rights

Currently, Ghana has a draft HIV and AIDS law. There are laws that protect PLHIV against discrimination, address their specific rights and needs as well as protecting vulnerable populations such as women and young people. The spirit and letter of the 1992 Constitution also prohibits discrimination against individuals based on disease or disability.

However a number of laws also exist which are obstacles for successful implementation of HIV prevention and care programmes in the country (See below).

On the other hand numerous polices have been developed to address HIV issues, however these do not wield the same level of compulsion as laws do.

Laws and Policies relating to HIV and AIDS

Many of Ghana's laws and policies indirectly support the human rights issues related to HIV and AIDS. Notable among them are:

- Ghana's Constitution 1992: This protects persons against discrimination and upholds fundamental human rights. Specifically;
- Article 17 " All persons shall be equal before the law, A person shall not be discriminated against on the grounds of gender, race, ethnic origin, religion, creed or social economic status" [45]
- Article 18 "no person shall be subjected to interference with the privacy of …. Correspondence or communication except in accordance with law as may be unnecessary in a free and democratic society" [45] This deals with disclosure and confidentiality.

Other laws are:

- The Labour Act, 2003 (Act 651): This deals with workplace discrimination including issues of annual leave, sick leave and unfair termination. It also ensures that workers work under safe, satisfactory and healthy conditions [46]. This provides for adequate protection for workers to be protected from contracting HIV on the job e.g. health workers.
- Labour Decree 1967, NLCD 157 [47]
- Industrial relations Act 1965, Act 299 [48]

- Workman Compensation Law 1987 [49]
- Factories, Offices and Shop Act 1990, Act 328 [50]
- Patients Charter 2002 [51]
- Ghana AIDS Commission Act, 2002 (Act 613)[44]: deals with the setting up of the Ghana AIDS Commission
- The Children's Act 1998 (Act 560): deals with the rights of children and the right to education, health care and shelter [52].
- The Domestic Violence Act 2007: that protect women and men against domestic violence [53].
- The laws also deal with issues of willful and or negligent transmission and the responsibilities of PLHIV such as Criminal Code 1960 (Act 29) section 76, 72 and 73 [54].
- The quarantine Ordinance CAP 77 (Law # 2, 1915) [55] and the Infectious Disease Ordinance CAP 78 ([56]) [56] were laws passed before the onset of HIV and AIDS. These laws cover infectious diseases and provide for the evacuation of affected areas, isolation, removal and detention of contacts. These laws will be reviewed and consolidated into a new Public Health Act to make the right to health care basic to all Ghanaians. Under the Public Health Act HIV&AIDS shall be notifiable conditions without identification of individuals.
- Civil Service Law , PNDC L327 [57]
- Civil Service (Interim) Regulations [58]

Polices that affect HIV and AIDS exist: The difficulty, however is that polices are administrative measures which do not wield the same level of compulsion as laws.[59]

These include:

- The National HIV/AIDS and STI Policy. This policy particularly mentions protection of human rights [60].
- Ghana Growth and Poverty Reduction Strategy II [61]
- Orphans and Vulnerable Children Policy [19, 62]
- National Social Protection Strategy [63]

Mechanisms for enforcement of laws and policies

Various mechanisms are in place to ensure that these laws are implemented including:

- The Commission on Human Rights and Administrative Justice established under the Commission on Human Rights and Administrative Justice Act, 1993 [64]. The Commission is an independent body set up to assist person to seek redress in issues of unfair treatment and human rights abuses. Though not set up for HIV specifically it provides the opportunity for such issues to be addressed in Ghana.

- The National Labour Commission: set up under the Labour Act, facilitates the settlement of industrial disputes, and investigating labour related complaints especially unfair labour practices and provides an avenue that PLHIV can use in unfair dismissal [46].

- The Police Service established under the Police Act 1970, has the statutory duty to prevent and detect crime and apprehends offenders[54]. In relation to sex related crimes

(e.g. rape or incest) they are best placed to enforce the law and prevent HIV/AIDS transmission [65].

- The Ghana Police Service established the Domestic Violence Victim Support Unit (DOVVSU) to cater for the increasing cases of abuse against women, men and children. DOVVSU currently has offices in all regions of the country.
- The Judiciary: The Judiciary have received specific training to address HIV issues and to have a better understanding of HIV matters.
- A legal aid system also exists in Ghana and was established and operates under the Legal Aid scheme Act (ACT 542) of 1997 [66]. It is an effective Legal Service for the poor in the Ghanaian society at minimal cost to enables them defend and prosecute the Human and Legal rights so that all citizens can go about their economic, social and political activities in freedom and with a sense of security. The Legal aid system provides Legal assistance to any person for purpose of enforcing any provision of the constitution and in connection with any proceeding relating to the constitution if the person has reasonable grounds for taking, defending, prosecuting or being a party to the proceedings.

The Number of civil society organisations also providing support for PLHIV and addressing their human rights violations include: International Federation of Women Lawyers (FIDA), Centre for Demographic Development (CDD), and Human Rights and Advocacy Centre (HRAC)

The country however, has laws that also present obstacles to effective HIV prevention, treatment, care and support for vulnerable populations. These include laws affecting Injecting drug Users, MSM and sex workers. The specific laws are:

- Criminal Code 1960 (Act 29) section 276: this criminalises prostitution and soliciting for sex. [54]
- Criminal Code 1960-97 Chapter 6, Sexual Offences Article 105: which criminalises homosexuality and lesbianism [54].

These laws criminalize prostitution and men who have sex with men and thus make organizing prevention programmes in these groups more challenging. They have often been the recipient of human rights abuses and discrimination from the law enforcing bodies and from their own peers [67]. Not much progress has been made in addressing laws which are obstacles for HIV interventions for FSW, MSM and IDU.

The Government continues to involve MARPS, PLHIV and other vulnerable populations in the development and implementation of HIV policy and programmes. This is through the inclusion of representatives to task teams and working groups. Represented in Expanded Technical Working groups, Monitoring and Evaluation Working groups and also receive funds for implementation.

Access to services

In general the country has a policy of free or subsidized HIV services. In the period under review through advocacy and review of programmes outcomes, HIV prevention services such as testing and Counselling and all aspects of PMTCT have been made free. Unfortunately, condoms

are still provided at a cost. ART services are also not free but are highly subsidized through funding from the GFATM. Discussion and advocacy is far advanced to integrate ART services into National Health Insurance Scheme (NHIS) to ensure that PLHIV receive free care [12]. Currently, treatment of opportunistic infections (OIs) is provided for under the NHIS.

The country has a non-discriminatory policy for all to receive access to HIV prevention, treatment, care and support services and every effort is made to ensure that there is equity in the distribution of services. In the year under review geographic access was improved by increasing of service to more sites in all regions in the country. 150 sites in 105 districts of the 170 districts are covered for ART services. Every effort was made to reach the decentralised level and provide services at the district, sub-district and even the community level through the Community Health Planning Services (CHPS).

In the period under review, "Know Your Status (KYS)" campaigns were undertaken all over the country to ensure an increase in the testing and counselling through mobile/ outreach services. This was provided in conjunction with the health service in many communities.

The country has a policy to ensure women's access to services outside the context of pregnancy and child birth, through educational programmes and KYS campaigns. This provides services for both genders. Indeed from the statistics more women have access to prevention and treatment services than men and future direction may require addressing the need for greater involvement of men.

The country does not have a policy to ensure the equal access for MARPs per se and other vulnerable populations to HIV prevention, treatment, care and support. The programmes are however set up to ensure equal access to all irrespective of creed, colour or religion. Thus all MARPS and vulnerable populations have equal rights to access care as any other person living in Ghana. While services are generic and are not specific for MARPS, there are 21 MARPS-friendly health facilities which provide services to MARPS. MARPS-friendly services are to be expanded across the country. Occasionally, MARPS experience human rights violations from the persons who are to protect them such as the police or to provide them with services such as the health worker. In the period under review this came to the fore through the advocacy and education of the service providers including the police and health workers.

With all these laws available the new HIV and AIDS Law will complement these laws in ensuring protection of PLHIV and MARPs.

Meaningful involvement of PLHIV

The Ghana AIDS Commission has involved PLHIV in all aspects of HIV policy and programme design and implementation. PLHIV are represented on the Ghana AIDS Commission, Technical task teams, and the Global Fund Country Coordination Mechanism.

In 2009, National Association of Positive Persons (NAP+) inaugurated a nine member board. The board continues to play an executive and advisory role to guide and direct the affairs of the organisation. The organisation's secretariat is currently being strengthened through the

engagement of professional staff and establishment of standard operating procedures and systems.

Funding was provided for NAP+ by the Ghana AIDS Commission to strengthen their institutional capacity at national and sub-national levels to effectively and efficiently coordinate and manage the activities of their member associations and to empower PLHIV to be more involved in the national response. The support was based on the gaps identified following an organizational assessment done in 2008.

Over 350 associations were supported in the period under review to support group meetings, refund for antiretroviral therapy, for the payment of premium for National Health Insurance (NHIS) and nutritional support [12].

The on-going nation-wide stigma reduction campaign through the mass media has been given new impetus with new more engaging messages in the mass media. The inauguration of the Heart to Heart campaign has encouraged PLHIV to come out into full public disclosure of their status. Despite this HIV related stigma is still high as is the growing level of homophobia across the sub-region which makes it difficult to work openly with sexual minorities. The DHS of 2008 indicated that stigma and discrimination against persons living with or affected by HIV was still an important issue.

Respondents rated polices and laws to promote and protect human rights of PLHIV at 6 for 2010, 5 for 2009 and 5 in 2007. According to the respondents, progress made since 2007 were:

- MARPs strategy with Operational Plan
- M&E Roadmap
- MARPs TWG
- Mechanisms to protect MARPs from abuse
- M-Friends and M-Watchers (involving Police, Lawyers and MARPs)
- engaging the judiciary and law enforcement services to reduce stigma and discrimination
- MARP friendly health facilities

Key challenges remaining were:

- Criminal Offenses Act
- Stigma and Discrimination

Prevention

Prevention programmes continue to be the main stay of the HIV response in Ghana. With a National prevalence below 2%, the majority of the population still remains HIV negative and needs to be maintained as such. Prevention must therefore remain the cornerstone of Ghana's response to halt and reverse the HIV epidemic in the long term. Combination of evidence-informed and targeted interventions in HIV programmes is the key for effective HIV prevention. Prevention and Behavioural Change Communication is one of the key intervention areas in the NSP.

TARGET 1. HALVE SEXUAL TRANSMISSION OF HIV BY 2015

Comprehensive knowledge on HIV is the first step in the adoption of behaviour that reduces the risk of HIV transmission. The knowledge and behaviour of most at-risk populations and other at-risk populations such as the youth play an important role in the contribution of the HIV epidemic in Ghana[5]. Monitoring the knowledge and behaviour of young people is key to attaining Ghana's goals.

Though awareness of HIV and AIDS have been high since 2003, where 98% of women and 99% of men were reportedly aware of HIV, comprehensive knowledge on HIV and AIDS, prevention and non-stigmatising behaviour is relatively low. [6, 36].

In the period under review Ghana was a beneficiary of the Global Fund Round 8 HIV Grant (Phase I). This grant addresses gaps in the national response such as 1) superficial understanding of HIV in many segments of the population including youth, and an inability to move people from general knowledge and awareness of risk to actually adopting safer behaviors; 2) insufficient targeting of MARPs and vulnerable groups; 3) slow integration of HIV/AIDS and Sexual Reproductive Health (SRH); 4) shortfalls in institutional and community capacities to rapidly scale-up comprehensive HIV services.

Recognizing that clients and partners of MARPs serve as a bridge between MARPs and the general population in HIV transmission, this Program targets MARPs, vulnerable groups and the general population. As part of health system strengthening measures directly related to HIV services, this Program targets blood safety, prevention of mother-to-child transmission (PMTCT), early infant diagnosis, and integration of HIV and sexually transmitted infections (STI) services.

As a part of strengthening the national health system in its response to HIV epidemic and emphasizing the need of stronger partnerships between the public health sector, civil society and the private sector, this Program is being implemented by multiple Principal Recipients, namely, the Ministry of Health, Ghana AIDS Commission, Planned Parenthood Association of Ghana, Adventist Development and Relief Agency of Ghana.

The goal is to reduce new HIV infections in the general population. The target Groups are:

- People living with HIV & AIDS (PLHIV);
- MARPs: MSM and their female partners, FSWs,

- Vulnerable groups: young people (aged 15-24), female porters; At-risk workers, Prison inmates, most-at-risk youth (15-24 years);
- Pregnant women; and Infants born to HIV-positive pregnant women; and
- The general population

The strategies are:

- To promote the adoption of safer sexual practices in the general population;
- To promote healthy behaviors and the adoption of safer sexual practices among PLHIV, MARPs and vulnerable groups;
- To promote the integration of SRH and HIV & AIDS services with emphasis on PMTCT and safe blood transfusions; and
- To strengthen the institutional capacity and community systems for scaling-up HIV & AIDS, STI and TB prevention services.

In the period under review the four PRs have achieved the following as depicted in Table 11

Table 11 Achievements under the GF Round 8 HIV grant

Service Delivery Area	2010 Achievements	2011 Achievements
Behaviour Change Communication (BCC) and Information, Education and Communication (IEC) using various media;		
Number of Media Houses disseminating HIV & AIDS prevention and stigma reduction messages	34 (3 TV stations and 31 FM Radio stations)	34 (3 TV stations and 31 FM Radio stations)
Counseling and testing (CT) – expand CT sites and integrate CT with SRH;		
Number of persons who received counselling and testing	1,063,085	1,151,034
Community outreach through peer educators and in school settings;		
Number of MARPs reached with HIV Prevention services	21,312	53,332
Number of youth reached with HIV Prevention services	331,690	
Number of At-risk workers reached with HIV Prevention services	60,245	120,676
Strengthening and expansion of PMTCT services and early infant diagnosis;		
Number of pregnant women tested for HIV	520,900	627,180
Number of HIV positive pregnant women who received ARV prophylaxis	5,845	8,057
Number of infants screened for HIV using DNA PCR.	N/A	1,952
Number of infants testing HIV positive at 2 months	N/A	129
Male and female condom distribution among MARPs, vulnerable groups and general population;		
Number of Male and female condoms distributed among MARPs	3,704,449	14,705,959
Number of Male and female condoms distributed among the general population	27,406,893	40,082,100
Stigma and discrimination reduction in all settings;		
Number of persons reached with stigma reduction messages	278,800	453,460
Payment of National Health Insurance (NHIS) premiums for PLHIV to increase their access to health services, including the management of opportunistic infections;		
Number of PLHIV registered with the National Health Insurance Scheme	6,237	15,415
Provision of STI prevention packages and increasing referral system for STI diagnosis and treatment;		
Number of STI clients	633	N/A

Source Ghana GF Round 8 HIV Reports

GENERAL POPULATION

Young people: Knowledge about HIV prevention

Indicator 1.1: Percentage of young women and men 15-24 who both correctly identify ways of preventing the sexually transmission of HIV and who reject major misconception about HIV transmission

This indicator measures comprehensive knowledge; which is defined as correctly identifying ways of preventing sexual transmission as well as rejecting three common misconceptions (a person can get AIDS from mosquito bites, by supernatural means and through sharing food with an infected person).

Despite efforts in HIV prevention in Ghana to improve knowledge on HIV and AIDS, little change has been noted in the comprehensive knowledge of young people. According to the Multiple Indicator Cluster Survey (MICS 2006), 25.1% of young women and 33% of young men aged 15-24 years had comprehensive knowledge of HIV and AIDS (i.e. Correctly identified ways of transmitting HIV and rejected misconception about HIV transmission)[68]. This is compared to the GDHS 2008, which showed that for respondents aged 15-24 years, 28.3% of females and 34.2% of men had comprehensive knowledge about HIV and AIDS. There is no recent data to show progress on this indicator.

Ghana, through the implementation of GFATM Round 8 grant intends to bridge this gap for effective HIV prevention interventions. The GFATM Round 8 HIV grant has significant inputs into communications targeted at key populations including MARPS, youth, and at-risk workers.

Sex before the age of 15

Indicator 1.2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

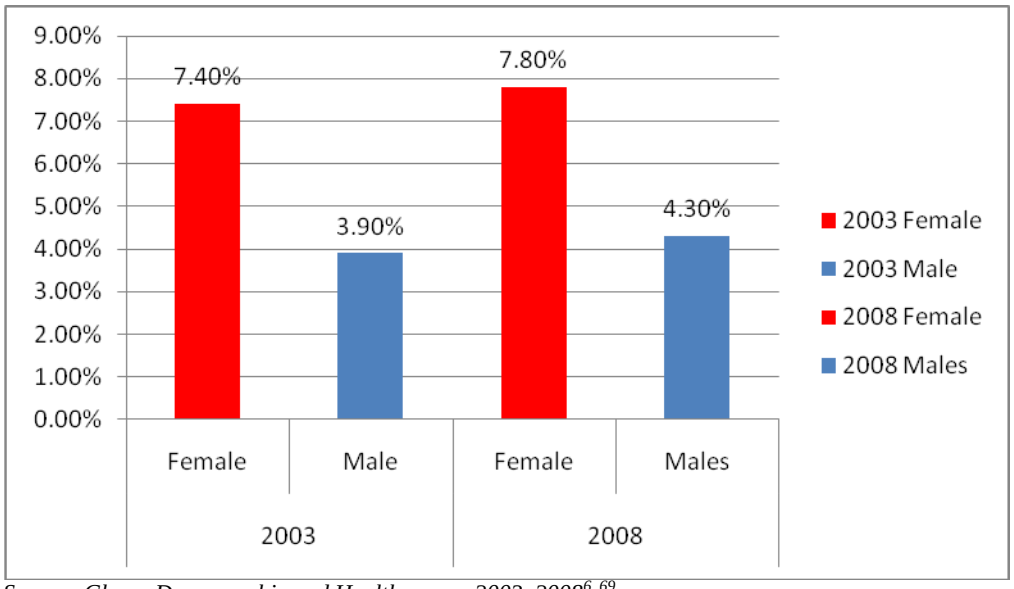
One of the HIV prevention goals is to delay sexual debut for as long as possible. This reduces the risk to HIV exposure. This indicator is measured in the GDHS. In 2003, 7.4% of women and 3.9% of men had sex before the age of 15 years. In the 2008 GDHS, 7.8% of women and 4.3% of men had sex before the age of 15 years. There has thus been a negative marginal change in the age of sexual debut in this age group. The table below shows the details.

Table 12 Percentage of 15 – 24 years who have had sexual intercourse before age 15 years

	2003		2008	
Age	Females	Males	Females	Males
15 - 17	8.1%	3.3%	7.5%	4.4%
18 - 19	6.3%	4.8%	9.3%	2.5%
15 – 19	7.4%	3.9%	8.2%	3.6%
20 -24	7.5%	3.9%	7.2%	5.2%
15 – 24	7.4%	3.9%	7.8%	4.3%

Source: Ghana Demographic and Health survey 2003 and 2008

Figure 8 Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 in 2003 and 2008



Source: Ghana Demographic and Health survey 2003, 2008[6, 69]

The data shows that females initiate sexual activity at an earlier age than males.

Multiple sexual partnerships

Indicator1.3 Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months

The transmission of HIV is dependent on the number of unprotected sex acts, and the number of sexual partners. Individuals who have multiple partners concurrently or serially have a higher risk of HIV transmission than individuals who have fewer links to a wider sexual network. The number of individuals with more than one partner in the past 12 months is monitored as a proxy to monitor the reduction in sexual partners. It is now known through research that having multiple concurrent sexual partners increases the risk as opposed to multiple serial sexual partners. This indicator is only of value if individuals do not just reduce the number of sexual partners but reduce the partners to only one.

In 2008, 11.3% of male and 1% of female respondents had more than one sexual partner in the past 12 months. Thus the males are more likely to have more than one sexual partner than the females. Multiple sexual partnership increases with age. The proportion of males who have multiple sexual partners increased from 3.1% among respondents aged 15 - 19 years to 9.6% among those aged 20 -24 years and 44.6% in respondents aged 25 - 49 years.

Table 13 Percentage of respondents 15–49 years who have sexual intercourse with more than one partner in the past 12 months

	2003		2008	
Age	**Female**	**Male**	**Female**	**Male**
15- 49	1.1%	9.9%	1.0%	11.3%
15 – 19	1.5%	2.4%	1.2%	3.1%
15 - 24	1.7%	5.5%	1.4%	5.9%
20 – 24	1.9%	10.4%	1.6%	9.6%
25 – 29	0.4%	13.8%	1.7%	16.7%
30 - 39	1.0%	13.5%	0.5%	15.5%
40 - 49	0.4%	11.1%	0.2%	12.4%

Source GDHS 2008

Condom use at last sex among people with multiple sexual partnerships

Indicator 1.4: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Using a condom during higher risk sex or when one has multiple sexual partners considerably reduces the likelihood of HIV transmission. HIV interventions thus promote the use of condoms to prevent HIV transmission. To monitor the risk behaviour for HIV, the percentage of respondents with more than one sexual partner reporting the use of a condom during their last sexual intercourse was assessed.

In 2008, 26.2% of male respondents aged 15- 49 years who had multiple sexual partners, used a condom with their last partner. The percentage for males aged 15 – 19 years was 24.4%, and for males aged 20 – 24 years the percentage was 49.2%. For male respondents aged 25 -29 years the percentage was 42.8% and for those aged 30 -39 years it was 19.6%. In the age group 40 -49 years the proportion was 3.5%.[69]. The GDHS does not report this indicator for females Due to the small number of women in the same category comparable data for females is not provided [69].

Higher risk sex in this instance is defined as 'Having sex with a person other than a spouse or cohabiting partner'. In 2008, 25.4% of women and 45.1% of men aged 15- 49 years used condom at the last 'higher-risk' sexual intercourse[7]. This compares with the results in 2003 where 28% of women and 44.8%% of men used condoms during their last higher risk sex[6]. Thus the rate of condom use has remained almost the same among both males and females between the two survey periods. Table 14 depicts the percentage of condom use during their last higher risk sex for the different age groups. Condom use among almost all the age groups had decreased during last higher-risk sex with the exception of the 25 – 29 age group among whom condom use increased slightly.

Table 14: Percentage of condom use during last higher risk sex.

	2003		2008	
Age	Female	Male	Female	Male
15- 49	28%	44.8%	25.4%	45.1%
15 – 19	33.5%	46.2%	24.4%	40.3%
20 – 24	32%	54.7%	31.1%	48.9%
25 – 29	27.4%	43.3%	31.3%	49.3%
30 – 39	13.1%	37.1%	11.0%	45%
40 – 49	11.2%	37.5%	6.3%	27.1%

HIV testing in the general population

Indicator 1.5: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results

The 2008 Ghana Demographic and Health Survey (GDHS) indicated that although 70% of women and 75% of men aged 15-49 years knew where to obtain an HIV test, only 16.9 % of women and 12.7% of men had ever tested and received the results of the test and only 6.8% of women and 4.1% of men had tested and received the results in the last 12 months. The table below shows the disaggregation by age and sex. The result in 2008 was similar to the results obtained in the Behaviour Surveillance Survey among adults conducted in 2006 which indicated that only 9% of adults had had an HIV test in the last 12 months [75]. Counselling and testing is thus still low in the general population.

Table 15: Percentage of respondents 15-49 who received an HIV test result and know their results in the last 12 months.

	2003		2008	
Age group	**Male**	**Female**	**Male**	**Female**
15- 24	1.6%	1.7%	8.2%	4.9%
15-19	1.1%	1.0%	1.6%	2.6%
20-24	2.4%	2.6%	5.7%	7.6%
25-29	4.9%	3.2%	4.7%	12.5%
30-39	4.2%	2.9%	5.7%	8.0%
40 - 49	3.6%	1.8%	2.9%	3.7%
overall	3.3%	2.3%	4.1%	6.8%

Source: Ghana Demographic and Health survey 2003 & 2008 [6, 69]

To address this, counselling and testing was scaled-up further during this reporting period. Programmatic data from the NACP indicates that by December 2010, 1,174 CT centres were providing CT services and each region and district undertook the 'Know Your Status Campaign'. In 2008 and 2009, 467,935 and 865,058 respectively were counselled and tested. In 2010, 1,063,085 individuals were counseled and tested, 79% were females and 21% were males. In 2011, 1,151,034 individuals were counselled and tested, 77% were females and 23% were males.

There is a significant annual increase in the number of people tested. Significantly more women access HIV testing services than men.

Table 16: The number of clients tested by Gender 2008-2009

	2008			2009		
	M	F	Total	M	F	Total
No of Clients Accessing HTC Services	84,690	383,245	467,935	196,342	668,716	865,058
No. of HIV Positive Clients	8,132	20,910	29,042	10,564	26,008	36,572
Prevalence in clients tested	9.6%	5.5%	6.2%	5.4%	3.9%	4.2%

Table 17: The number of clients tested by Gender 2010-2011

	2010			2011		
	M	F	Total	M	F	Total
No of Clients Accessing HTC Services	222,309	840,776	1,063,085	221,202	929,832	1,151,034
No. of HIV Positive Clients	12,896	36,760	49,656	14,090	42,801	56,891
Prevalence in clients tested	5.8%	4.4%	4.7%	6.4%	4.6%	4.9%

From the results it is clear, that though considerable efforts have been made towards increasing counselling and testing in Ghana much more needs to be done to ensure counselling and testing in the general population becomes universal.

HIV prevalence in young people

Indicator 1.6: Percentage of young women and men aged 15- 24 who are HIV infected

The goal of this indicator is to measure the reduction of the HIV infection by 25% in 2010 and 50% by 2015. Trends of HIV prevalence in 15 -24 years are an indication of recent trends in HIV incidence and risk behaviour.

The National HIV Prevalence and AIDS Estimates report indicated a prevalence of 0.65% in 2010 and 0.6% in 2011 in this age group within the general population. The prevalence among pregnant women aged 15 – 24 was 2.0% in 2010 and 2.1% in 2011. The graph below shows a general downward trend in the prevalence. In 2004, when the prevalence was higher, and recognizing that this age group was a marker for the incidence of new infections, steps were taken to scale up prevention interventions among the youth. These interventions covered both in- and out-of-school youth.

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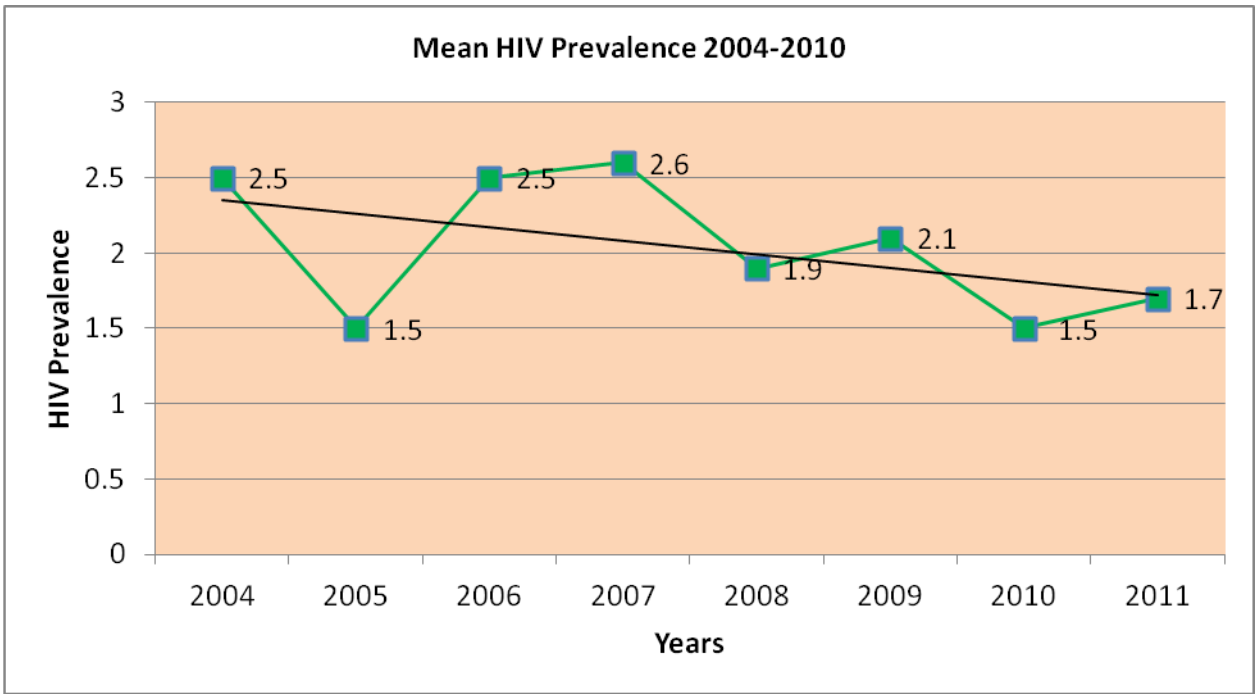
Figure 9 HIV Prevalence Trend In 15 -14 Age Group, 2004 - 2011



Source: HIV Sentinel Survey Report 2011

HIV prevention among in-school youth

The Ministry of Education is responsible for the supervision and coordination of all pre-professional educational activities and programmes. The Ministry established a series of HIV prevention programmes including Population and Family Life Education Programmes and developed curricula on youth counselling, peer education and HIV and AIDS life skills education for the teacher training colleges. The Ghana Education Service, an agency of the Ministry of Education is responsible for pre-tertiary education.

The Ghana Education Service in collaboration with UNICEF, initiated the school based HIV and Reproductive Health Life Skills Education, known as the HIV-ALERT Model in basic schools. This model is a mixed package of interventions to enable participating schools raise their HIV and AIDS response to a state of "Alertness". It 'pulls together' all school based activities to give momentum to HIV and AIDS activities in terms of scale, depth and quality. It seeks to institutionalize HIV and AIDS into the education sector [12].

It has three pillars namely: Teacher–Led, Child–Led and School-community–based Pillars. The project seeks to achieve universal coverage of school-based education outlined in the educations strategic plan for 2003 -2015.

The project is being rolled out in all ten regions of Ghana as at the end of 2010. In 2008, 7 regional teams were trained, 19,876 peer educators, 5,053 school teachers and 767 circuit supervisors were trained. Ghana has 7,969 Junior High Schools (JHS) with a student population of 1,100,000 as at December 2011. The HIV Alert model is implemented in the Junior High

Schools. An Alert certification tool has been developed to guide assessment and certification of schools in their HIV Alertness in three phases i.e. Inception phase, Pass Phase and Alert Phase. At the end of 2011, out of the 1,100,000 students, 874,000 had been reached with the Alert program. Of the 7,969 JHS, 895 were certified as HIV and AIDS Alert. A school becomes HIV Alert when its students have been enrolled and completed all the six modules in the program, and satisfied key Alert indicators. The Alert model is delivered by trained peer educators with support from trained supervising teachers or school health teachers. During the period under review 22,422 teachers and 30,756 peer educators (students) were trained to promote youth counselling, peer education and HIV and AIDS Life Skills Education.

Under the GF Round 8 HIV grant, all 42 institutions including universities, polytechnics and teacher training colleges and Technical & Vocational schools are being engaged in HIV prevention activates. These activities include, BCC using the Peer approach, testing and Counselling, Condom distribution, referrals for complementary services. Key implementing partners include Planned Parenthood Association of Ghana (PPAG) and FHI360.

In 2010, 259,199 tertiary students were reached with HIV prevention services. While in 2011, FHI360 reached 27,178 tertiary students. They distributed 655,786 condoms to students, 17,229 students were tested for HIV.

HIV prevention among out-of-school youth

The program designed for Out of school youth are similar to those for in-school youth. The out-of-school youth include apprentices, young artisans, and porters. Key implementing partners in this area include PPAG, ADRA and several national NGOs. Through the Multi-sectoral HIV and AIDS program funded by the GAC, 29 national NGOs implemented youth targeted HIV prevention interventions in all the 10 regions of the country. Through the efforts of implementing partners 917,466 youth were reached with HIV risk reduction and other prevention messages. 195,227 out-of-school youth tested and counselled for HIV in 2010.

The UNFPA Ghana CO ended the implementation of the fifth country programme (2006–2010) with one year extension in 2011. During the year under review, the UNFPA Ghana Country Office supported the Ghana Health Service(Upper East, Upper West, Northern, Central and Volta Regional Health Directorates), National Youth Authority SWAA, CEDEP, Theatre for a Change, PPAG, Curious Minds, Pathfinder International and Village Exchange Ghana to implement integrated HIV prevention and SRH interventions that targeted out of school youth, young people with disability and migrants (i.e. head porters and truck porters) in selected districts in six regions: Northern, Upper East, Upper West, Central, Volta and Greater Accra. The interventions supported included peer education, interactive theatre, condom promotion and distribution, provision of life planning skills and provision of youth friendly services (including HTC services).

About 67,628 out of school youth were reached with HIV prevention and SRH information and counselling services. In addition 107, 833 male condoms were distributed to sexually active young people. As part of the project activities, 5,899 young female migrants (i.e. head porters) and 518 truck porters in Accra were reached with HIV prevention/SRH information and HTC services.

Persons with disability were also reached with services. 185 young persons with disability were reached with HIV prevention education and HTC services.

The UNFPA Ghana CO also supported the GAC to organise a two day national consultation to generate inputs for the development of an action matrix on HIV and young people.

SEX WORKERS

Sex workers: prevention programmes

Indicator 1.7 Percentage of sex-workers reached with HIV prevention programmes

According to the draft IBBSS Report there was notably high awareness of HIV prevention methods among the respondents. The majority of respondents (81.5%) had heard or seen messages about the use of condoms and lubricants. Over seventy percent (73.7%)had received information about importance of HIV testing while 47.2% said they were aware of the importance of STI screening and management. Over one-third (36.4) of the FSWs were knowledgeable about the importance of reducing their sexual partners as an HIV and STI prevention method. This knowledge was evenly distributed among roamers and seaters.

Overall, electronic media was the main source of information. An overwhelming majority (83.9%) of female sex workers reported that the radio was their most popular source of information on HIV/AIDS, followed by TV at 72.4%. About two-thirds (64.4%) and 45% mainly get their information from NGOs and peers respectively. Family was the least mentioned source of information (7.3%).

Approximately half (56.3%) of FSWs reported that they had contact with a peer educator in the 12 months prior to the survey. Among them, Brong Ahafo region had 96.4% of the respondents reached by peer educator. Upper West, Central and Ashanti regions were well covered by peer educators as 83.9%, 76.5% and 73.6% of the respondents respectively had been reached. Eastern region had only 6.5% of respondents reporting to have been served by peer educators in the last one year. Over half of the respondents (53.9%) had contact with a peer educator more than once in the last one year while about one-third (33.5%) contacted peer educators at least every three months. Almost one-third (32.2%) of roamers had been contacted by peer educators every three months compared to 36.3% of seaters.

Sex workers: condom use

Indicator 1.8: Percentage of sex workers reporting the use of a condom with their most recent client

From the Modes of Transmission model it is evident that sex workers, the clients and non-paying partners and partners of their clients together contribute about 31.1% to HIV incidence. Thus sex workers play a major role in HIV transmission in the country. The consistent use of condoms by sex workers with all partners would go a long way to reduce HIV transmission.

About nine out of ten (92.0%) of FSWs surveyed used a condom during their most recent sex act with a paying client. 90.3% of Roamers and 95.9% of Seaters reported using a condom during their last sex act. Greater Accra, Brong Ahafo and Western regions reported a near universal condom use at 99.2%, 98.1% and 96.2% respectively. Condom use was lowest in Volta region where only three-quarters (75.3%) of FSWs reporting use of a condom in their last sex act with a paying client[1].

Of those FSWs who used condoms with their most recent paying partner, the majority (87.7%) reported that sex workers themselves suggested the use of condom, whereas 9.1% reported that the idea was mutual; i.e. from both the FSW and her client.

Over three-quarters (79.2%) of FSWs said that they used condoms every time they had sex (consistently) with a paying client;74.6% of Roamers used condoms consistently compared to 89.9% of Seaters. Consistent condom use was reported by 98.4% and 94.4% of FSWs in Greater Accra and Brong Ahafo regions respectively. Only half (50.9%) of FSWs from the Volta region, 55.9% of FSWs from Upper East and less than two-thirds of Upper West (62.3%) and Northern regions (64.7%) reported consistent condom use.

The main reasons cited for not using condoms during sex with paying clients are that the 'client refuses' (31.3%), the 'client pays more for sex without a condom' (20.2%) or that the FSW did not feel like using the condom or did not like it' (14.2%). Notably, 8.4% of the clients said they don't use condoms consistently because they do not have condoms.

Whereas condom use with paying clients is very high, condom use with non-paying partners was generally low. Almost forty percent of the respondents (39.9%) reported to have never used a condom with their husband or boyfriend(s) or pimp, while about one-third (35.3%) claimed they used it sometimes. Only 20.1% reported to have used condom consistently with their non-paying partners. The Great Accra region had the highest proportion (57.9%) of the respondents reporting never using condoms with their non-paying partners, followed by Ashanti region (54.7%) and the Western region (45.6%). Seaters (58.5%) are less likely to use condoms with their husbands or boyfriend(s) compared to roamers (38.6%).

The most common reason given by respondents (57.5%) for not using condoms with their husband or boyfriend(s) or pimp is the level of trust they have for their partner. Some respondents (15.1%) also claimed non-paying partner refused to use the condom. More seaters (58.4%) reported not having used a condom based on trust compared with the roamers (55.5%).

Consistent condom use with paying partners is generally high, with 79.2% of FSWs using condoms every time they have sex with a paying partner. However, when it comes to sex with their non-paying partners, consistent condom is only practiced by 20.1% of FSWs.

HIV testing in sex workers

Indicator 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

According to the IBBSs 2011 about two-thirds (66.7%) of FSWs said they had their most recent HIV test within the past 12 months compared to one-fifth (20.1%) who reported to have had their test between one to two years ago. The findings also showed that 59.9% of FSWs have ever had an HIV test. FSWs from the Brong Ahafo region reported having the highest HIV testing rate of 80.4%. This is followed by the Greater Accra (73.5%) and Ashanti regions (65.0%). The Eastern region, which hosts the highest proportion of sex workers, has the lowest reported rates for HIV testing, with only 33.1% of FSWs having ever been tested. Testing was more common among Seaters (70.7%) compared to Roamers (55.0%).

HIV prevalence in sex workers

Indicator 1.10 Percentage of sex workers who are living with HIV

HIV prevalence is measured among the general population and MARPs in Ghana to monitor trends in the HIV epidemic and to assess the impact of the HIV prevention interventions. According to the 2011 IBBSS, 11.1% of FSWs are HIV positive. This result shows a reduction in HIV prevalence among FSWs from 25% in 2009. Prevalence was higher (21.4%) among Seaters than Roamers (6.6%)

Greater Accra Region had the highest rates of HIV prevalence (16.3%). Other regions with high HIV prevalence include Ashanti (13.0%), Northern Region (11.1%) and Western Region (10.5%). HIV prevalence was lowest in the Upper West Region (4.1%).

Respondents who reportedly were divorced or widowed were found to be at highest risk. 23.2% of respondents who were found to have separated from their spouses, and 23.0% divorced respondents had HIV compared to 10.3% who were currently married. A higher HIV prevalence of 15.1% was recorded among respondents with no formal education compared to 10.5% among those who have ever been to school. Respondents who have ever been married (19.5%) were nearly three times more likely to be HIV infected compared to those who had never been married (6.9%). In addition, those who were currently married (19.7%) were at higher risk of HIV infection compared to those who were not married (7.3%). In addition, respondents who had HIV were more likely to have HSV-2. The data shows that 70.1% of HIV negative respondents had HSV-2 compared to 95.1% of HIV infected respondents.

MEN WHO HAVE SEX WITH MEN

Men who have sex with men (MSM) have been neglected in HIV programming in sub-Saharan Africa, frequently ignored in national strategies and hidden in the face of intolerance, stigmatization, and punitive laws. In Ghana, community-based organizations (CBOs) have been at the forefront of HIV interventions for MSM. Among the small number of CBOs working with this highly vulnerable population are the Accra-based WAPCAS, and Center for Popular Education and Human Rights, Ghana (CEPEHRG), Maritime Life Precious Foundation (Maritime) in Takoradi and MIDAK in Kumasi. With the support of GAC and PEPFAR, these organizations have been part of much-needed efforts to reach MSM with prevention messages, condoms, and lubricant and to increase uptake of HIV-related services using various approaches including cell phone-based communications.

Men who have sex with men: prevention Programmes

Indicator 1.11 Percentage of men who have sex with men reached with HIV prevention programmes

The GAC in collaboration with CDC (Atlanta) and Institute for Global Health of University of California San Francisco (UCSF) has undertaken mapping, size estimation and integrated Bio-behavioural surveillance among MSM in Ghana. According to the preliminary report[8], 95.7% of MSM were reached with HIV prevention programs in the past 12 months. Detailed analyses are yet to be carried out on the findings.

Men who have sex with men: condom use

Indicator 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Men who have sex with Men (MSM) contribute to HIV infection in the country. From the Modes of transmission study, 7.9% of HIV incidence is attributable to MSM and their partners. Thus safer sexual practices in this group will reduce HIV transmission.

The Ghana Men's study (2011) showed that 60% of MSM reported the use of a condom the last time they had anal sex with a male partner.[9] This report is incomplete and therefore further details cannot be provided at this point.

HIV testing in men who have sex with men

Indicator 1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

The recent Ghana Men's Study (2011) established that 26.3% of MSM had been tested in the past 12 months and know their results.[1] This report is incomplete and therefore further details cannot be provided at this point.

HIV prevalence in men who have sex with men

Indicator 1.14 Percentage of men who have sex with men who are living with HIV

According to preliminary results of the Ghana Men's Study 17.5% MSM were found to be HIV positive.[1] This report is incomplete and therefore further details cannot be provided at this point.

[8] This report is preliminary and should not be quoted.
[9] These results are preliminary and should not be quoted.

Table 18 Number of MARPs receiving HIV services

Indicator	2010	2011
Number of MARPS reached with HIV prevention services	21,312	53,332
Number of condoms distributed to MARPS	3,704,449	14,705,959
Number of MARPS counselled and tested for HIV	3,502	24,288
Number of MARPS receiving STI diagnosis and treatment		29,150

There is long history of MARPS HIV interventions in Ghana. The West African Project to Combat AIDS and STI (WAPCAS) started FSW interventions in 1996. They have since expanded their programs for Accra, Tema and Kumasi to all the 10 regions of Ghana. HIV prevalence among sex workers in 2001 was more than 80%. The prevalence reduced to about 58% in 2002 as a resulting from AIDS related deaths, especially among Seaters. A survey in 2006 showed that HIV prevalence among sex workers was 38%, which reduced to 25% in 2009. The high level of HIV prevalence among sex workers engaged the attention of government and its partners to scale up interventions towards Universal Access. In 2005 SHARP (AED) project also initiated MSM interventions in Accra, Tema and Kumasi. The MARP programs seek to promote 10 key behaviours:

i. Use condoms consistently and correctly
ii. Use non-oil based lubricants properly
iii. Get tested and know your HIV results
iv. Disclose your HIV status to regular partners
v. Promptly seek and appropriate and effective treatment, including treatment of STIs
vi. Adhere to treatment, including ART, OIs and STI
vii. Reduce number of multiple and concurrent sexual partners
viii. Actively participate in program design and implementation
ix. Eat a healthy diet
x. Protect yourself against infectious diseases such as TB, Malaria and Diarrhoea.

The package of prevention services for MARPS includes HIV Testing and Counselling. Diagnosis and management of STIs, Post Exposure Prophylaxis, BCC using the peer approach, Condom and Lubricant promotion and distribution, Sexual and Reproductive Health and Family Planning. This package of services is provided at 31 MARP Drop-in Centres (DICs) across the country. Drop-in Centres are manned by trained peer educators and counselors who provide the services including referrals to complementary services. The key innovative intervention is the use of mobile phones to provide counselling and referral services for MSM and FSW, known as "Text me! – Flash me! Helpline Program". In this program, a toll-free phone service gives easy access of MARPs to HIV service providers. Providing services to MARPS in a culturally

stigmatizing environment such as Ghana's requires a human rights approach to ensure their protection. The M-Friends and M-Watchers program is a rapid response mechanism involving peers and law enforcement and legal professionals who support the protection of human rights of MARPs.

On the prevention front, respondents scored prevention an average of 9 in 2011 compared with an average of 6.75 in 2009, and 7.1 in 2007. The main achievements they identified were:

- MARPs strategy developed with Operational Plan
- M&E Roadmap outlined
- MARPs Technical Working Group established
- Mechanisms to protect MARPs from abuse
- M-Friends and M-Watchers Initiative (involving Police, Lawyers and MARPs)
- Engaging the judiciary and law enforcement services to reduce stigma and discrimination
- Health Facilities with MARPs-friendly health workers

The identified challenges are:

- Criminalization of homosexuality
- Stigma and Discrimination is still pervasive

TARGET 2.REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50 PER CENT BY 2015

Safer injecting and sexual practice among injecting drug users are essential to reduce the transmission from this group of MARPs. Injecting drug users (IDU) risk HIV transmission from contaminated equipment and can spread HIV through sexual transmission to the wider population and to themselves through sharing of needles. Often the risk is complicated by other high risk behaviours such as sex work or casual sex thus increasing the risk of HIV transmission further.

The MOT study has estimated that IDU contribute to 1.6% to the HIV incidence.

People who inject drugs: prevention programmes

Indicator 2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

People who inject drugs: condom use

Indicator 2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

People who inject drugs: safe injecting practices

Indicator 2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

HIV testing in people who inject drugs

Indicator 2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

HIV prevalence in people who inject drugs

Indicator 2.5 Percentage of people who inject drugs who are living with HIV

Data is not currently available on the condom use and use of sterile equipment during this reporting period. There is likewise no data on their HIV testing seeking behaviour and hence HIV prevalence among this group is unknown.

TARGET 3. ELIMINATE MOTHER-TO-CHILD TRANSMISSION OF HIV BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS

Prevention of mother-to-child transmission

The Declaration of Commitment of UNGASS in June 2001 set the goal of reducing "the proportion of infants infected with HIV by 20% by the year 2005 and by 50% by the year 2010, by ensuring that 80% of pregnant women accessing antenatal care receive information, counseling and other HIV-prevention services and - Increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce MTCT, as well as to voluntary and confidential counseling and testing, breast milk substitutes and the provision of a continuum of care" [70].

Ghana has a unique opportunity to achieve its goal. The national antenatal coverage has been consistently over 90% of the expected pregnancies [71]. This affords an opportunity for reaching at least 90% of pregnant women with PMTCT, but creates a challenge of ensuring that PMTCT is provided at all antenatal clinics to achieve this goal. The number of Antenatal clinics and the PMTCT uptake at each clinic providing PMTCT is thus critical for achieving this target.

Progress in PMTCT has also been tremendous. Ghana adopted the policy of using ART for PMTCT in 2006. In 2009, PMTCT services were provided at the national (tertiary), regional, district, health centre level facilities in both public and private health facilities. Significant success has been chalked in further decentralizing PMTCT to the community level through Community Based Health Planning Services (CHPS).

The number of PMTCT centres increased from 135 in 2005 to 1,174 functional sites by December 2011. The number of clients counselling and testing as part of ANC services has increased from 257,466 in 2008, 381,874 in 2009 to 520,900 in 2010. The number of positive PMTCT clients receiving ART has increased from 4,991 in 2008 but decreased to 3,643 in 2009 and rose again to 5,845 in 2010. The Percentage of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother to child transmission has increased from 38.1% in 2008 to 64% in 2011.

Indicator 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

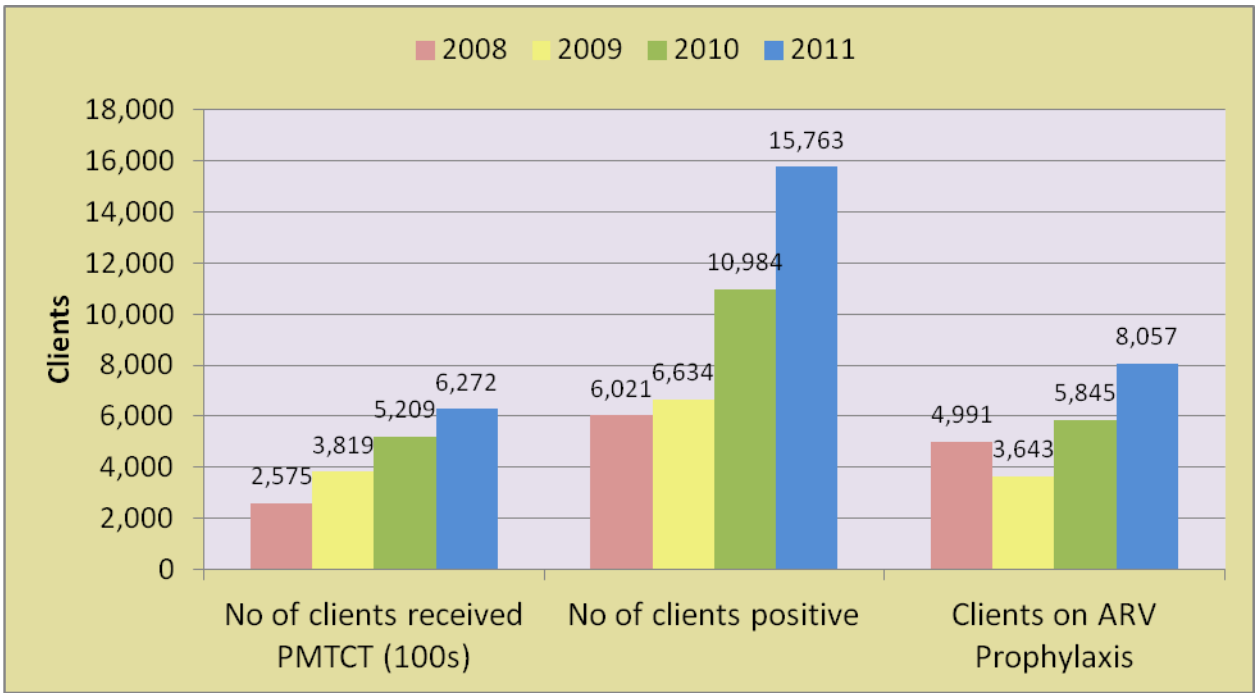
Table 19: PMTCT services in 2008 to 2011

Indicator	2008	2009	2010	2011
No of clients received PMTCT	257,466	381,874	520,900	627,180
No of clients positive	6,021	6,634	10,984	15,763
Percentage of Clients positive	2.3%	1.7%	2.1%	2.5%
Clients on ART	4,991	3,643	5,845	8,057
Percentage of HIV Positive clients detected through PMTCT on ART	82.9%	54.9%	53.2%	51.1%
Estimated number of HIV-infected Pregnant women in the last 12 months	13,095	12,990	13,316	12,661
Percentage of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother to child transmission	38.1%	28%	44%	64%

Source: National AIDS Control Programme, 2010 Annual Report, National HIV Estimates 2011

The initial decrease in the number of PMTCT clients receiving ART has been attributed to the new regimen instituted in 2007 which requires client to have a CD4 count test conducted prior to the initiation of either prophylaxis or ART. This results in delays in receiving therapy and a reduced number of clients accessing services at the end of the reporting period. In 2010 and 2011 only 53.2% and 51.1% respectively of HIV +ve Mothers detected through PMTCT services received ART compared with 82.9% in 2008.

Figure 10 PMTCT Service Data 2008 - 2011



Source NACP 2010 Annual Report and NACP Annual Statistics

Early infant diagnosis

Indicator 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

HIV disease progression is rapid in children; they need to be put on treatment as early as possible because without early treatment almost 50% of children would be dead by the second year

In line with the national goal of virtual elimination of mother-to-child transmission of HIV the Programme built capacity of institutions and health care workers in early diagnosis of HIV exposed infants. Five institutions were equipped in 2009 with DNA PCR machines. 85 service providers at regional, district and facility levels were trained to undertake Early Infant Diagnosis using the Dried Blood Spot method.

This indicator measures progress in the extent to which infants born to HIV-positive women are tested within the first 2 months of life to determine their HIV status and eligibility for ART, disaggregated by test results. It also assesses the impact of PMTCT interventions in reducing new infections.

The Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth was 18% in 2011.

Mother-To-Child Transmission Of HIV (Modelled)

Indicator 3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months paediatric HIV infections through mother-to-child transmission

The percentage of children who are HIV-positive should decrease as the coverage of interventions for PMTCT and the use of more effective regimens increases. The transmission of HIV from mother to child can be calculated by using the Spectrum model. The Spectrum computer programme uses the information on:

a. the distribution of HIV-positive pregnant women receiving different antiretroviral regimens prior to and during delivery (peripartum) by CD4 category of the mother
b. the distribution of women and children receiving antiretrovirals after delivery (postpartum) by CD4 category of the mother
c. the percent of infants who are not breastfeeding in PMTCT programmes by age of the child
d. mother-to-child transmission of HIV probabilities based on various categories of antiretroviral drug regimen and infant feeding practices

To achieve the UNGASS goal to reduce the number of children infected through MTCT by 50% data needs to be collected to determine the HIV incidence among these HIV exposed infants. In Ghana, this data was not systematically collected in 2008 and 2009.

The model estimated the indicator result as 9% for 2011.

TREATMENT CARE AND SUPPORT

TARGET 4. HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015

HIV treatment: antiretroviral therapy

Ghana continues to scale-up clinical services for PLHIV including ART. The scale-up of clinical care has continued in the public sector with linkages to the private sector through a concerted coordinated programme led by the NACP. The scale-up in 2010 and 2011 focused on providing more services to the decentralised level while strengthening the central level and achieving the targets specified in the Universal Access strategy.

The scale-up has been facilitated by the increased resources from the Government of Ghana and donor partners, including, USAID, and the GFATM. Health facilities providing ART increased from 3 in 2003, to 150 by December 2010. These health facilities have provided ART for PLHIV at the district, regional and (Tertiary) national health facilities in both the public and private sector.

The number of adults and children receiving ART has also increased concomitantly with increasing numbers each year. The details can be seen table below. In all in 65,087 PLHIV (62,081 adults and 3,006 children) have been put on ART since the onset of the programme in Ghana and 59,007 (56,050 adults and 2,957) of these are currently still on ART representing 90.7%.

Indicator 4.1: Percentage of women and men with advanced HIV infection receiving antiretroviral therapy

Ghana has pledged to achieve provide ART to 66% of clients who need it by 2010.By the end of 2011, much progress had been made. Figure 11 illustrates the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy. The graph shows the steady increase in overall coverage of HIV services to those who need it (adults and children) from 0.4% in 2003 to 36% in 2010 and 51.6% in 2011. The coverage of ART for children in particular has increased from 0% in 2003, to 16.2% in 2011. From 2009 the percentage of children on ART was 25.5%. This dropped to 12.6% in 2010, and increased to 16.2% in 2011. The ART coverage for adults has also increased from 35.3% in 2008 to 58.2% in 2011. This shows steady progress the country is making towards achieving its target of putting 85% of PLHIV who need treatment on ART.

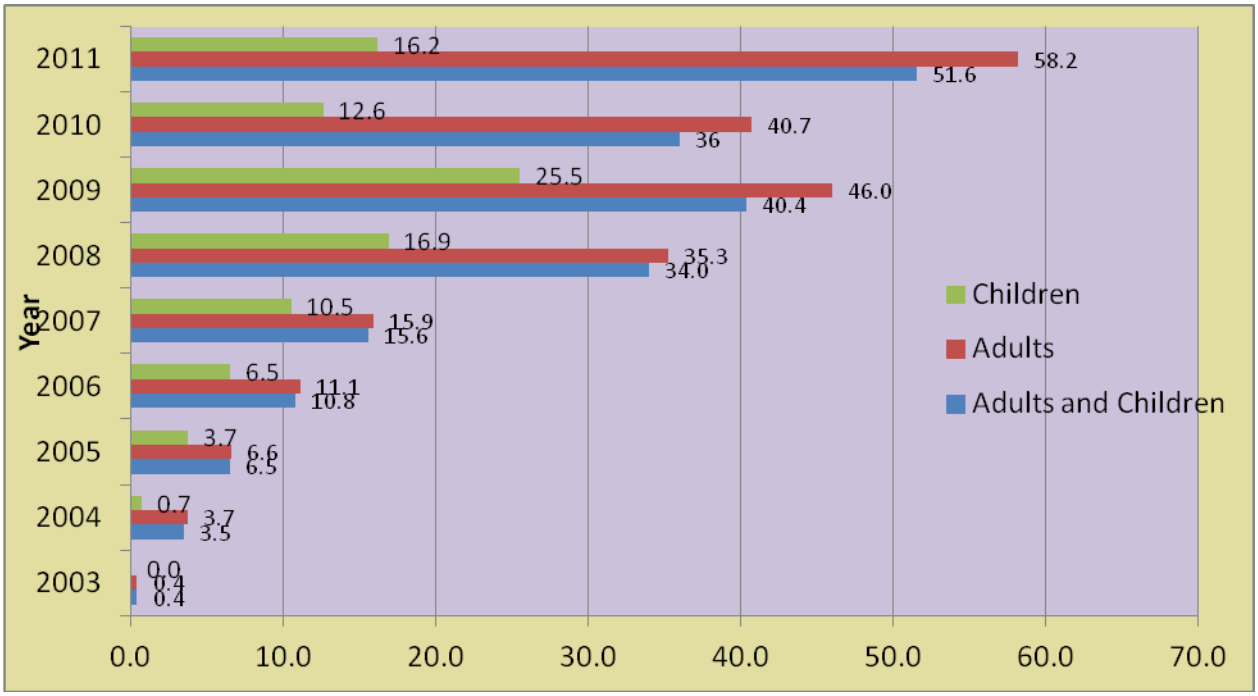
Table 20: Annual Number of Clients Accessing ART Services

Indicator	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Total Number put on ART	197	1,831	2,032	3,278	6,091	10,185	10,131	13,814	14,383	65,087
Males on ART	85	764	762	1,218	2,180	3,066	3,104	4,046	3,953	19,178
Females on ART	112	1,067	1,270	2,060	3,911	7,119	7,027	9,768	10,430	42,764

15+	197	1,804	1,913	3,156	5,783	9,735	9,409	12,920	13,441	62,081
<15	0	27	119	122	308	450	722	894	942	3,006

Source: NACP Annual Report 2005 – 2010 and NACP 2011 Annual statistics [72, 73, 76, 77]

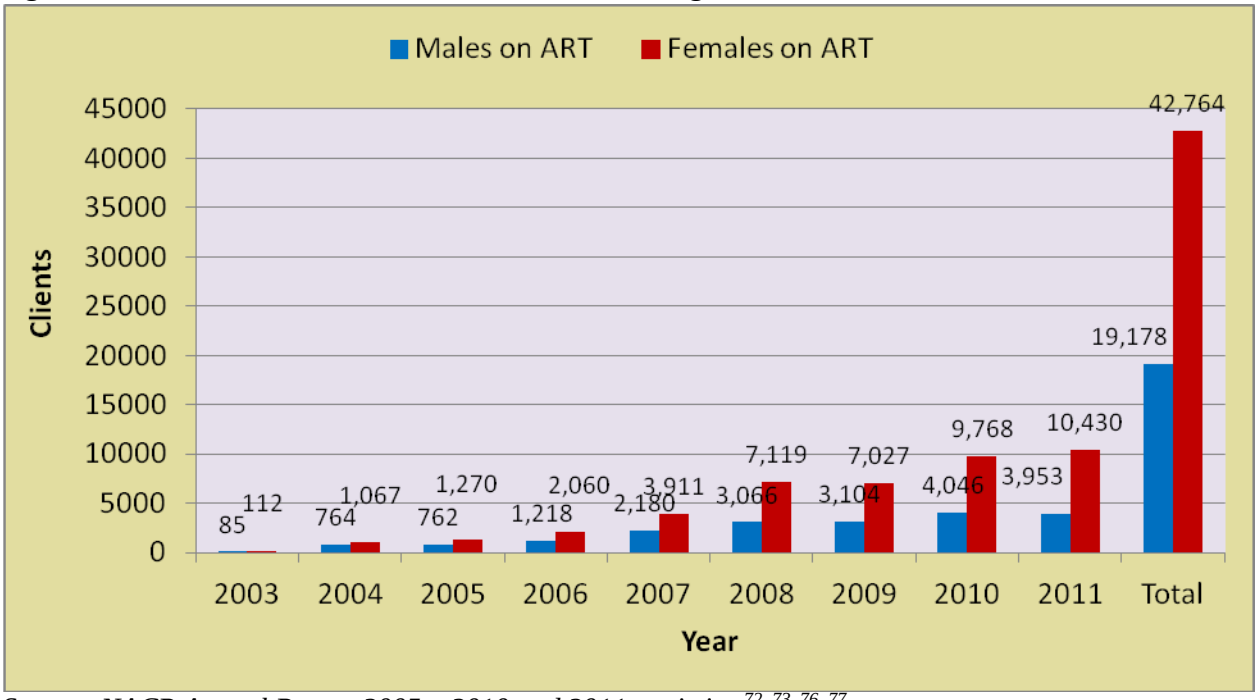
Figure 11 Percentage of adults and children with advanced HIV on ART in 2003 to 2011



Source: NACP Annual Statistics, 2011 HIV and AIDS Estimates and Projections

The data also shows that over the years a significantly larger number of females have initiated ART services compared to males. In 2009, 66.9% of clients accessing ART were women and this proportion increased to 70.7% in 2010 and 72.5% in 2011. This could be attributed to the numerous entry points which affords women the opportunity to have access to services, such as counselling and testing and PMTCT as well as the differential health seeking behaviour of men.

Figure 12: The number of male and females initiating ART in 2003 to 2011



Source: NACP Annual Report 2005 – 2010 and 2011 statistics [72, 73, 76, 77]

Twelve month retention on antiretroviral therapy

Indicator 4.2: Percentage of adults and children with HIV known to be on treatment 12 months after the initiation of antiretroviral therapy

One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals [78]. As more PLHIV have access to ART the quality of services requires monitoring. Collection and reporting on percentages of PLHIV who remain on treatment can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

Ghana embarked on its large scale ART programme in 2004 and some clients have been on treatment for number of years. As part of monitoring indicators to detect early warning for HIV resistance, the NACP has instituted measures to monitor the progress of these indicators. One such early warning indicator measures the percentage of adults and children who remain on first line ART after 12 months after initiation. This is measured for each ART site. For the 2010 cohort the overall value for this indicator was 71%.[32]

On the whole respondents scored treatment care and support 8.25 in 2009 and 9 in 2011. The key achievements they identified were:

- Scale up of Early Infant Diagnosis
- Provision of equipment and supplies to more health facilities especially in the regions
- Improvements in the TB/HIV collaboration activities

Key Challenges yet to be addressed include:

- Level of coverage of service to all PLHIV
- Lack of Human resource and mal-distribution of resources to the urban areas
- Drug and other commodity Stock-outs
- Weak Health Information Systems

TARGET 5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50 PER CENT BY 2015

Co-management of tuberculosis and HIV treatment

The HIV prevalence among TB patients in Ghana is estimated at 14.8% in 2011. The trend for HIV prevalence among TB patients, based on routine HIV testing among TB patients is persistently downwards. The proportion of HIV positive TB patients has ranged between 40% in 2005 and 23% in 2010. Ghana has made steady progress in providing HIV testing to TB patients which has moved from 7% in 2005 to 86% in 2010. The major challenge is putting all HIV positive TB patients on ART which is still as low as 20%. Providing Isoniazid Preventive Therapy (IPT) to PLHIV is not yet established because this has not been agreed as policy in Ghana.

Table 21 TB-HIV Services for TB patients (2005-2010)

Year	# TB cases notified (all forms)	# HIV tested	% HIV tested	# HIV positive	% HIV Positive	% offered CPT	% offered ART
2005	12,124	844	7	340	40	100	37
2006	12,511	2,136	17	711	33	69	14
2007	12,964	5,695	44	1,621	28	72	17
2008	14,467	7,373	51	1,630	22	87	24
2009	15,286	9,870	65	2,218	22	72	24
2010	15,145	10,442	69	2,451	23	86	20

Source: NSP 2011-2015

Whereas the trend for screening TB patients for HIV is increasing all the time (from 7% in 2005 to 69% in 2010, the screening of HIV patients for TB is very low. Records at the NACP show that by December 2009, only 12% of PLHIV were screened for TB. Gaps in the coverage of screening for the two diseases include inadequate recording and reporting on TB/HIV collaboration at health facility level as health workers consider filling of the screening tool as additional work. The screening tool is also not always available in all health facilities.

Indicator 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

In 2010 a total of 4,073 TB cases (Male: 2,120 and Female: 1,953) tested positive for HIV. 487 received both DOTS and ART (Male: 235 Female: 252) representing 11.9% of the cases diagnosed. In 2011 a total of 4,285 TB cases (Male: 2,059, and Female: 2,226) were HIV

positive. 796 received both DOTS and ART (Male: 363, Female: 433) representing 18.5% of the cases diagnosed.

TARGET 7: CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS

National Commitments and Policy Instruments (NCPI

Civil Society involvement

The civil society has been involved in the HIV response from the onset through the Ghana HIV/AIDS Network (GHANET), NAP+, and other PLHIV associations, WAPCAS and Faith Based Organizations at all levels. Through interactions with the Ghana AIDS Commission, civil society has played an active role in policy formulation and planning of Interventions at all levels.

In 2010 and 2011 civil society played an active role in the development of POW 2010 and 2011; took decisions in prioritising areas of intervention and refocusing on prevention interventions for 2010 and 2011 and participated in all the relevant national technical working groups.

Different types of civil society organisations are involved at different levels. At the national level, umbrella organisations and networks are involved in the national policy formulation and planning, these include GHANET, NAP+, Alliance for Reproductive Health, the Ghana Business Coalition against AIDS (GBCA), ISODEC, FBOs, Society of Women Against AIDS. At the district level local NGOs and CBOs are involved in HIV activities targeting specific populations.

Civil society organizations have been involved in the implementation of the GFATM Round 8 HIV project as Principal recipients and subrecipients. The Principal recipients were the Adventist Development Relief Agency (ADRA) an FBO, and the Planned Parenthood Association of Ghana. These organizations went through organizational capacity assessments to improve their systems as conditions precedent to implanting the Round 8 HIV project.

Following the challenges identified in 2007, 2008 and 2009 reviews, a new approach was used to build the capacity of NGOs and CBOs. Umbrella organisations have been used to build the capacity of the smaller organisations and this has aided quality of activities implemented at the community level. These organisations are assessed and are required to prepare an annual work plan for which (when approved) they are provided with funding based on their performance.

Respondents rated the efforts to increase civil society participation in 2007 at 7 for both and 2009 at 7. Though civil society participation in policy formulation, planning and monitoring has improved, the level of funding for implementation had not improved.

Workplace Programmes

Workplace HIV Policy Guidelines were published through the collaboration of the Ghana AIDS Commission, National Tripartite Committee and ILO and circulated to implementers at all levels[36]. Following the National Workplace HIV and AIDS Policy dissemination, a growing number of MDAs, private sector organizations and Metropolitan, MMDAs have adapted the generic policy to develop their own workplace policies.

In 2008 and 2009, The German Development Cooperation (GDC) via its technical wing GIZ contributed, to the implementation of HIV and TB mainstreaming workplace policy for all staff and their families of the public and private sector organizations it is supporting, namely the revenue agencies (CEPS, IRS, VAT), selected state institutions (GWCL and Ministry of Justice), and with the GFATM Round 8 HIV grant, the hospitality industry. Through a number of innovative Public Private Partnership Projects GIZ has harnessed the support of international private companies to partner with local government institutions to support HIV workplace programmes. All these programmes have innovatively linked HIV to other diseases such as TB, and lately other non-communicable and lifestyle conditions, thus broadening the scope and reducing the resistance to implementation of the activities. The activities focus on prevention through peer education and educational programmes, counselling and testing and integrated into care if needed.

Ghana AIDS Commission during the period under review also supported the Ghana Business Coalition against AIDS (GBCA), the Ghana Employers Association and the ILO, and GIZ to support private sector enterprises and the informal sector to implement workplace HIV&AIDS activities. The GBCA, GEA, GIZ and ILO undertook several activities to support Workplace HIV programmes in the private sector, these include advocacy, testing and counseling, condom distribution, peer education training, policy development, quality assurance and information seminars.

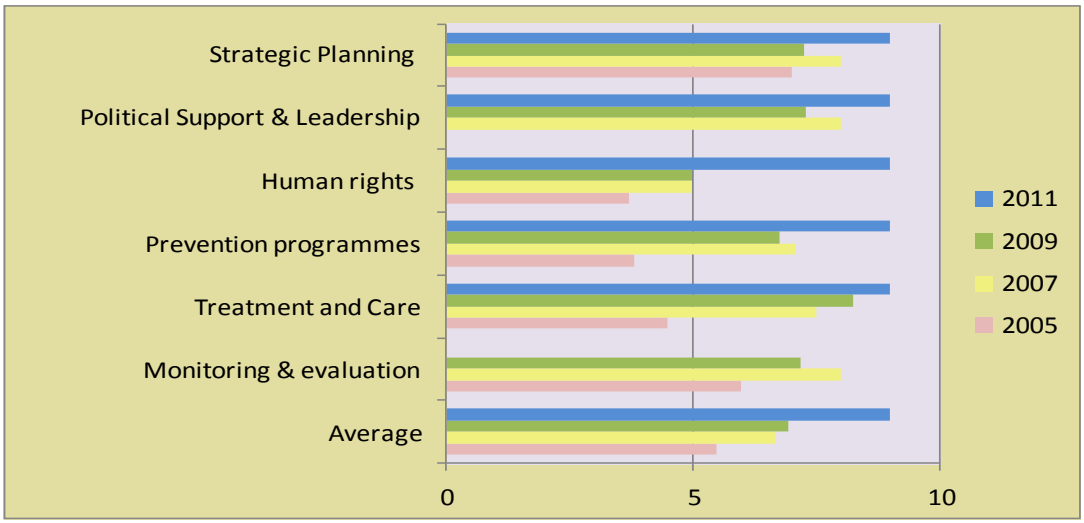
7.1 SUMMARY OF NATIONAL COMPOSITE INDEX

Table 22 Results of National Composite Policy Index (NCPI) in 2011

Area\Score	2005*	2007	2009	2011
Strategic Planning	7	8	7.25	9
Political Support & Leadership		8	7.3	9
Human rights	3.7	5	5	9
Efforts in implementation of HIV prevention programmes	3.8	7.1	6.75	9
Care and support	4.5	7.5	8.25	9
Efforts to meet needs of OVC		6	5	9
Civil society/ involvement	6	7	7	9
Monitoring and evaluation	6	8	7.2	
Average	**5.5**	**6.68**	**6.95**	**9**

The results of the four successive UNGASS/GARP surveys 2005, 2007, 2009 and 2011 are depicted in Table 22. On the whole, the results show that respondents thought that the various intervention areas ranked at level 9, reflecting the confidence reposed by stakeholders in Ghana's HIV response.

Figure 13: Trend Analysis of NCPI, 2005, 2007, 2009, 2011



7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months

DHS

Orphans school attendance

In 2008 and 2009, it was estimated that 18,082 and 17,058 adults respectively died of AIDS. With the new estimates it is expected that in 2010 a further 14,934 adults would die. It is expected that with the death of these adults their children will be orphaned and will have to face life without the presence of one or both of their parents, putting them at risk of poverty and causing them to adopt behaviours that will increase their vulnerability to HIV. The estimates for 2008 and 2009 indicate that there are approximately 140,000 orphans.

Considerable progress has been made in support of orphans and vulnerable children (OVC). With the increasing recognition of the implication of the situation of families and communities, support for OVC has intensified during this reporting period. The National Policy Guidelines on Orphans and Vulnerable Children was disseminated in 2006. An action plan is being developed in conjunction with UNICEF for the implementation of the Policy Guidelines.

In 2008 OVC were supported through a number of mechanisms: The Livelihood empowerment against Poverty (LEAP) implemented by the Ministry of Manpower, and Employment (MME) and its implementing agency ; the Department of Social Welfare (DSW) initiated this scheme in March 2008. The LEAP provided conditional and unconditional cash transfer for the extremely poor households who have no alternative means of meeting subsistence. The main objectives are to reduce poverty and hunger, stimulate access to social services (health and education in particular), empower subsistence and impact positively on women and children during pregnancy and reduce the rate of MTCT of HIV/AIDS, among target groups.

Indicator 7.3: Current school attendance among orphans and among non-orphans aged 10-14 years.

In Ghana, according to the GDHS study, 1.0% of children aged 10 -14 had lost both parents, while 10.5 % had lost one or both parents. Among these 67% were attending school. Among children age 10 -14 who have both parents alive and living with at least one parent, 86 % are attending school).

Table 23: Current school attendance among orphans and among non-orphans aged 10-14 years

	School attendance		
	2003	**2006**	**2008**
Orphans	65%	88.9%	67%
Non orphans	81%	85.8%	88%
Ratio of orphans over non-orphans	0.80	1.04	0.76

Source GDHS 2008 (MICS 2006)

The ratio of school attendance in orphans to non-orphans in 2009 is 0.76. This is a decrease from the 2006 MICS survey and 2003 GDHS. Respondents ranked efforts on OVC as 6 in 2007 and 6 in 2009.

7.4 Proportion of the poorest households who received external economic support in the past 3 months

BEST PRACTICES

Through the implementation of the national response stakeholders have noted a number of best practices that have facilitated the HIV response and added value and quality to its implementation. These best practices have been collected as part of the periodic reporting of the GFATM Round 8 HIV Project.

Best practice

The mainstreaming of HIV and AIDS into the Medium Term Development Framework of Metropolitan, Municipal and District Assemblies (MMDAs) of the Ghana government is a collaborative activity between Ghana AIDS Commission (GAC), Ministry of Local Government and Rural Development (MLGRD) and the National Development Planning Commission (NDPC) and the Assemblies.

The Government of Ghana has developed a Medium Term Development Framework "Ghana Shared Growth and Development Agenda 2010-2013 (GSGDA) which presents the national aspiration and direction for development and growth as a country. All districts and sectors are by law enjoined to use the document to guide them in preparing their development plans for 2010-2013.

The development of the National HIV and AIDS Strategic Plan 2011-2015 took inspiration from the GSGDA as a way of contributing to the achievement of objectives in the national framework.

The mainstreaming of HIV and AIDS into the Medium Term Development Framework of Metropolitan, Municipal and District Assemblies meant an overall review of the MMDA Medium Term Development Plans from the perspective of HIV and AIDS; identifying gaps and challenges and the provision of a simple step-by-step HIV and AIDS mainstreaming guide or checklist to facilitate the strengthening of the plans.

All Metropolitan, Municipal and District Assemblies have undergone training to update their Medium Term Development Framework Plans which will be the basis for future HIV and AIDS funding for the decentralized levels of government.

Protection of the rights of MARPs

The M-Friends and M-Watchers program is a rapid response mechanism involving peers and law enforcement and legal professionals who support the protection of human rights of MARPs.

Use of technology to facilitate access to counselling and services.

The key innovative intervention is the use of mobile phones to provide counselling and referral services for MSM and FSW, known as "Text me! – Flash me! Helpline Program". In this program, a toll-free phone service gives easy access of MARPs to HIV service providers.

Community Enhancement Methodology

The use of community conversation through Story Telling and Reflections under the Community Capacity Enhancement methodology developed by the UN as part of Stigma Reduction activities

is yielding positive results. The methodology allows community people the opportunity to identify, explore their concerns and reflect on their attitudes, share their fears, speak out on the negative information they have about PLHIV, and take decisions and to relate to PLHIV in a positive ways. Through the community conversation, some PLHIV are encouraged to disclose their status to family members and community people.

The Heart to Heart Campaign
The Heart to Heart campaign, which is partnership with the Network of Associations of PLHIV in Ghana provides a human face to the HIV and AIDS disease through open disclosure of HIV sero-positive status by PLHIV. The ultimate aim is to help reduce stigma and discrimination against PLHIV.

It is anticipated that by working together with 'real' HIV infected persons in this campaign, the message about stigma elimination will be better received. It is expected that the personal risk perception of people will be heightened and that they will take steps to avoid being infected. It is also expected that the campaign will encourage the use of HIV services by Ghanaians. Ultimately the campaign should lead to a change in beliefs, perceptions, behaviours and practices of all Ghanaians towards PLHIV.

Peer Education
Working with peer educators to reach out to their peers in schools and communities with HIV and AIDS information and services, has been a key strategy that has worked over the years. In tertiary institutions

HIV Testing & Counseling
- House-to-house sensitization to mobilize people for HTC during outreach HTC sessions
  This approach (although labour intensive) was used to good effect in mobilizing target populations for Counselling and testing during outreach HTC sessions.
- HTC is done in conjunction with other screening exercises like blood pressure measurement, breast examination, etc. This reduces stigma associated with HIV testing
  This method has been used with gratifying results to virtually remove the stigma that would otherwise arise with HIV-only testing. This enables more people to feel bold to test for HIV ad obtain their results. GIZ also implemented a programme which integrated HIV testing with other health screening programmes making the 'Know Your Status' a 'Know Your Health Status' campaign where screening for Diabetes and Hypertension is added to HIV testing. This when adopted serves to reduce the stigma associated with HIV testing.

Condom distribution
Condoms are distributed through non-traditional distributors such as peer educators, through hairdressing salons, barbering shops, etc. This reduces shyness that is sometimes associated with buying condoms from traditional sources like clinics, pharmacy shops etc.

Community Governance and Oversight

The use of community governance (steering committees and oversight committees by ADRA was also seen to be very useful in ensuring accountability and value for money at the community level.

Know Your Status Campaign

In 2008 and 2009, the country embarked on a large scale "know your status campaign". This campaign comprised of sensitisations, counselling and testing and demand creation for HIV services. This campaign was taken to all regions of the country. Through the Ghana Health Service, testing was provided free of charge at each hospital. Mobile Counselling and testing/ Outreach services were also provided to the community to reach the community members who do not readily access health facilities. Both the health sector and the CBOs at the community level were engaged. Strong linkages were made to health facilities to ensure referral of HIV positives and those who require other services. This campaign greatly improved the uptake of counselling and testing and served as an entry point for care.

HIV ALERT Programme

UNICEF and Ghana Education Service's (GES) HIV School ALERT Model is an innovative approach to fully integrate a coordinated plan for school- based HIV and AIDS education. It is mixed package of interventions to enable schools raise their HIV and AIDS response to a state of "ALERTNESS". The ALERT Model seeks to reach teachers, schools and the community, hence the three 'pillars' of the ALERT Model: Teacher–Led Pillar, Child–Led Pillar and School community–Directed Pillar. It involves pre-and in-service training of teachers and training of students as peer educators as well as monitoring and certification of schools. Once the school has implemented a certain minimum package of interventions it raises its level of HIV and AIDS response to a state of 'ALERT'[80].

Models of Hope

Models of Hope are a group of PLHIV who assist at the ART clinics. These are recruited from PLHIV support groups and work with the clinic staff to provide some basic support. They perform simple non medical task, such as organising patients, registering patients and providing psychosocial and adherence counselling. This helps to relieve health workers of some of their task and frees them to provide other services. This has been scaled-up in all regions of the country.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress on key challenges reported in 2009

In the 2009 UNGASS report the key challenges identified were:

- coverage of prevention programmes targeted at the youth especially out-of-school youth, and the general population addressing the gaps in Knowledge and behaviour,.

Progress: The implementation of the GF Round 8 HIV project has completed its first phase in 2010 and 2011.

- Inadequate number of skilled human resources at the lower levels of the health system and at the community level

Progress: Through task shifting and multi-tasking policies, This issue has been addressed to a large extent. The CHPS approach continues to receive priority attention and is a key strategy to bring skilled manpower to the peripheral communities.

- High human resource turn over

Progress: This is largely being addressed by the same methods as on the case above.

- Inadequate coordination and management of HIV/AIDS activities at the community level

Progress: Additional support has been mobilized to the periphery through its Technical Support Units, who have been adequately resourced to better coordinate the field activities. Civil Society capacity building has been implemented through training clinics.
Community systems strengthening through Community steering and oversight committees implemented by ADRA.
M-friends and M-watchers program has strengthened communities response to violations to human rights.

- The low level of National commitment to HIV/AIDS activities coupled with inadequate direct government funding and high donor dependence for HIV/AIDS activities.

Progress: Government has made firm commitments to the AIDS Response by allocating $100million over five years. Government also continues to be the largest financier in terms of fixed infrastructure, human resources and other consumable logistics to the AIDS Response. In 2011 alone the government has financed the addition of approximately 16,000 new cases of HIV into ART.

- Stigma and discrimination (both perceived and actual) of PLHIV and MARPS

Progress: Through the mass media awareness and sensitization on stigma and discrimination has been identified as a topical issue. The Heart to Heart campaign has enabled more PLHIV to come out openly to join the effort at reducing stigma, by showing the true face of HIV, thus negating the negative perceptions that exist in the minds of the unexposed. Presidential call for elimination of Stigma and Discrimination.
The Community capacity enhancement methodology has enhanced community dialogue to discuss and dispel fears about HIV and AIDS.
The Heart to Heart campaign is aimed at a reduction of self stigmatization by PLHIV.
Recommendations have made and presented to the National Constitutional Review

- Inadequate coverage of services to all PLHIV at the community level

Progress: The KYSC is assisting in identifying more candidates to be enrolled into care. More effective referral system. Provision of Home based care services in some of the

regions. Nutritional support in five regions. NHIS. Urban Poverty Reduction Program providing monthly stipends.

- Frequent drug and other commodity stock-outs

Progress: This issue is being addressed at the Ministry of Health and with the collaboration of development partners, private sector and appropriate agencies. The Central Medical Stores is undergoing major restructuring in its systems to enable better management and storage of commodities.

A strategic review of the public sector healthcare supply chain in Ghana sponsored by the USAID | DELIVER PROJECT was undertaken. The strategic review was primarily intended to support the Government of Ghana (GOG) in developing its strategic vision for the public sector healthcare supply chain and to help USAID and other Partners decide where best to channel their support for strengthening the public sector healthcare supply chain. Subsequently a Commodity Security (CS) working group was formed in 2011 comprising Development partners and MoH officers, other stakeholders as well as CS experts to act on the findings of the strategic review and prepare a strategic plan for addressing the issue.

Weak Health Information Systems

Progress: This is being addressed at the within the Health Sector at National Level. In addition the GAC has developed (in collaboration with stakeholders in relevant sectors) a comprehensive National M&E plan which is harmonized across sectors.

An assessment of the Country Response Information System software has been undertaken and a report has been presented.

- Wide gap between the policies and laws and their enforcement

Progress: A Committee has been set up to consider the review of certain constitutional and legal barriers to HIV and AIDS programmes enshrined in the Ghana Constitution of 1992.

A complete review of the legal framework was conducted that led to the production of a report underlining of numerous legal provisions that protect the fundamental rights of every Ghanaian with emphasis on vulnerable groups and follow-up mechanisms that guarantee their effectiveness.

A national consultation for the improvement of the legal framework concerning human rights and HIV and AIDS in Ghana has been held to exchange ideas on the issues; identify the perspectives and strategies that guarantee the effectiveness of the legal framework in the Ghana context and to elaborate recommendations for the improvement and strengthening of the judicial and other law enforcement systems

An Act in this respect has been drafted which is intended to create a favorable environment for all aspects of HIV and AIDS and other STI prevention, care and support. One of the objectives of the Act is to ensure that the basic human rights of every Ghanaian, especially persons infected with HIV or AIDS are respected, protected and upheld.

- Coordination within each sector as well as supra-ministerial coordination

The Vice president is personally involved in harnessing the commitment of allied Ministries.

- Inadequate M& E system in some sectors

Progress: A harmonized National M&E system and Plan is now in place.

Through the Global Fund Round 8 grant, 751,069 by PPAG 68,204 by ADRA out of school youth were reached between 2010 and 2011 with 87.4% (656,143) within age 10 - 24 years (PPAG Dashboard). This is as a result of the increased numbers in group discussions organised by the Peer Educators. The inclusion of workplace programs has enabled the targeting of a captive population, who are undoubtedly key actors in the transmission of HIV, as evidenced by their earning power and the interactions that take place at the workplace. The clients of FWs are invariable income earners and it therefore makes sense to target workers.

Coordination of activities at the national level has improved. Various MDAs are implementing HIV activities and providing information to GAC. GAC is developing a database for HIV activities. Through various mechanisms and technical working groups there has been improved strategic planning and stakeholder buy-in. Regular and planned meetings of all technical working groups are being held. Through this, GAC has a better understanding of HIV activities being implemented and has played an improved coordination role.

Every effort was made to address the late funding provided for MDAs and NGOS. Using a new mechanism of pre-selected large NGOs do not need to follow the long process of proposal writing and selection. Currently work plans are submitted for approval and this has reduced the funding time-line.

Improved planning using evidence-based approach and programmatic data has improved forecasting for HIV commodities. However, more needs to be done to ensure that the time lag between ordering of commodities and their arrival at the end user level is reduced.

In 2010 and 2011, efforts continued in all areas to build the human capacity in all areas of HIV intervention. To mention a few, training was conducted for health workers in CT PMTCT and ART and the capacity of small NGOs was built by larger NGOs. However, the ongoing attrition of health personnel is still a major concern.

Challenges faced throughout the reporting period of 2010 – 2011

The main challenges faced that hampered implementation of national response were:
Constraints

- Issues relating to the procurement and commodity security system led to delays and anxieties among implementers and beneficiaries of programs. The country's stringent procurement system is still yet to rum seamlessly to allow for smooth program implementation
- Prices of condoms are not uniform at project sites. Whereas some organizations distribute them for free, others (especially those obtained from the government sector) are sold. sell them. This makes it difficult for those organizations who sell to distribute their condoms effectively.

Remedial Measures

The Country is addressing the bottlenecks in the procurement system through consultative meetings between program and technical experts and development partners to develop a

workable plan to ameliorate the problem. Meanwhile the Voluntary Pooled Procurement (VPP) platform is being considered as an alternative procurement mechanism.

For Commodity Security and Supply Chain issues, four strategic models were presented in a report:

1. Private sector model – private sector becomes the supplier of first resort to public sector facilities
2. Maintain current model – current ad hoc system with private sector main supplier of essential medicines, and CMS and programs together supplying program items and CMS supplying certain supplies on an ad hoc basis
3. Focused Public Sector Model – CMS becomes supplier of selected program items with private sector providing other essential medicines
4. Public Sector Model – CMS becomes supplier of first resort to public sector facilities

.

Concrete remedial actions that are planned to ensure achievement of UNGASS targets

Strategic planning and Political and Legal environment

- GAC will continue to play the effective leadership and coordination roles to ensure that all interventions, actions, recommendations from reviews are fully implemented and the response is focused and effective to achieve the targets.
- GAC shall hold sectors accountable, while it coordinates effectively at the national level.
- The GAC should ensure that the necessary capacity is strengthened to coordinate, plan, support implementation and monitor progress of activities at all levels in all sectors.
- GAC should ensure that advocacy on laws that pose obstacles to HIV interventions is stepped up and addressed

Policy, Advocacy and Creating an Enabling environment

- A massive effort should be made to advocate for improved political will and commitment to achieve set targets in 2010 and 2015.

Prevention

The National Integrated Behaviour Change Communication and IEC Strategy for all AIDS response in Ghana published in 2005 [82], should be reviewed or redesigned to include current emerging issues and take into account research findings from various studies (e.g. DHS) and address current gaps.

- Comprehensive prevention programmes should be drawn up taking the DHS results into consideration and addressing the issues directly.
- PMTCT should be fully integrated into antenatal service and provided as part of safe motherhood. Effort should be made to ensure full integration of services to enable ANC clients access services at ‘one stop shop’ to prevent moving from one service point to another

- Implementation of early infant diagnosis should be rapidly scaled- up to see the impact of PMTCT services have on HIV transmission in Ghana.

Treatment Care and Support

- To address the human resource challenges for ART, large number of persons would need to be trained to fill in the gaps created due to attrition of staff.
- Pre-service training of health care providers (Doctors, Nurses, and Laboratory staff) should incorporate HIV and AIDS and all aspects of service provision (including ART in particular) into the curricula of training institution as soon as possible.
- Task-shifting to free critical staff (doctors and nurses) with greater involvement of other cadres of staff in ART provision would reduce the burden on critical staff, improve the efficiency, quality of service and waiting times at service provision points.
- The use of Models of Hope and other civil society organisations should be scaled-up to facilitate and provide support for services.
- The capacity for Logistics Management and Information Systems, procurement and distribution of drugs and response to early warning systems need to be strengthened.
- Stigma and discrimination should be addressed at service delivery points as part of the ant-stigma campaign. Training should be conducted for staff and incorporated into ART training. Innovative ways for motivating staff to continue to work with the influx of clients should also be explored.

Resource mobilisation

- There is the need for greater governmental commitment with provision of more resources for HIV is required in the face of dwindling external resources.
- There is the need to ensure that 0.5% of the District Common Fund is provided for HIV/AIDS activities at the district level and is utilised effectively.
- Resource mobilisation needs to be done to ensure that funds are available for ART in the ensuing years.
- The private sector and its umbrella organizations should be empowered and resourced to make the private sector a major contributor and participant in the National Response.

Monitoring and Evaluation

- Capacity should be built in all sectors including the private sector and civil society to ensure the provision of accurate and quality information.
- Information dissemination and sharing between sectors and the GAC should be intensified. All actors should make it a point to provide GAC with information on their activities for effective coordination.
- Ensure that research is commissioned on all UNGASS indicators to address data gaps for better monitoring
- Ensure that the data generated is used for future planning
- Ensure that the implementation of the recommendations is monitored

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

In 2010 and 2011 development partners contributed substantially to the national response by the provision of technical and financial support to the Ghana AIDS Commission, the CCM and other implementers in the country.

Partners continued to be actively involved in the committees of the Ghana AIDS Commission especially, in the Research Monitoring and Evaluation, expanded technical working group and various task teams. Partners also provided adequate information on their funding envelope, though there are still some gaps identified.

The key development partners who provide financial support for the HIV and AIDS response in Ghana are The Global Fund for AIDS TB and Malaria, Bilateral agencies such as USAID, GIZ, DANIDA and UN agencies. These funds are provided to the GAC's pooled fund or earmarked funds or directly to implementing partners usually international NGOs, local NGOs or MDAs for implementation.

In 2010, development partners contributed US$158,764,061 for the HIV response. International Organisations still provide the majority of funds (77.3%) for the HIV response. Support was provided mainly to strengthen the health care system, prevention programmes, care and treatment as well as research.

Actions that need to be taken by development partners to ensure achievement of UNGASS targets

To ensure the achievement of the UNGASS targets, partners will need to take the following remedial actions**.**

- Continue support to GAC in its coordination role
- Provide adequate information flow and feedback on their support to the country to GAC.
- Ensure that where direct funding is provided to the implementing agencies reports are presented to GAC to enhance GAC's coordination.
- Support GAC to implement recommendations of reviews such as the UNGASS and the Universal Access Report.
- Ensure that funding and technical assistance gaps are filled

MONITORING AND EVALUATION ENVIRONMENT

The Ghana AIDS Commission is responsible for monitoring and evaluation (M&E) of the National HIV/AIDS response. The national M&E system is based on the principle of one national M and E system. It has six defined sub-principles:

- One National M & E Unit
- One national multi-sectoral M & E plan
- One national set of standardised indicators
- One national level data management system
- Effective information flow

- National M&E capacity building [83]

This M&E function is carried by the Research, Monitoring and Evaluation Division. In 2010 and 2011, the M&E unit was provided with more personnel. The Unit is led by the Director of Research Monitoring and Evaluation and supported by the Research Coordinator, a Monitoring and Evaluation (M&E) Coordinator, four M&E Officers, Data Manager, Data Management Officer, Research Officer, Data Quality Assurance Manager, and one administrative secretary. Three of the four M&E Officers are members of the Technical Support Units of the Regional AIDS Committees at sub-national levels.

A research, monitoring and evaluation technical committee continues to support the GAC. It is comprised of GAC, M&E specialist, MDAs, CDC, UNAIDS, UNICEF, University of Ghana, University of Cape Coast, Ministry of Health, Ministry of Food and Agriculture, Noguchi Memorial Institute for Medical Research, NACP, WAPCAS, FHI360, GIZ and representative from PLHIV. The RM&E committee is responsible for monitoring a national set of indicators and report on the national response.

In 2010 and 2011a number of activities were under taken to strengthen the national M& E system.

Strengthening of Technical Committee
In 2009, the Research Monitoring and Evaluation Committee (Technical Committee's) terms of reference were revised to guide its operations with a view to improving coordination and the quality of technical and operational management of research, monitoring and evaluation activities in line with national guidelines and international standards and practice. The revision of the terms of reference necessitated reconstitution of the membership to bring on board new skill-sets that are not currently available within the committee.

M&E Road Map
As part of the commitment to strengthening the monitoring and evaluation systems of the national response an integrated Road Map for monitoring and Evaluation based on the Organizing Framework for Functional National M&E Systems (12 Components) was developed and implemented in 2009 and 2010. The costed M&E Roadmap sought to address major weaknesses in Strategic information generation, analysis, reporting and use[12]. Key results of the implementation of the M&E Roadmap include:

- Restructuring of the National M&E Unit at GAC and expanding staff size to ensure appropriate skill mix and expertise
- Indicator harmonisation and standards improvement in data collection, analysis and reporting
- Improvements in community-level M&E systems
- Establishment of technically sustainable MARPs Surveillance system
- Improvements in data quality through the application of international standards
- Repositioning of the national M&E agenda for results
- Stronger M&E advocacy and building of M&E culture at national and sub-national levels
- Integration of HIV M&E in public, private, CSO and FBOs operations. This is eveident in the establishment of functional M&E units in all HIV implementing organisations

Mapping, Size Estimation and Integrated Bio-behvioural Surveillance Surveys Among MARPs

In collaboration with its partners, the Ghana AIDS Commission initiated Mapping, Size Estimation (MSE) and Integrated Bio-behavioural Surveillance Surveys (IBBSS) among MSM, FSWs, IDUs and Prison inmates. A national scale study with nationally representative sample of this nature is unprecedented in Ghana and in most African countries. Previous BSS have been program based, limited to a few geographic areas (Accra, Tema and Kumasi) and involved only a small sample. In line with the costed M&E Roadmap, these studies sought to address critical data gaps in strategic information. GAC partnered with local research institutions such as Regional Institute for Population Studies (RIPS), Noguchi memorial Institute for Medical Research (NMIMR) and School of Public Health of University of Ghana and Medical School of University of Cape Coast. Funding partners include CDC, GFATM, UNFPA, UNICEF, DANIDA, GIZ and government of Ghana. Institute for Global Health of the Medical School of the university of California, San Francisco (UCSF) provides technical assistance to the local partners.

Data Quality Assurance System

GAC established data quality assurance system through the development of a data quality assurance manual, appointment of data quality assurance manager, and institutionalizing routine data quality audit and assessment at all levels of M&E in Ghana. Multiple data quality assessments were carried out in 2010 and 2011 at service delivery, district, regional and national levels. These included quarterly routine data audits on implementing partners activities by GAC, Onsite Data Verification (OSDV) by the local funding agency of the GFATM and annual national data quality assessment by GAC. USAID also carried out data audit on PEPFAR implementation in Ghana. These assessments together identified key weaknesses in the program and data collection and management systems. GAC through a consultative process with its stakeholders develop corrective action plan to address those weaknesses.

Development of National M&R Plan 2011-2015

In collaboration with its partners and stakeholders, the GAC developed a National HIV and AIDS Monitoring and Evaluation Plan 2011-2015 to support the implementation of the national Strategic Plan. The costed M&E Plan was prepared through a broadbased stakeholder consultative process. All partner M&E systems are aligned to it.

CRIS Customisation

The GAC has developed data collection tools for collection of primary data from the source of implementation. The primary data is aggregated and entered into the Country Response Information System (CRIS) at the decentralized level and then channeled upstream to GAC. However, CRIS does not have a physical data model and lacks features that facilitate the detail tracking of primary programme and financial data. These have made the current installation of CRIS **very slow** and not able to perform as required. To address this weakness, there is the need to customize CRIS3 with capability to capture data at the service delivery level, and channel it upstream to the District/Region and from there to the National level as has been done for other countries like Botswana. This will support the data management system, and is intended to enhance the National and Sub-national databases. It is also to enable the M&E system ensure that there is quality data collected from all sources, improve data analysis and strengthen existing

data audit and verification processes under the NSP 2011-2015. An assessment of functional requirements was carried out by Blue Infinity, the CRIS software developer. The consultant will customise the software based on the agreed functional requirements for piloting and eventual release for rollout in June 2012.

Institutionalizing M&E Training at School of Public Health

Over the years, GAC tried to address M&E capacity needs through training of staff of implementing partners throughout the country. This effort was very expensive and unsustainable. In collaboration with Morehouse School of Medicine, School of Public Health of the University of Ghana was engaged to develop a curriculum and train HIV M&E personnel in core modules. Two training workshops were held in both 2010 and 2011 for 50 participants each year. A unique feature of this training is the development and implementation of a project by each of the participants to address a particular M&E problem in their workplace. The training is evaluated at multiple levels and has strong mentoring mechanisms that support participants to identify an M&E problem/challenge that affects or directly impact on their organisation's performance, develop an action plan to address the problem and monitors the implementation of the action plan, and finally prepares a project report.

International Technical Assistance and collaboration

In 2010 and 2011, the GAC received technical assistance to strengthen national M& E system.

- Cooperative Agreement with CDC
  In 2011, GAC signed a cooperative agreement with the Centers for Disease Control and Prevention (CDC). The agreement focuses on strengthening community level M&E system. Community level M&E system is recognised as one of the newly evolving area and GAC wants use the advantages offered by this collaboration to make contribution in identifying best practices for the community of practice.

- Evaluation of MARPs Programs
  Through the leadership of the GAC, MSM and FSWs HIV prevention, treatment and care services have been expanded throughout the country. A national MARPs Strategy and operational plan have been produce. Effectively measuring the results of these interventions requires strong M&E system that generates and use quality data. In collaboration with USAID and Measure Evaluation of University of North Carolina, a MARPs program evaluation roadmap was developed in 2011. The roadmap is guiding routine program monitoring, process evaluation, mid-term and end-line evaluation processes.

- **Technical Assistance for MARPs Surveillance**

The Global Health Institute of University of California, San Francisco campus (UCSF) provided technical assistance to GAC and its local partners to strengthen the national M&E system. The technical assistance covers surveillance among MARPs and the development of modules for capacity building data analysis and scientific writing. The UCSF team provided training for national stakeholders on IBBSS and mapping and size estimation of MARPs, respondent driven sampling RDS and RDS data analysis.

Overall, respondents scored the M& E efforts of the AIDS program in 2011 as 9 compared with 7.2 in 2010.

(b) Challenges faced in the implementation of a comprehensive M&E system;

The main challenges faced in M&E include:

- Inadequate number of skills human resource capacity to deal with the load of data and analysis at the sub-national level.
- Database not fully functional
- Not all implementers provide data in a timely fashion.

(c) Remedial actions planned to overcome the challenges

- Continue the scale up of CRIS to all districts to support sub-national HIV databases
- Strengthen data dissemination at the decentralised level
- GAC continues to engage development partners and stakeholders to work through the existing M&E structures to ensure effective functioning of the unified national M&E system

CONCLUSION

Overall, Ghana has improved its Strategic planning processes, with wider stakeholder consultation and a more rigorous process of external and peer review. The epidemic in Ghana has stabilized and the National response continues to enjoy high level political support. The commitments being made by government in the light of worldwide challenges to financing if the HIV response are encouraging.

Steady progress is being made towards achieving global and national targets. The degree of stakeholder involvement has improved greatly, with greater involvement of persons living with the disease and civil society in general.

There are still challenges in the area of human rights for MARPs, quality of services and procurement and commodity security. Access to care and treatment services still lag behind prevention services and desired target for prevention behaviours have not yet been achieved.

This GARP report has provided information for the country and suggests the way forward that national authorities need to take, to achieve the national targets. The implementation of these recommendations will provide impetus to reducing the transmission of HIV and achieving Universal Access and the Millennium Development Goals.

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ANNEXES

ANNEX 1. Persons contacted and participants of workshops

Persons contacted for individual interviews

Name	Position	Institution
Ghana AIDS Commission		
1. Dr. Angela El-Adas	Director General	Ghana AIDS Commission
2. Dr. Richard Amenyah	Director, Technical Services	Ghana AIDS Commission
3. Mr. Kyeremeh Atuahene	Director, Research Monitoring and Evaluation	Ghana AIDS Commission
4. Dr. Joseph Amuzu	Director, Policy and Planning	Ghana AIDS Commission
Ministry of Health / GHS		
5. Mr. Kwadwo Asante	M&E coordinator	National AIDS Control Programme
6. Dr. Nii Nortey Hanson-Nortey	Technical Officer	National TB Control Program
7. Mr. Kwame Afutu	M&E Manager	National TB Control Program
8.		
Others		
9. Professor Felix Asante	Consultant/ Snr. Research Fellow	Institute of Statistical Social and Economic Research, University of Ghana
10. Mrs Comfort Asamoah Adu	Executive Director	WAPCAS
11. Ms Esi Awotwi	HIV and AIDS Advisor	UNFPA
12. Nana Fosua Clement	Prevention Specialist	FHI360

ANNEX 2. National Composite Policy Index (NCPI) 2010 Process and Responses

COUNTRY: GHANA

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

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Date of Submission: 29th March 2012

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

NCPI Data Gathering and Validation Process

For purpose of completion of the NCPI, the questionnaire was administered to government officials in relevant sectors (Ghana AIDS Commission, Ministry of Health, NACP, Ministry of Education, Ghana Education Service, Ministry of Justice, Ministry of Local Government and Ministry of Women and Children Affairs.)

Two stakeholder workshops was held on 12th and 16th March 2012 with participants from the public sector (12 March), and UN system, other development partners and civil society (16th March) who worked in groups. Each group worked on particular sections on the NCPI. The groups presented their sections in a plenary section and feedback was provided by all participants. Discussions were held until there was a consensus.

The average of the government responses and the respondents at the stakeholder workshop were Government Officials were computed and used for the NCPI.

A validation meeting was held on 29th March 2012 with a wider stakeholder audience of the Expanded Technical Working Groups of the Ghana AIDS Commission where the NCPI as well as the whole report was validated. Scores on Human Rights, Treatment, Care and Support and OVCs were changed based on other information that was not available to the stakeholder group.

Some participants involved in the NCPI for previous years had changed.

Respondents for the National Composite Index Part A

GAC Staff

1. Dr. Richard Amenyah - Director Technical Services and Ag. Director - General
2. Kyeremeh Atuahene – Director RM&E
3. Emmanuel Larbi – M&E Coordinator
4. Isaiah Doe Kwao – Data Quality Assurance Manager
5. Welbeck Amoani Twum – Technical Support Unit Coordinator (Brong Ahafo)
6. Kenneth Yeboah – M&E Officer
7. Kwasi Gyimah Okai – Data Management Officer
8. Raphael Sackitey - Data Management Officer
9. Dennis Annang – National Service Personnel

Government Officials

1.	C/Supt. J. Blantari	Police Service	Prog. Coordinator
2.	DO III James Kwateng	Ghana National Fire Service	Focal Person
3.	ASP P. A. Dadzie	Prisons Service	Focal Person
4.	Morrison Opam Adjei	Ministry of Justice and Attorney General's Department	Focal Person
5.	Kwadwo Asante	National AIDS Control Person	M&E Officer
6.	Faustina Acheampong	Ministry of Women and Children's Affairs	Focal Person
7.	Mercy Amoo – Darku	Ministry of Defense	PPME Officer
8.	Christoper Conduah	National Development Planning Commission	GA
9.	Steve Grey	National Population Council	Deputy Director
10.	Derrick Oppong – Agyare	Consultant	

GHANA AIDS COMMISSION

DATA SOURCE MEETING FOR COMPLETION OF NATIONAL COMMITMENTS & POLICY INSTRUMENT (NCPI) PART A FOR 2012 GLOBAL AIDS RESPONSE PROGRESS REPORT

MONDAY 12TH MARCH 2012

GAC CONFERENCE ROOM

1.0 PRESENT

GAC Staff

10. Dr. Richard Amenyah - Director Technical Services and Ag. Director - General
11. Kyeremeh Atuahene – Director RM&E
12. Emmanuel Larbi – M&E Coordinator
13. Isaiah Kwao – Data Quality Assurance Manager
14. Welbeck Amoani Twum – Technical Coordinator
15. Kenneth Yeboah – M&E Officer
16. Kwasi Okai – Data Management Officer
17. Raphael Sackitey - Data Management Officer
18. Dennis Annang – National Service Person

Government Officials

11. C/Supt. J. Blantari Ghana Police Service Prog. Coordinator
12. DO III James Kwateng Ghana National Fire Service Focal Person
13. ASP P. A. Dadzie Ghana Prisons Service Focal Person
14. Morrison Opam Adjei Ministry of Justice and Attorney General's Dept Focal Person
15. Kwadwo Asante National AIDS Control Program M&E Officer
16. Faustina Acheampong Ministry of Women and Children's Affairs Focal Person
17. Mercy Amo – Darku Ministry of Defense PPME Officer
18. Christoper Conduah National Development Planning Commission GA
19. Steve Grey National Population Council Deputy Director
20. Derrick Oppong – Agyare Consultant

2.0 Opening

The meeting started at 10:25am with a prayer by Kenneth Yeboah . Dr. Richard Amenyah explained the purpose of the meeting and asked that the meeting should proceed while waiting for the other participants. He also expressed the view that there may be the need to break into smaller groups to fill the questionnaire.

3.0 Overview

a. Mr. Atuahene before giving the overview of the meeting asked that participants introduce themselves. He explained the need to work in an expedited manner because there is a deadline for reporting of 27th March to meet.
b. Report from the meeting will capture those who were involved and the organizations they work for so it does not give the impression that it was filled by GAC.
c. Mr. Atuahene restated the fact that the invitation was to let participants help with answering the NCPI and it will take first part of the day till lunch.
d. He further explained the UN declaration and new commitments made by countries in the 2011 HLM in New York in July last year. The Global AIDS Response Progress Report (formerly UNGASS) has the National Commitments & Policy Instrument (NCPI) component, and is required that one part be completed by Government Officials and the other by CSOs.
e. He also explained the scoring process for the questionnaire to be given at certain point and the range was from 0 - 10 (lowest to highest), and in some cases 0-5 (lowest to highest).
f. He made participants aware of the need to objective in answering the questions and that it must be fact based. If participants were not sure about the facts related to the questions, there will be the need to refer from available source documents.

4.0 NCPI Questionnaire

This was filled with Mr. Kyeremeh leading the process, and participants joined in answering the questions.

5.0 Conclusion

Mr. Kyeremeh thanked all participants for coming on short notice and also appreciated the team work. The meeting ended at 12:30pm.

GHANA AIDS COMMISSION

DATA SOURCE MEETING FOR COMPLETION OF NATIONAL COMMITMENTS & POLICY INSTRUMENT (NCPI) PART B OR 2012 GLOBAL AIDS RESPONSE PROGRESS REPORT

FRIDAY 16TH MARCH 2012

GAC CONFERENCE ROOM

6.0 PRESENT

GAC Staff

1. Kyeremeh Atuahene – Director RM&E
2. Emmanuel Larbi – M&E Coordinator
3. Isaiah Kwao – Data Quality Assurance Manager
4. Olivia Graham - Technical Coordinator
5. Kwasi Okai – Data Management Officer
6. Raphael Sackitey - Data Management Officer
7. Dennis Annang – National Service Personnel

Civil Society Organizations, Bilateral and UN organizations

1.	Very Rev. Philip T. Norgbodzi	Methodist Church Ghana	Prog. Manager
2.	Paul Sono	ADRA Ghana	Director M&E
3.	Esther Boateng	Action Aid Ghana	Prog. Manager
4.	Adeline Mensah	FSDA Ghana	Director
5.	Rev. Daniel Opong - Wereko	PRS&D	Director
6.	Emma Anaman	WFP	Prog. Officer
7.	Rhodaline B. Addo	HRAC	Representative
8.	Florence Dossche	HRAC	Representative
9.	Adwoa Aidoo	World Education	Representative
10.	Stephen Konde	World Education	Representative
11.	Gurumurthy Rangaiyan	UNAIDS	M&E Advisor
12.	Cecilia Senoo	HFFG	Executive Director
13.	Ahulu Monica	SWAA Ghana	M&E Officer
14.	Kingsley Odum Sam	OICI	Prog. Coord
15.	Esi Awotwi	UNFPA	Prog. Analyst
16.	James Mensah Boamah	GCNH	M&E Officer
17.	Emmanuel Adiku	Pro-Link	M&E Officer
18.	William Addo	GBCA	Prog. Manager
19.	Newton Obeng	ILO	Prog. Assistant
20.	Franklin Asuo	PPAG	Prog. Manager

7.0 Opening

a. The meeting started at 9:39am with a prayer by Rev. Daniel Opong - Wereko.
b. Participants were made to do self introductions. Mr. Atuahene explained that member state of the UN made declarations to report to the UN on the progress of implementation. This was reviewed last year at the HLM in New York in July.
c. He continued by saying that the review came up with commitments to halt the spread of the disease. The GARP report covers HIV correspondence activities which are covered in National Commitments & Policy Instrument (NCPI) which is an overview of what organizations are doing, Government's commitment to cover key populations, M&E tracking reports, human resource issues and how the money is spent.
d. Different persons are needed to complete the questionnaire; representatives from selected Government Institutional filled the questionnaire on Monday.
e. Mr. Atuahene continued by stating that the questionnaire covers
    1. Civil Society Involvement
    2. Political Support Leadership
    3. Human Rights
    4. Prevention
    5. Treatment Care and Support
f. He also explained the scoring process for the questionnaire to be given at certain point and the range was from 0 - 10 (lowest to highest), and in some cases 0-5 (lowest to highest).
g. He made participants aware of the need to objective in answering the questions and that it must be fact based. If participants were not sure about the facts related to the questions, there will be the need to refer from available source documents.
h. Participants agreed that all they will work together as a team instead of breaking into groups.

8.0 NCPI Questionnaire

This was filled with Mr. Kyeremeh leading the process, and participants joined in answering the questions.

9.0 Conclusion

Mr. Kyeremeh thanked all participants for coming on short notice and also appreciated the team work effort and stated that the report will be submitted before 31st March. He reminded Sam from OICI to send the necessary data to complete the report. The meeting ended with a prayer by Monica Ahulu at 12:40pm.

National Commitments and Policy Instrument (NCPI)

Part A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	

IF YES, what was the period covered *[write in]*: 2011 - 2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. ***IF NO or NOT APPLICABLE***, briefly explain why.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*: GAC

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes		Yes	No
Health	Yes		Yes	No
Labour	Yes		Yes	No
Military/Police	Yes		Yes	No
Transportation	Yes		Yes	No
Women	Yes		Yes	No
Young People	Yes		Yes	No
Other *[write in]*:	Yes		Yes	No
MARPS, PLHIV, Agriculture, Tourism, Finance.	Yes		Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes	
Migrants/mobile populations	Yes	
Orphans and other vulnerable children	Yes	
People with disabilities	Yes	
People who inject drugs	Yes	
Sex workers	Yes	
Transgendered people		No
Women and girls	Yes	
Young women/young men	Yes	
Other specific vulnerable subpopulations31	Yes	
SETTINGS		
Prisons	Yes	
Schools	Yes	
Workplace	Yes	
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	
Gender empowerment and/or gender equality	Yes	
HIV and poverty	Yes	
Human rights protection	Yes	
Involvement of people living with HIV	Yes	

IF NO, explain how key populations were identified?

31 Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?

KEY POPULATIONS

1.5. Does the multisectoral strategy include an operational plan?

Yes	

1.6. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes		
b) Clear targets or milestones?	Yes		
c) Detailed costs for each programmatic area?	Yes		
d) An indication of funding sources to support programme implementation?	Yes		
e) A monitoring and evaluation framework?	Yes		

1.7. Has the country ensured "full involvement and participation" of civil society[32] in the develop-ment of the multisectoral strategy?

Active involvement		

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
Regional consultancies

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

32 Civil society includes among others: networks and organisations of people living with HIV,women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes		

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners			

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:
N/A

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes		

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes		
National Development Plan	Yes		
Poverty Reduction Strategy			N/A
Sector-wide approach	Yes		
Other *[write in]*: NDPF	Yes		

2.2. IF YES, are the following specific HIV-related areas included in one or more of the develop-ment plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	Yes		
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes		
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes		
Reduction of stigma and discrimination	Yes		
Treatment, care, and support (including social security or other schemes)	Yes		
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes		
Other[write in below]: **Orphans and Vulnerable Children**	Yes		

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes		

3.1 IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	***4***

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?

Yes	

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs		

5.3. Is HIV programme coverage being monitored?

Yes	

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	

(b) ***IF YES***, is coverage monitored by population groups?

Yes	

33 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

IF YES, for which population groups?
PLHIVs, MARPs, OVCs, Youth, Women, Disabilities, Uniformed Services, General Population
Briefly explain how this information is used?

(c) Is coverage monitored by geographical area?

Yes	

IF YES, at which geographical levels (provincial, district, other)?
National, Regional, District, sub-district / community
Briefly explain how this information is used?

5.4. Has the country developed a plan to strengthen health systems?

Yes	

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

6. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area?
- Government pledge of $100m - Costed strategy with Operational Plan using broad based processes at all levels - Development of MTP for decentralized structures - Partnership Forum looking at annual program of work for the year
What challenges remain in this area:

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. ***Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?***

A. Government ministers

Yes	

B. Other high officials at sub-national level

Yes	

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
- Heart to Heart - Launch of NSP - Chairing of AIDS Commission and Business Meeting - Led delegation to the 2011 HLM in New York

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

Yes	

IF NO, briefly explain why not and how HIV programmes are being managed:

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	
Have active government leadership and participation?	Yes	
Have an official chair person?	Yes	
***IF YES**, what is his/her name and position title?*		
His Excellency Prof. John Evans Attah Mills		
Have a defined membership?	Yes	
***IF YES**, how many members?*		
45		
Include civil society representatives?	Yes	

***IF YES**, how many?*		
5		
Include people living with HIV?	Yes	
***IF YES**, how many?*		
1		
Include the private sector?	Yes	
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes		

IF YES, briefly describe the main achievements?
- Country Coordinating Mechanism (CCM) - Partnership Forum (PF) and Business Meeting (BM) - Expanded Technical Working Group (ETWG)
What challenges remain in this area:
- Government and private sector interaction very low

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

%

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	
Coordination with other implementing partners	Yes	
Information on priority needs	Yes	
Procurement and distribution of medications or other supplies	Yes	
Technical guidance	Yes	

Other [write in below]:	Yes	
M&E, PLHIV		

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

Yes	

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	

IF YES, name and describe how the policies / laws were amended
Policies have been reviewed, laws are still the same.
Name and describe any inconsistencies that remain between any policies / laws and the National AIDS Control policies

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area:

- Financial commitment

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	No	
Men who have sex with men	No	
Migrants/mobile populations	No	
Orphans and other vulnerable children	Yes	
People with disabilities	Yes	
People who inject drugs	No	
Prison inmates	No	
Sex workers	No	
Transgendered people	No	
Women and girls	Yes	
Young women/young men	Yes	
Other specific vulnerable subpopulations *[write in]*:	Yes	
Aged persons over 70 years		

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
Ghana's Constitution 1992: This protects persons against discrimination and upholds fundamental human rights. Specifically; • Article 17 " All persons shall be equal before the law, A person shall not be discriminated against on the grounds of gender, race, ethnic origin, religion, creed or social economic status" • Article 18 "no person shall be subjected to interference with the privacy of …. Correspondence or communication except in accordance with law as may be unnecessary in a free and democratic society". This deals with disclosure and confidentiality.

Briefly explain what mechanisms are in place to ensure these laws are implemented:
The Commission on Human Rights and Administrative Justice established under the Commission on Human Rights and Administrative Justice Act, 1993 [64]. The Commission is an independent body set up to assist person to seek redress in issues of unfair treatment and human rights abuses The National Labour Commission: set up under the Labour Act, facilitates the settlement of industrial disputes, and investigating labour related complaints especially unfair labour practices and provides an avenue that PLHIV can use in unfair dismissal The Police Service established under the Police Act 1970, has the statutory duty to prevent and detect crime and apprehends offenders. Domestic Violence Victim Support Unit (DOVVSU) to cater for the increasing cases of abuse against women, men and children The Judiciary A legal aid system also exists in Ghana and was established and operates under the Legal Aid scheme Act (ACT 542) of 1997 Civil Society Organizations: International Federation of Women Lawyers (FIDA), Centre for Demographic Development (CDD), and Human Rights and Advocacy Centre (HRAC).

Briefly comment on the degree to which they are currently implemented:

2. Does the country have laws, regulations or policies that present obstacles[34] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	
Men who have sex with men	Yes	
Migrants/mobile populations		No
Orphans and other vulnerable children		No
People with disabilities		No
People who inject drugs	Yes	

Prison inmates	Yes	
Sex workers	Yes	
Transgendered people		No
Women and girls		No
Young women/young men		No
Other specific vulnerable populations [write in below]:		

34 These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

35 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
Five (5) Ghana cedis policy on accessing Treatment by PLHIV
Briefly comment on how they pose barriers
Cost of services not affordable to some PLHIV Laws criminalizing sodomy and solicitation To be completed by consultant

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and commu-nication (IEC) on HIV to the general population?

Yes	

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	
Avoid commercial sex	Yes	
Avoid inter-generational sex	Yes	
Be faithful	Yes	
Be sexually abstinent	Yes	
Delay sexual debut	Yes	

Engage in safe(r) sex	Yes	
Fight against violence against women	Yes	
Greater acceptance and involvement of people living with HIV	Yes	
Greater involvement of men in reproductive health programmes	Yes	
Know your HIV status	Yes	
Males to get circumcised under medical supervision	Yes	
Prevent mother-to-child transmission of HIV	Yes	
Promote greater equality between men and women	Yes	
Reduce the number of sexual partners	Yes	
Use clean needles and syringes	Yes	
Use condoms consistently	Yes	
Other [write in below]:	Yes	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	

1 ***Does the country have a policy or strategy to promote life-skills based HIV education for young people?***

Yes	

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes	
Secondary schools?	Yes	
Teacher training?	Yes	

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes	

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	

2.4 Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

Yes	

Briefly describe the content of this policy or strategy:

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

 Check which specific populations and elements are included in the policy/strategy

	IDU36	MSM37	Sex workers	Customers of Sex Workers	Prison inmates	Other populations38 *[write in]*
Condom promotion	x	x	x	x		
Drug substitution therapy	x					
HIV testing and counseling	x	x	x	x	x	x
Needle & syringe exchange		x	x	x	x	x
Reproductive health, including sexually transmitted infections prevention and treatment	x	x	x	x		x
Stigma and discrimination reduction	x	x	x	x	x	x
Targeted information on risk reduction and HIV education	x	x	x	x	x	x
Vulnerability reduction (e.g. income generation)	x	x	x	x	x	x

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area:
- MARPs strategy with Operational Plan - M&E Roadmap - MARPs TWG - Mechanisms to protect MARPs from abuse - mFriends and mWatchers (involving Police, Lawyers and MARPs) - engaging the judiciary and law enforcement services to reduce stigma and discrimination - MARP friendly health facilities
What challenges remain in this area:
- Criminal Offenses Act - Stigma and Discrimination

36 IDU = People who inject drugs 37 MSM = men who have sex with men 38 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection

(e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

4. Has the country identified specific needs for HIV prevention programmes?

Yes	

IF YES, how were these specific needs determined?
- Health promotion needs: AB&C, delay in sexual debut, empowering the youth, condoms for peacekeepers, availability, accessibility and affordability of condoms. - Situational analysis: this led to the development of the NSP (Epi Analysis and Bio Behavioral Analysis)

IF NO, how are HIV prevention programmes being scaled-up?

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety				4	
Condom promotion				4	
Harm reduction for people who inject drugs					N/A
HIV prevention for out-of-school young people				4	
HIV prevention in the workplace				4	
HIV testing and counseling				4	
IEC39 on risk reduction				4	
IEC on stigma and discrimination reduction				4	
Prevention of mother-to-child transmission of HIV				4	
Prevention for people living with HIV				4	
Reproductive health services including sexually transmitted infections prevention and treatment				4	
Risk reduction for intimate partners of key populations				4	
Risk reduction for men who have sex with men				4	
Risk reduction for sex workers				4	
School-based HIV education for young people				4	
Universal precautions in health care settings				4	
Other*[write in]*:				4	

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

39 IEC = information, education, communication.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	

If YES, Briefly identify the elements and what has been prioritized:
- Trained health workers - ARVs - Lab Services - PMTCT - OIs - STIs - TB/HIV - Logistics and supply chain management Home Based Care Nutritional Support

Briefly identify how HIV treatment, care and support services are being scaled-up?
- Ensure all districts have at least one health center - Currently, 160 treatment centers in 110 district; coverage to all 170 districts by 2015. No. of PMTCT sites out of X Health Stations Comprehensive Home and Community Based Care operational in 3 Regions Food by prescription for all undernourished and underweight PLHIV Food basket program in five regions expanded from 3 Northern Regions. Enrolment of PLHIV in NHIS and LEAP

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy			3		
ART for TB patients			3		
Cotrimoxazole prophylaxis in people living with HIV				4	
Early infant diagnosis		2			
HIV care and support in the workplace (including alternative working arrangements)			3		
HIV testing and counselling for people with TB				4	

HIV treatment services in the workplace or treatment referral systems through the workplace			3		
Nutritional care		2			
Paediatric AIDS treatment			3		

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women			3		
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)		2			
Post-exposure prophylaxis for occupational exposures to HIV				4	
Psychosocial support for people living with HIV and their families			3		
Sexually transmitted infection management				4	
TB infection control in HIV treatment and care facilities			3		
TB preventive therapy for people living with HIV		2			
TB screening for people living with HIV			3		
Treatment of common HIV-related infections				4	
Other*[write in]*:					

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	

Please clarify which social and economic support is provided:
- LEAP - NHIS Free treatment for the indigent

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

Yes	

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitu-tion medications?

	No

IF YES, for which commodities?

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area?

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	

6.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	

6.4. ***IF YES***, what percentage of orphans and vulnerable children is being reached?

%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area?
Reaching the beneficiaries Funding challenges

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	In progress	No

Briefly describe any challenges in development or implementation:

1.1. IF YES, years covered *[write in]**:***

2011 - 2015

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?

Yes, all partners			

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include? 3. Is there a budget for implementation of the M&E plan?

A data collection strategy	Yes	
IF YES, does it address:		
Behavioural surveys	Yes	
Evaluation / research studies	Yes	
HIV Drug resistance surveillance	Yes	
HIV surveillance	Yes	
Routine programme monitoring	Yes	

A data analysis strategy	Yes	
A data dissemination and use strategy	Yes	
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	
Guidelines on tools for data collection	Yes	

3. Is there a budget for implementation of the M&E Plan?

Yes		

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

%

4. Is there a functional national M&E Unit?

Yes		

Briefly describe any obstacles:

4.1. Where is the national M&E Unit based?

In the Ministry of Health?		
In the National HIV Commission (or equivalent)?	Yes	
Elsewhere *[write in]*?		

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Kyeremeh Atuahene	Yes		2003
Emmanuel Larbi	Yes		2002
Samuel Dery	Yes		2007
Clive Ashby	Yes		2010
Kenneth Yeboah	Yes		2010
Isaiah Doe Kwao	Yes		2010
Kwasi Gyimah Okai	Yes		2010
Raphael Sackitey	Yes		2010
Jewel Lamptey	Yes		2010

	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

1 ***Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?***

2 ***Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?***

Yes	

Briefly describe the data sharing mechanisms
What are the major challenges in this area:

6. Is there a central national database with HIV- related data?

Yes	

IF YES, briefly describe the national database and who manages it.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above		

IF YES, but only some of the above, which aspects does it include?

6.2 Is there a functional Health Information System[40]?

At national level	Yes	
At subnational level		No
IF YES, at what level(s)? *[write in]*		

7. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes	

40 Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

8. How are M&E data used?

For programme improvement?	Yes	
In developing / revising the national HIV response?	Yes	
For resource allocation?	Yes	
Other *[write in]*:	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

9. In the last year, was training in M&E conducted

At national level?	Yes	
IF YES, what was the number trained:		
At subnational level?	Yes	
IF YES, what was the number trained		
At service delivery level including civil society?	Yes	

IF YES, how many?

9.1. Were other M&E capacity-building activities conducted other than training?

Yes	

IF YES, describe what types of activities

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

National Commitments and Policy Instrument (NCPI)

Part B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. CIVIL SOCIETY[41] INVOLVEMENT

1. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?***

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. CSO participating in the formulation of policies and strategies development. Eg. TWG and stakeholders consultation meetings 2. Data provided by CSO are used to make informed decisions. Eg. Consultation meetings

2. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?***

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. Some partners like ADRA, PPAG and FHI 360 had been involved in budgeting meetings using gold modeling. 2. CSO was involved in budget planning but were represented in the budgeting process.

41 Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

3. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:***

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. All activities are budgeted for just that they are not covered due to limited resources. 2. Funds are not allocated for all activities.

4. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?***

a. Developing the national M&E plan?

LOW					HIGH
0	1	2	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. Data are used for decision making. E.g. Condom allocation distribution processes. Condom distributed in a particular year can be used to make projections in the subsequent years.

5. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?***

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. Various types of CSO organizations are involved in planning and coordination processes of the National Response. E.g. NAP+ represent PLHIV support groups whiles the Faith based Organization like CHAG embarks on HIV stigma campaigns and treatment care and support services.

6. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:***

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
1. Sufficient funds are not obtained for HIV/AIDS activities. For example, the country itself does not have the funds to support HIV/AIDS activities. 2. In-country technical resources are use to support CSO. Technical assistance plan has been developed to enhance the capacity of CSO's.

7. ***What percentage of the following HIV programmes/services is estimated to be provided by civil society?***

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	>75%
Men who have sex with men	<25%	25-50%	51–75%	>75%
People who inject drugs	<25%	25-50%	51–75%	>75%
Sex workers	<25%	25-50%	51–75%	>75%
Transgendered people	<25%	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%

Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
1. Representation in various national working groups. 2. Program management and M&E 3. Organizational development (capacity enhancement) 4. Standardization and harmonization of operations and procedures policies on HIV/AIDS 5. Increased in funding for CSO for HIV Interventions 6. Stronger partnership with government institutions 7. Research on MARPS and other vulnerable groups. 8. Enhanced participation of PLHIV in consultation meetings.
What challenges remain in this area:
1. Inadequate capacity for implementation and management of resources. 2. Inadequate resources 3. Insufficient Technical expertise 4. Logistical inadequacies like computers and other office equipment. 5. Lack of visibility of PLHIV in prevention activities due to stigma 6. Lack of standardization of procedures.

II. POLITICAL SUPPORT AND LEADERSHIP

1. ***Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?***

Yes	No

IF YES, describe some examples of when and how this has happened:
1. Government has established Technical Working Group for MARPS with full and active participation of MARPs and NGOs. 2. National MARPS strategy and operational plans had been developed and implemented. 3. Resources had been made available to support MARP programs. 4. Drop in centres had been established for MARPS. 5. IEC materials produced and stigma reduction campaign relating to MARPS undertaken. 6. Mapping and size estimation and IBBS study undertaken. 7. Positive MARPS support group established 8. Heart to heart anti-stigma campaign launched. 9. Rapid response system and right protection mechanisms established e.g. M-watchers and M-friends.

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No

Other specific vulnerable subpopulations *[write in]*:	Yes	No
Aged persons over 70 years		

1.2 ***Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?***

Yes	No

1.3 ***Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable sub-populations?***

Yes	No

IF YES to Question 1.1 and 1.2, briefly describe the contents of these laws:
Ghana's Constitution 1992: This protects persons against discrimination and upholds fundamental human rights. Specifically; • Article 17 " All persons shall be equal before the law, A person shall not be discriminated against on the grounds of gender, race, ethnic origin, religion, creed or social economic status" • Article 18 "no person shall be subjected to interference with the privacy of …. Correspondence or communication except in accordance with law as may be unnecessary in a free and democratic society". This deals with disclosure and confidentiality.
Briefly explain what mechanisms are in place to ensure that these laws are implemented
The Commission on Human Rights and Administrative Justice established under the Commission on Human Rights and Administrative Justice Act, 1993 [64]. The Commission is an independent body set up to assist person to seek redress in issues of unfair treatment and human rights abuses The National Labour Commission: set up under the Labour Act, facilitates the settlement of industrial disputes, and investigating labour related complaints especially unfair labour practices and provides an avenue that PLHIV can use in unfair dismissal The Police Service established under the Police Act 1970, has the statutory duty to prevent and detect crime and apprehends offenders. Domestic Violence Victim Support Unit (DOVVSU) to cater for the increasing cases of abuse against women, men and children The Judiciary A legal aid system also exists in Ghana and was established and operates under the Legal Aid scheme Act (ACT 542) of 1997 Civil Society Organizations: International Federation of Women Lawyers (FIDA), Centre for Demographic Development (CDD), and Human Rights and Advocacy Centre (HRAC).
Briefly comment on the degree to which they are currently implemented
These Laws are more likely to be implemented in urban settings. The legal system is overwhelmed and justice tends to be dispensed slowly.

2. Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	***No***

42 These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[43] *[write in]*:	Yes	No

Briefly describe the contents of these laws, regulations or policies
Five (5) Ghana cedis policy on accessing Treatment by PLHIV
Briefly comment on how they pose barriers
Cost of services not affordable to some PLHIV Laws criminalizing sodomy and solicitation To be completed by consultant

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	***No***

43 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection

(e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of the policy, law or regulation and the populations included.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	***No***

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy
The NSP 2011-2015 uses rights based public health approach.

7. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	***No***

IF YES, briefly describe this mechanism:
1. DOVSU records attenders 2. CHRAG also document and respond on human right abuse on PLHIV.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-of charge to all people in the country		Provided free-of charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services[44]	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
PLHIV**:** ART, treatment for opportunistic infection, positive prevention and family planning, nutritional support, psychosocial support and PMTCT. MARPS**:** Prevention education, ART, anti-stigma campaigns, PMTCT, and STI management. YOUTH**:** Prevention programs, ART, PMTCT et. WOMEN CHILDREN AND ORPHANS: PEP

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	***No***

1 ***In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?***

Yes	***No***

2 ***Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?***

Yes	***No***

IF YES, briefly describe the content of this policy/strategy and the populations included:
The NSP aims at reducing new infection by 50% by 2015, elimination of mother-to-child transmission, expanding access to prevention treatment and care services towards universal access. The strategy also prioritises MARPs group such as MSM, IDUs, prisoners and FSWs

44 Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	***No***

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
MARPS**:** Drop in centres, condom promotions, M-watchers and M-friends, support groups, text me flash me. PLHIV: Support groups, bulk text message, models of hope activities.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	***No***

IF YES, briefly describe the content of the policy or law:

The Policy seeks to implement the ILO recommendation 200 which discourages HIV screening for general employment purpose

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	***No***

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	***No***

IF YES on any of the above questions, describe some examples:

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key popula-tions concerning their rights (in the context of HIV)[45]?

Yes	***No***

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

Yes	***No***

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	***No***

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	***No***

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	***No***

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other *[write in]*: Churches and other religious bodies.	Yes	No
Sports	Yes	

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
1. Enhanced Advocacy 2. Workplace policies 3. Domestic policies 4. Establishment of Domestic Violence and Victim Support Unit (DOVVSU) in Police service. 5. M-friends and M-watchers 6. PEP for rape victims
What challenges remain in this area:
1. There are still in place laws that pose obstacles to access to HIV/AIDS services. 2. Stigma and discrimination. 3. Homophobia. 4. Misconception and superstition. 5. Socio-cultural practices also pose obstacles to access HIV/AIDS services.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
1. Human rights institutions' capacity has been strengthen to support HIV/AIDS activities. 2. Awareness on the various law that protect the rights of PLHIV and other groups. 3. MARPS programs had been scaled up.

What challenges remain in this area:
1. Weak Coordination between the human right group and the CSO's 2. Limited capacity of human rights institutions and over-centralization 3. Inadequate funding for human rights institutions.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
1. Situational analysis. 2. Consultations 3. Based on evidence.
IF NO, how are HIV prevention programs being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC[47] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
This shown in Table 11 of the main GARP Report.
What challenges remain in this area:
1. Supply chain management. ie. Stock management and procurement of commodities. 2. Problem of behaviour change. 3. Limited capacity and resources. 4. Socio-cultural practices. 5. Stigma and Disclosure.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:
1. Anti-retroviral treatment, nutrition, 2. PEP 3. PMTCT 4. Home based career 5. Referral system
Briefly identify how HIV treatment, care and support services are being scaled-up?
1. Scale up in ART sites/services centres 2. Increasing in nutritional assistance 3. Expansion services to cover more individuals.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
1. Nutritional support increased 2. Support groups formed
What challenges remain in this area:
1. Funding gap 2. Accessibility in terms proximity to centres 3. Stigma 4. Stock out of ART drugs. 5. Early infant diagnosis. 6. Cost of the ART drug.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

2.3 . IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

0.42%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
1. Action plan 2. OVC assessment. 3. Training for OICI 4. Livelihood Empowerment Against Poverty Program (LEAP)- provides direct cash transfare to OVC households
What challenges remain in this area:
1. Funding gaps. 2. Inadequate resources to implement OVC action plan.

Ghana AIDS Commission

Minutes of the Validation Meeting of Global AIDS Response Progress Report Held on 29th March, 2012 in the Conference Room of the Ghana AIDS Commission

1.0 Present

1. Angela El-Adas	-	GAC
2. Emmanuel Adiku	-	Pro-link Organization
3. Patricia Agyeiwa	-	ADRA Ghana
4. Clement Azigwe	-	NAP+ Ghana
5. Benjamin Kwarteng	-	ADRA Ghana
6. Anita D'Almeida	-	Danish Embassy
7. Kow E. Mensah	-	GIZ
8. Harriet Manu	-	Ghana Armed Forces
9. Margaret Kaba	-	MOE
10. Angela Bannerman	-	Private Consultant
11. Kinsley Odum Sam	-	OICI
12. Mercy A. Zoomah Issah	-	NDPC
13. Akua Ofori-Asmadu	-	ILO
14. Esi Awotwi	-	UNFPA
15. Gurumurthy Rangaiyan	-	UNAIDS
16. Eva Haizel	-	MOYS
17. John K. A. Manu	-	NYA
18. Derek Aryee	-	GBCA/CCM/Consultant
19. Henry Nagai	-	FHI 360
20. Yetsa Gadabor	-	SWAA
21. Victor Ntumi	-	GHANET
22. Joseph Amuzu	-	GAC
23. Kyeremeh Atuahene	-	GAC
24. Kenneth Yeboah	-	GAC
25. Jewel Lamptey	-	GAC
26. Dinah Tetteh	-	GAC
27. Dennis Annang	-	GAC

2.0 Opening

The Meeting commenced at 10:24 am with a prayer by Mr. John Manu after which there were self introductions by participants. In her opening remarks, the chairman, Dr Angela El-Adas welcomed participants to the meeting. She indicated that the purpose of the meeting was to validate the report put together by the consultant on the Global AIDS Response Progress (GARP). She said the consultant would make a presentation after which members would have the opportunity to make inputs and critique positively. She further expressed her appreciation to the impressive turnout of participants despite the short notice. She mentioned that the process had been supported regularly by UNAIDS.

3.0 Presentation by Consultant

The consultant mentioned that there were few elements that still needed to be cross checked. He gave a presentation on the content of the report covering purpose of the report, methodology used and structure of the report. He said, the issue of IDU would be addressed in the next reporting period.

Comments after the presentation

3.1 Best Practices

- The definition of best practice should be looked at.
- Mainstreaming of HIV at the district levels should be captured.
- HIV integration should be captured
- Political commitment that make it best practice should be considered with specifics. E.g. consistent political commitment over a period of time. What has been achieved by this commitment?
- Placing of the National Coordinating body is very important. Therefore the fact that GAC is under the Office of the President is a justification of being a best practice. This shows Ghana has high level commitment
- Instituting an HIV Alert award scheme as part of the Best Teacher Award scheme should be captured.
- Should capture the timely interventions of Police and DOVSU and their commitment to rape victims by administering PEP
- Should capture Heart-to-Heart campaign

It was then agreed that members could identify some areas of best practices in bullet points and send it to the consultant via email. The following volunteered to prepare brief write ups and submit as follows:

1. Akua Ofori-Asumadu (ILO) - Strengthening community structures
2. Gurumurthy Rangaiyan (UNAIDS) - High level commitment

3. Henry Nagai (FHI360) - MARP
4. Yetsa Gadabor (SWAA) - Condom distribution
5. Kyeremeh Atuahene & Consultant - Issues from status report
6. Joseph Amuzu (GAC) - Gender Mainstreaming
7. Anita D'Almeida (Danish Embassy) - Free drugs and other commodities

3.2 NCPI

Members were taken through the ranking of the NCPI in addition to looking at the details of the questions in the report and some of the weights/rankings awarded by participants at the data sources meetings for the 2011 report and were altered as follows:

- Political Support ranking was reduced from 9 to 8
- Human Right ranking was reduced from 9 to 6
- Treatment, care and support was reduced from 9 to 8.5
- Efforts to meet needs of OVC was reduced from 9 to 7

3.3 Challenges

The challenges had to do with addressing the 2009 challenges.

It was suggested that the program data should be used to show where we were and where we are now.

Programs covering youth - progress made should include:

- Project management groups specifically for HIV at the community level
- Community level discussions among key group
- There should be documentation on how coordination had been structured at the community level. e.g. improved capacity through training clinics.
- How the community takes responsibility for M-friends and M-watchers to help protect the right of MARP.

Stigma and discrimination

- High level call for the elimination of stigma
- Use of UN model – community capacity enhancement methodology where it allows members to share their views.

Empowerment of PLHIV

- Reduction of self stigmatization – what has led to that, greater involvement of positive women in leadership. Training positive women in reproductive health rights.
- Urban poverty reduction program where monthly stipend are provided.

Weak health information

This should be addressed from the CRIS assessment report.

3.4 Other issues

- Should cite the 2006 IBBSS study results in the narrative
- Those who tested and knew their status should be captured.
- Graph on PMTCT should be relooked at
- The ART graph should be properly formatted

4.0 Conclusion

It was agreed that all comments/inputs would be sent to the consultant by 4:30 pm on 29th March 2012. All members agreed that GAC should go ahead and submit the report if all the comments made were effected. The Director General apologized for not making the draft report available to participant prior to the meeting. She explained that the consultant was working on it throughout the night. It was agreed that all participants who were part of the validation would be captured in the report. The DG expressed her appreciation to participants for their commitment.

5.0 Closing

Ms Patricia Agyeiwaa prayed and the meeting closed at 2:04 pm.