GHANA'S PROGRESS REPORT ON THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION (UNGASS) DECLARATION OF COMMITMENT ON HIV AND AIDS

REPORTING PERIOD

JANUARY 2008 – DECEMBER 2009

SUBMISSION DATE: MARCH 2010

Prepared by:

GHANA AIDS COMMISSION

Technical Assistance from UNAIDS

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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
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
GTZ	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
WB	World Bank
WHO	World Health Organisation

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2. Status at a Glance

2.1 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 and 2007. This report covers the period of 2008 and 2009 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 UNGASS 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.

2.2 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 2006 – 2010. Annual Programme of Work 2008 and 2009
    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, patient tracking systems, programmatic data, National AIDS Spending Assessment 2007, and 2008.
    f. Programme Reviews: the National Composite Policy Index, Joint Programme Review (JPR) 2007 report,[i] and Ghana Country UNGASS Report, 2003, 2005 and 2007,

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 UNGASS report was prepared and presented at a stakeholder forum on 17th March 2010 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 finalise the report.

2.3 The 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]. Using the National Estimates and projections for HIV the National HIV prevalence in 2009 was 1.9% [4].

The HIV prevalence in Ghana varies with geographic areas, gender, age and residence. In 2009, in the 40 sentinel sites, HIV prevalence ranged from 0.7% in North Tongu district to 5.8% in Agomanya and Koforidua. Four sites had HIV prevalence of 5.0% and above in 2009. The prevalence in the urban sites was higher than in rural sites. The Regional prevalence ranged from 2.0% in the Northern Region to 4.2% in the Eastern Region [3]. Although all regions with the exception of the Eastern showed a rise in prevalence, the trend analysis over several years indicate a general decline in HIV prevalence in 9 out of the 10 regions [3].

In 2009, the prevalence was highest in 40 – 44 year groups (4.0%) and lowest in 45 – 49 year group, (1.8%). The prevalence in the young people aged 15 – 24 years was 2.1%, which was higher than in 2008 (1.9%)[3].

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. A 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].

Knowledge and behaviour may affect an individual's risk of HIV infection. The HIV transmission is dependent on a number of behavioural factors these include the number 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%), 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% of females and 34% of males [6,7].

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.

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 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 240,802 adults and children living with HIV (21,202 children). It was estimated that in 2008 63,137 adults and 6,086 children needed ART and in 2009 64,978 adults and 6010 children were in need of ART. The estimated annual AIDS deaths for 2008 and 2009 were 18,082 and 17,058 respectively [9]. AIDS deaths are estimated to increase in 2010 [4].

2.4 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 National Response has benefited from improved strategic planning in the period under review, 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. Since the development and implementation of the Ntional 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 serve as the operational plans of the NSFII. These are costed operational plans for which specific interventions and expected outputs 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 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
- Technical review meeting 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 period under review saw the installation of a new government and a rejuvenation of the commitment to HIV/AIDS. The government inaugurated a new Commission to support policy formation and the direction of the national response. In all, 47 commissioners were inaugurated in August 2009 [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 management of Opportunistic Infections and Other Related HIV Diseases: Ministry of Health October 2008 [14].
2. Guidelines for Antiretroviral Therapy: Ministry of Health September 2008 [15]
3. National Guidelines for Prevention of Mother to Child transmission of HIV (PMTCT): Ministry of Health, September 2008 [16].
4. National Guidelines for the Development and the Implementation of HIV counselling and Testing: Ministry of Health, September 2008 [17].
5. Guidelines for Management of Sexually Transmitted Infections: Ministry of Health, September 2008 [18].
6. National Policy Guidelines on Orphans and Other Children made Vulnerable by HIV/AIDS: GAC. January 2005 [19].
7. Early childhood Care and Development Policy: Ministry of Women and Children's Affairs [20].
8. National Social Protection Strategy (NSPS) 2007 [21].
9. National Gender and Children's Policy: Ministry of Women and Children's Affairs [22].
10. National Domestic Violence Policy: MOWAC, 2008 [23].
11. HIV/TB Workplace Policy for the Revenue Agencies of Ghana: December 2007 [24].
12. HIV/TB Workplace Policy for Serious Fraud office of Ghana, November 2007 [25].
13. HIV/TB Workplace Policy Ministry of Justice December 2008 [26].
14. Growth and Poverty Reduction Strategy (GPRS II) (2006 – 2009), November 2005 (NDPC) [13].

These policies and guidelines have helped to maintain the momentum of the National HIV/AIDS response

Due to availability of funds and immense effort of implementers in 2008 and 2009, prevention, care, treatment and support were scaled-up and the number of persons with access to services increased. In 2009, 28% of HIV positive pregnant women and 40% 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.

2.5 UNGASS Indicators

Table 1: UNGASS Indicators

Name of Indicator	Indicator value 2006/ 2007	Indicator value 2008	Indicator value 2009	Comments (Data Source for 2008 and 2009)
National Commitment and Action Indicators				
1. AIDS Spending Total AIDS spending	$52,445,091.00	$38,850,940	(data collection for 2009 yet to be commissioned)	Data from 2007 and 2008 draft NASA report [27]
2. Government HIV and AIDS Policies	Average score 6.68		Average score 6.95	
National Programme Indicators				
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	100%	100%	Information from National Blood Bank Statistics
4. Percentage of adults and children with advanced HIV infection receiving Antiretroviral therapy	Adult &Children 15.56% Adult 15.9% Children 10.5% (December 2007)	Adults & children 34% Adults 35.3% Children 17%	Adults &Children 40.4% Adults 46.0% children 25.5% Male 39.4% Female 53.3%	Programmatic Data NACP 2008 Annual report and 2009 Annual Statistics
5. Percentage of HIV Positive pregnant women who received anti-retroviral to reduce the risk of mother to child transmission	6.2% (2006) 10.1 % (September 2007)	36%	28%	Programmatic Data NACP 2008 Annual Report and 2009 Annual Statistics
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV				Data not readily available
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 month and who know their results	(Data collected every five years)	**Female** **15 – 49 6.8%** 15-19 2.6% 20-24 7.6% 25-49 24.2% **Male** **15 – 49 4.1%** 15-19 1.6% 20-24 5.7% 25-49 13.3.2%	(Data collected every five years)	Ghana Demographic and Health Survey 2008 [28]

Name of Indicator	Indicator value 2006/ 2007	Indicator value 2008	Indicator value 2009	Comments (Data Source for 2008 and 2009)
8. Percentage of most at risk populations that have received an HIV test in the last 12 months and who know their results	**Roamers** 48% in Accra 22% in Kumasi, **Seaters,** 45% in Accra 40% in Kumasi **All sex workers** 38.7% (2006) [29]	Data not available	Data not available	Data not available for 2008 and 2009 Mapping sizes estimation and IBBS for MARPS is being done in 2010
9. Percentage of most of risk populations reached with HIV prevention programmes	Data was not available		FSW 47.9%	Programmatic data from WAPCAS Annual statistics reports. [30] Data obtained from estimated number of FSW for denominator. Study just started to map and enumerate MARPS.
10. Percentage of orphaned and vulnerable children aged 0 – 17 whose households received free basic external support in caring for the child	1.1% (2006)	7.4%		Ghana Demographic and Health Survey 2008 [28]
11. Percentage of schools that provided life skills-based HIV education in the last academic year	58.2% (2006)	All schools 79.1% Public schools 84% Private schools 59.9%		Ministry of Education Data Base, 2009 [31]
Knowledge and Behaviour Indicators				
12. Current school attendance among orphans and among non-orphans aged 10-14	Non –orphans 85.8% Orphans 88.9% (2006) Ratio of school attendance= 1.03	Orphans : 67% Non- orphans: 88% The ratio of school attendance is 0.76	(data collected every five years)	Ghana Demographic and Health Survey 2008 [28]
13. Percentage of young women and men 15-24 who both correctly identify ways of preventing sexually transmission of HIV and who reject major misconception about HIV transmission	Female 15 -24 years 25.1% Male 15- 24 years 33.0% Total 27.06 % (2006)	Male 15- 24 yrs 34.2% 15 -19 yrs 30.4% 20 – 24 yrs 39.1% Female 15- 24 yrs 28.3% 15 -19 yrs 27.2% 20 -24 yrs 29%	Data collected every five years	Ghana Demographic and Health Survey 2008 [28]

Name of Indicator	Indicator value 2006/ 2007	Indicator value 2008	Indicator value 2009	Comments (Data Source for 2008 and 2009)
14. Percentage of most at risk populations who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV transmission	Data not available	Data not available	Data not available	Data not available as composite indicator. For individual values data see text
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		Females 15- 24 yrs 7.8% 15 – 19 yrs 8.2% 20 – 24 yrs 7.2% Males 15- 24 yrs 4.3% 15–19 yrs 3.6% 20–24 yrs 5.2%	Data collected every five years	Ghana Demographic and Health Survey 2008 [28]
16. Percentage of women and men aged 15-49 which have had sexual intercourse with more than one partner in the past 12 months	Women 15 -49 yrs – 22% Men 15- 49 yrs – 40% (2006)	Females 15- 49 yrs 1.0% 15 – 19 yrs 1.2% 20 – 24 yrs 1.6% 25 – 49 yrs 2.9% 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	Ghana Demographic and Health Survey 2008 [28]
17. 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	Women -33.4% Men 55.3% (2006)	Females Males 26.2% 15 – 19 yrs 24.4% 20 – 24 yrs 49.2% 25 -29 yrs42.8% 30 -39 yrs19.6% 40 -49 yrs 3.5% 25 -49 22.07%		Data not available for females. Only higher risk sex is available Ghana Demographic and Health Survey 2008 [28]

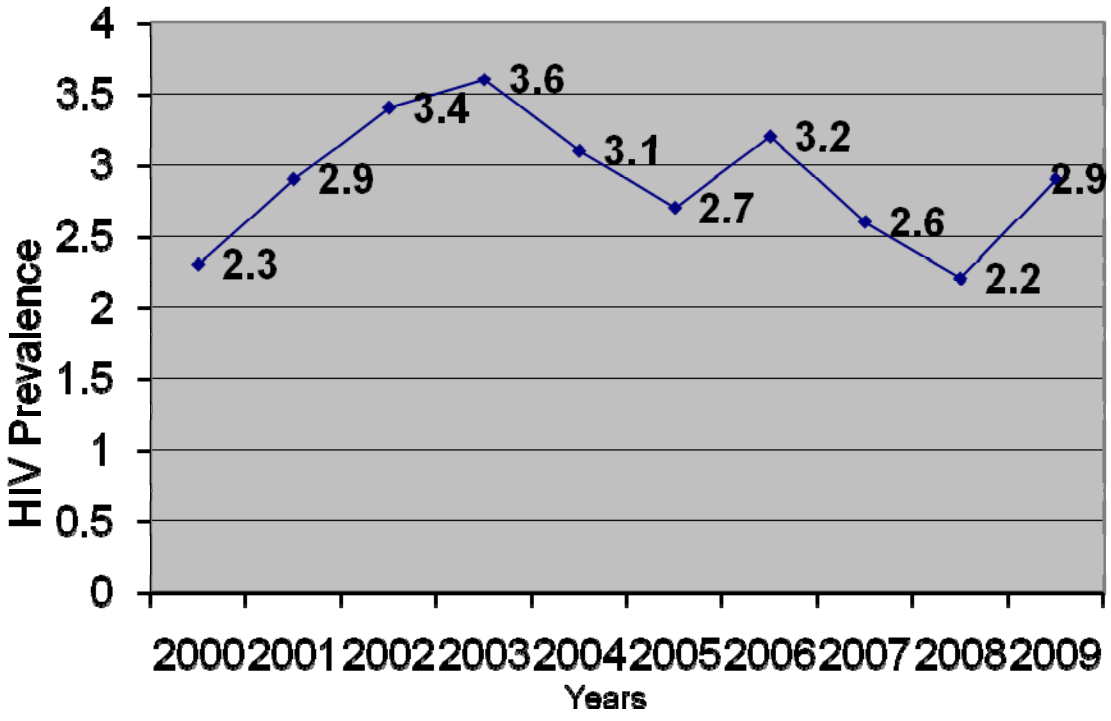
Name of Indicator	Indicator value 2006/ 2007	Indicator value 2008	Indicator value 2009	Comments (Data Source for 2008 and 2009)
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	FSW- (98 - 100%) with paying partner 91% every time 5.3% almost every time 3.3% sometimes 0.3% rarely 33.7% Non paying partner (2006)[29]	Data not available	Data available	Behaviour Surveillance survey Draft Report 2009 [8]
19. Percentage of men reporting the use of condom the last time they had anal sex with a male partner	48.1% (2006)	Data not available	Data not available	Data not available
20. Percentage of injecting drug users reporting the use of condom the last time they had sexual intercourse		N/A	N/A	Study yet to be commissioned
21. Percentage of injecting drug users reporting the use of sterile injection equipment the last time they injected	N/A	N/A	N/A	Study yet to be commissioned
Impact Indicators				
22. Percentage of young women and men aged 15 – 24 who are HIV infected	2.5% (HSS 2006) 2.6% (HSS 2007)	1.9%	2.1%	HIV sentinel surveillance 2009 (2010) [3]
23. Percentage of most at risk populations who are HIV infected	**FSW** **Roamers** 36.8% in Accra 24.0% in Kumasi **Seaters** 52.2% in Accra 39.3% in Kumasi All sex workers 38.7 **MSM** 25% (2006)	FSW Overall 25% **Roamers** 17.4% in Accra 21.2% in Kumasi **Seaters** 32.6% in Accra 28.7% in Kumasi All sex workers 25%		Behavioural Surveillance Survey 2009 Draft report [8]
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			89.8% Early Warning Indicators	Data obtained from Early warning indicators from first line retention from the NACP database. [32] Data collected from a sample of the sites.
25. Percentage of infants born to HIV-infected mothers who are infected				Data not yet available Early Infant Diagnosis now being integrated into routine programming

3. 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 generalised epidemic. (WHO definition of a generalised epidemic is when the prevalence is greater than % in the general population) By definition, the HIV prevalence among pregnant women has been consistently above 1% but has not exceeded 4%. In 2008, the estimated adult national prevalence was 1.7% and 236,151 persons (98,306 males, 137845 females) were living with HIV and AIDS. In 2009, The national HIV prevalence was estimated at 1.9 [1, 9]. It is estimated that 240,802 (100,228 males and 140, 574 females) were living with HIV in 2009 and 22,541 and 23,236 new infections occurred in 2008 and 2009 respectively [9].

Data on the HIV prevalence among pregnant women is obtained from the HIV Sentinel Surveillance Survey (HSS). HSS data has been collected from antenatal 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, 19 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 stabilised. It rose to 3.4% in 2002 and peaked at 3.6% in 2003 and seems to be on a decline. The prevalence in antenatal attendants was 2.2% in 2008 (95% CI 2.18 – 2.22%) and 2.9% (95% CI 2.49 – 3.3) in 2009 [3]. Figure 1 below shows the HIV prevalence from 2000 to 2009 indicates a gradual declining trend of HIV prevalence in Ghana since 2003.

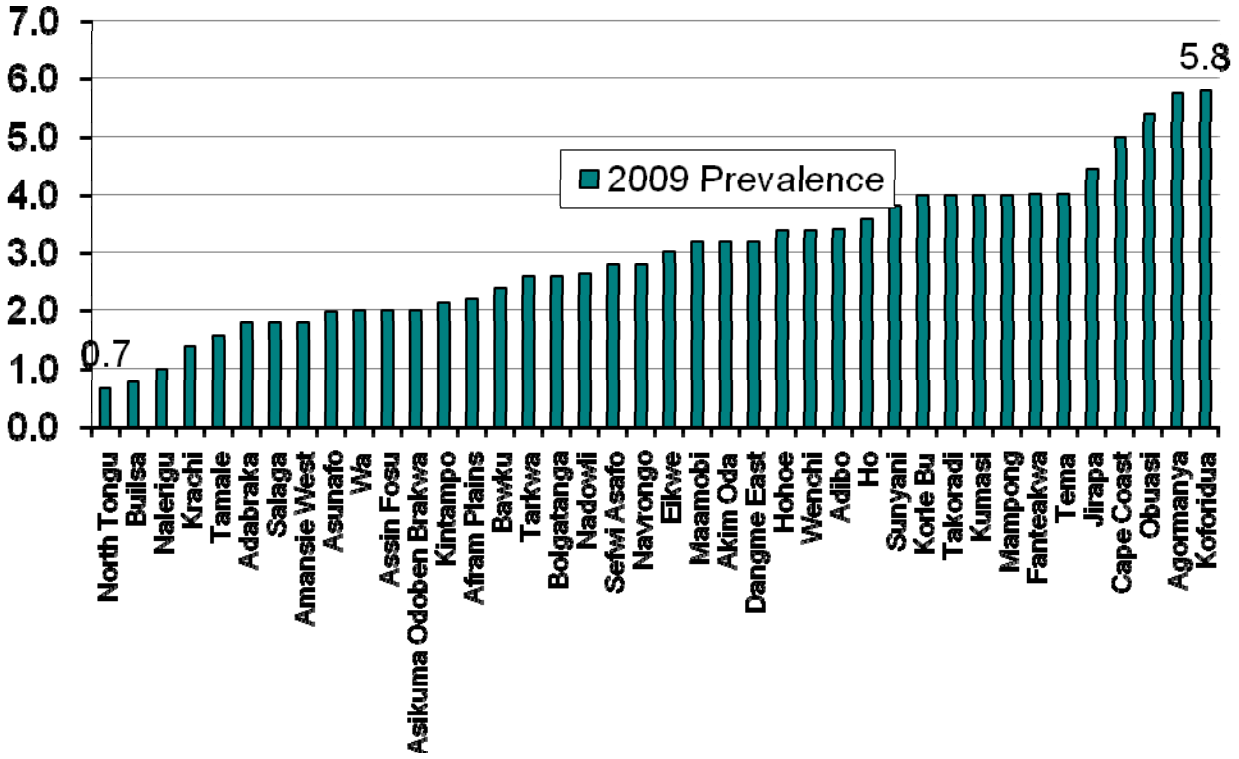
Figure 1: Median HIV prevalence trends for 2000-2009



Source: NACP, HIV Sentinel Surveillance 2009 [3]

The HIV prevalence varies considerably in geographic region, gender, age, and residence. According to the 2009 HSS, the prevalence in antenatal attendants ranged from 0.7% in North Tongu in the Volta Region to 5.8% in Agomanya and Koforidua in the Eastern Region. As can be seen in figure 2 below, twenty out of the forty HSS sites had prevalence of 3% and above and four sites had a prevalence of 5% or more. This compares with only one site which recorded HIV prevalence greater than 5% during the last reporting period (December 2008).

Figure 2: HIV Prevalence by site in 2009



Source NACP HSS (2009)[3]

The Regional HIV prevalence ranged from 2.0% in the Northern Region to 4.2% in the Eastern Region. As depicted in figure 3 below, six of the ten regions (Eastern, Ashanti, Greater Accra, Western, Upper West and Central) had HIV prevalence 3% or more. The median and mean HIV prevalence in urban areas is slightly higher than in rural areas.

Figure 3: HIV Prevalence by Region in 2009

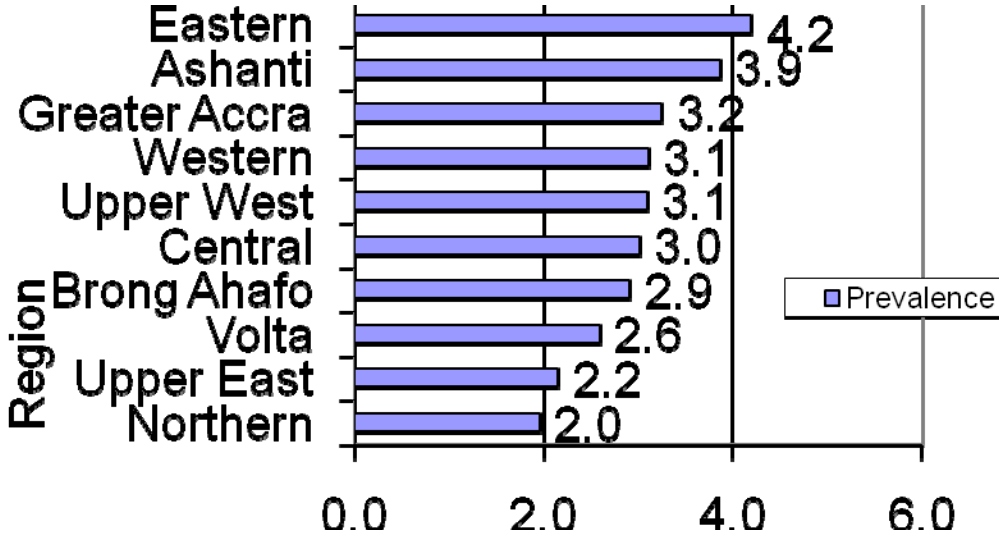
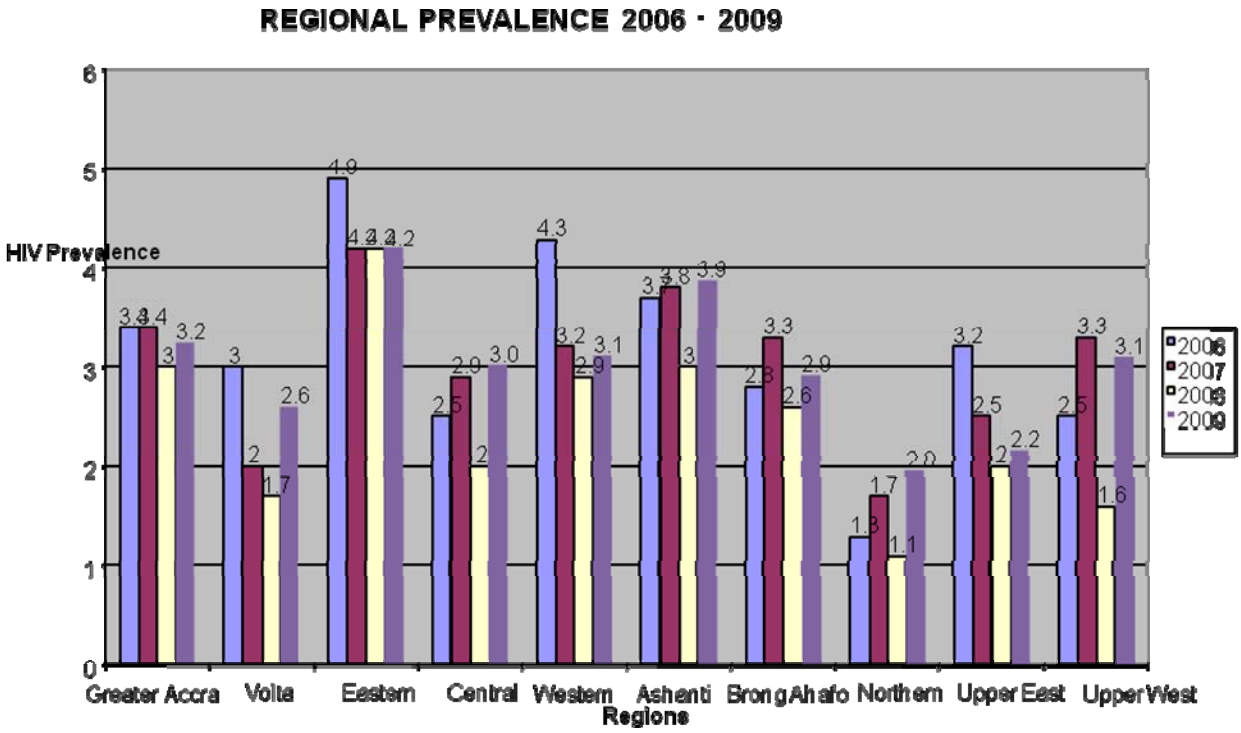


Figure 4: Trend in Regional HIV Prevalence, 2006 - 2009

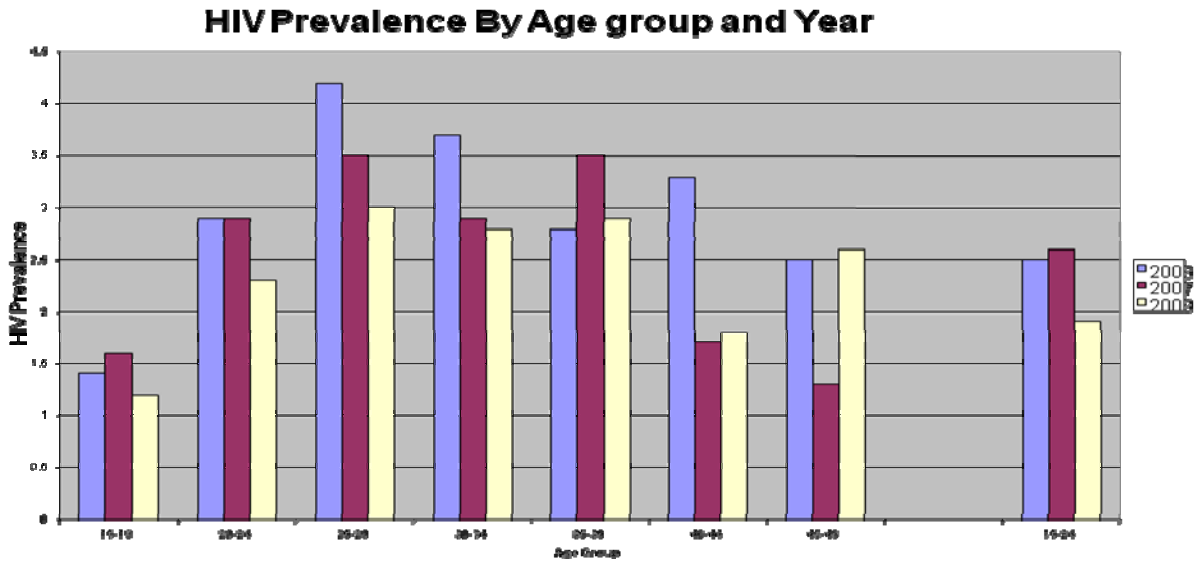


Source NACP HSS (2009)[3]

As denoted in Figure 4 above, with the exception of the Eastern Region, all regions recorded an increase in prevalence from 2008 to 2009. The Upper West Region recorded the highest increase from 1.6 to 3.1%, followed by the Northern Region which increased from 1.1% to 2.0%.

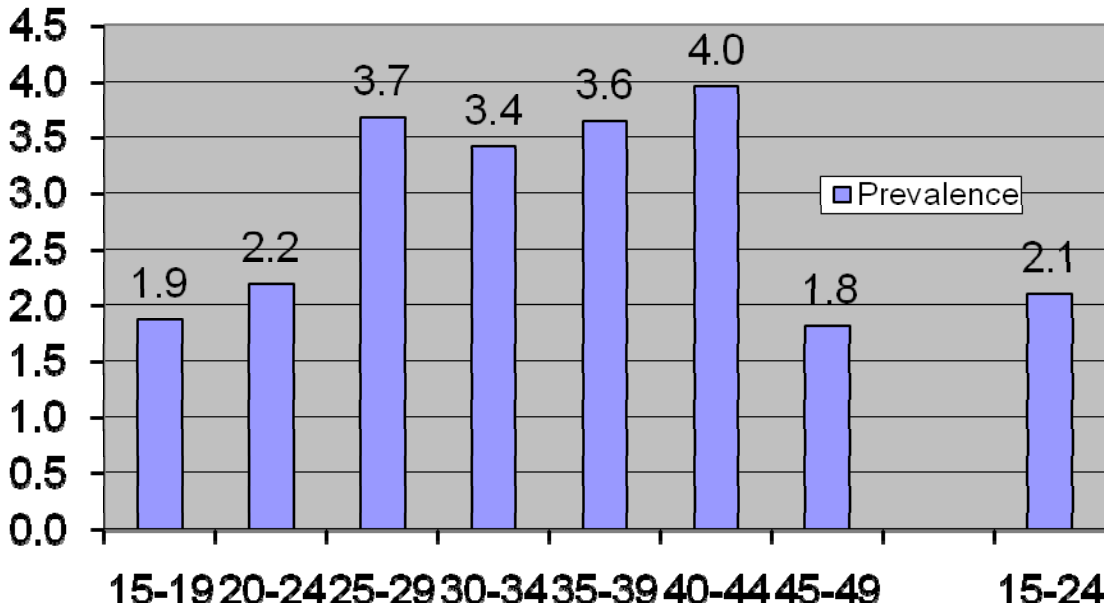
Regional specific linear trends revealed a gradual increase in the Upper West Region and a decline in the other nine regions.

Figure 5: HIV Prevalence by Age group in 2006 – 2008



Source NACP, 2009 HSS 2010 [3]

Figure 6: HIV Prevalence by Age Group



Source NACP, 2009 HSS 2010 [3]

HIV prevalence varies across age groups. In 2009, the prevalence was highest (4.0%) in 40 – 44

age group and lowest (1.8%) in the 45 - 49 age group. The prevalence of the youth aged 15 – 24 years which is an indicator of new infections was 2. 1% in 2009 [3]. The HIV prevalence in this age group also seems to be stable. The prevalence increased from 1.9% in 2005 to 2.5% in 2006 and 2.6% in 2007 and reduced to 1.9% in 2008 and has increased to 2.1% in 2009 [3]. It is unclear whether differences between these small changes in prevalence are significant and data would need to undergo further analysis.

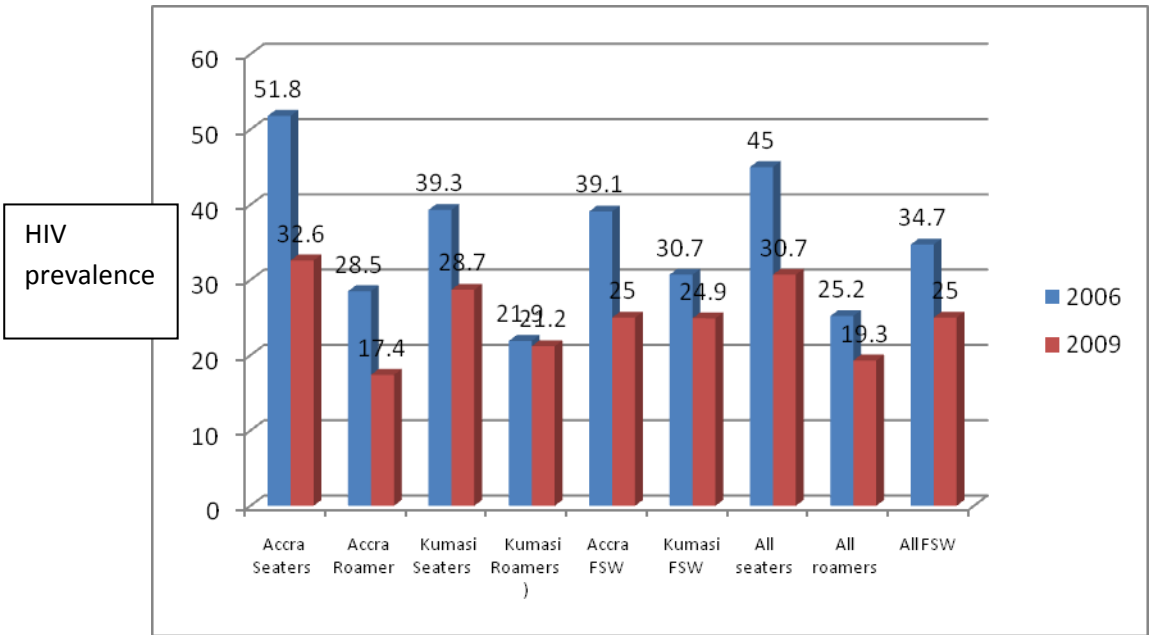
The HIV prevalence in Most at risk groups (MARPS); mainly female sex workers (FSWs) and Men who have sex with men (MSM), is significantly higher than the general population[5]. According to a Behavioural Surveillance Survey (BSS) conducted in Accra and Kumasi, the overall HIV prevalence in FSW in 2009 is 25%.[33] This compares with 34.7 % in 2006. In the period under review, the HIV prevalence in all categories of sex workers reduced as can be seen in Table 2 and Figure 7 below.

Table 2 HIV prevalence in FSW in Ghana in 2006 and 2009

Location and type category of sex worker	2006	2009
Accra		
Roamers	28.5	17.4
Seaters	51.8	32.6
All Accra FSW	39.1	25.0
Kumasi		
Roamers	21.9	21.2
Seaters	39.3	28.7
All Kumasi FSW	30.7	24.9
All roamers	25.2	19.3
All seaters	45.0	30.7
Overall	**34.7**	**25.0**

Source: Bio-behavioural Surveillance Survey 2008 [8]

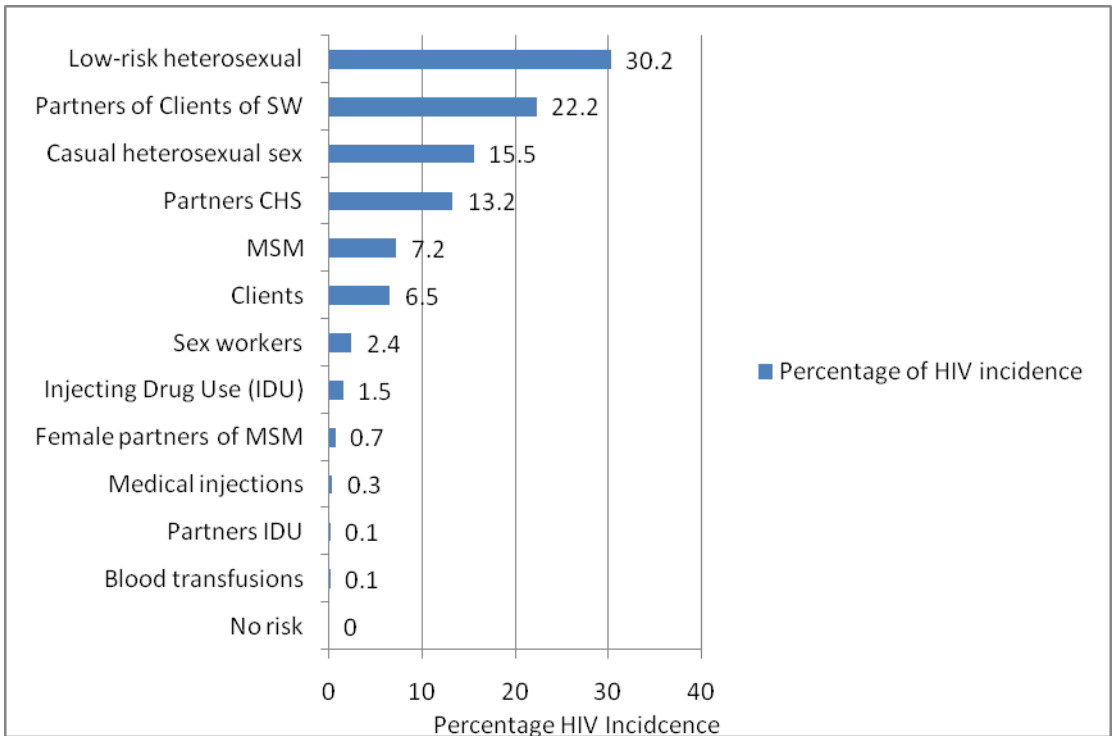
Figure 7: Trend of HIV prevalence in FSW in Ghana in 2006 and 2009



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].

Figure 8: Contribution of different population groups (aged 15 – 49) to HIV incidence in 2008



Source Modes of Transmission Study, 2009 [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.

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. In 2008 it was estimated that there were 236, 151 adult and children living with HIV (20,808 children) and a total of 22,541 new infections [9], while in 2009, there were 240,802 adults and children living with HIV (21,202 children). It was estimated that in 2008 63,137 adults and 6,086 children needed ART and in 2009 64,978 adults and 6010 children were in need of ART. The estimated annual AIDS deaths for 2008 and 2009 were 18,082 and 17,058 respectively [9]. These estimations have increased with the new estimates for 2010 [4].

4. 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/STD 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 and its enactment into law in 2002, started the multi-sectorial approach 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.

4.1 National Strategic Framework

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 NSFI (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.

The goals of NSF II were:

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

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]

NSF has clearly outlined milestones and monitoring and evaluation framework.

Annual Programmes of Work (APOWs) were developed for the implementation of the NSF from 2006 to 2010 to ensure the objectives were achieved within the set period. A detailed budget for each APOW was developed for each year and the sources of funding identified and secured for implementation. The NSF also formed the basis of resource mobilisation and proposals submitted to various funding agencies including the GFATM Round 8 (RD8).

The process of assessment, analysis of NSF I and consultative nature of the development of the NSF II which had been noted in the past continued in 2008 and 2009. This resulted in better planning, budgeting and funding and direction for implementation of prioritised activities over the reporting period. The improved planning and budgeting enabled Ghana mobilise more funds for specific intervention areas in 2009 through the GFATM and other funding mechanism for a wider spectrum of HIV and AIDS Interventions.

4.2 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. In this report data is taken from the National AIDS Spending Assessment (NASA) study for 2007 and the draft report of 2008.
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 2008, US$ 38,850,940 was provided for HIV and AIDS. This is an overall reduction in spending (of about US$ 13,594,151) from US$52,445,091 in 2008 to $38,850,940 in 2009 [39]. In 2008 a reduction in spending was noted in treatment care and support, programmes managements and administrative strengthening, social protection and social services as well as HIV related research. (Table 3)

Table 3: Spending Priorities, 2007 and 2008

Key areas of expenditure	Grand Total 2007	Grand total in 2008	Increase in Spending
Prevention	6,339,069.00	8,550,916	2,211,847
Treatment Care and Support	21,026,047.00	9,554,075	- 11,471,872
Orphans and Vulnerable Children	153,233.00	425,999	272,766
Programme Management and Administrative Strengthening	18,566,509.00	11,603,866	- 6,962,643
Incentives for Recruitment and Retention of Human Resources	2,788,821.00	4,661,299	1,872,478
Social Protection and Social Services (Excluding OVC)	1,256,559.00	754,620	- 501,939
Enabling Environment and Community Development	902,332.00	2,138,620	1,236,288
HIV and AIDS – related Research (Excluding Operations Research)	1,412,512.00	1,161,545	- 250,967
Grand Total	**52,445,091.00**	38,850,940	- 13,594,151.00

NASA 2007, 2008 draft [39, 40]

Table 4 shows the amounts funding agents spent on key intervention areas. The majority of the funds, 32,588,547 (83.9%) was sourced from international organisations, 5,339,318 (13.7%) was provided through public funds and private sources of funding was 923,075 (2.4%) [40]. The GFATM, The World Bank and Bilateral agencies were the key sources of funding in 2008.

Table 4: Key spending priorities by funding agents

Key areas of expenditure	Public	Private	International Organisations	Grand total in 2008
Prevention	1435,438	244,210	6,871,268	**8,550,916**
Treatment Care and Support	2,074,572	-	7,479,503	**9,554,075**
Orphans and Vulnerable Children	-	3,781	422,218	**425,999**
Programme Management and Administrative Strengthening	1,077,602	42,333	10,483,931	**11,603,866**
Incentives for Recruitment and Retention of Human Resources	49,567	57,751	4,553,981	**4,661,299**
Social Protection and Social Services (Excluding OVC)	20,848	-	733,772	**754,620**
Enabling Environment and Community Development	376,896	575,000	1,186,724	**2,138,620**
HIV and AIDS – related Research	304,395	-	857,150	**1,161,545**

(Excluding Operations Research)				
Grand Total	**5,339,318**	**923,075**	**32,588,547**	**38,850,940**

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.

Though no public spending was recorded on OVC, in July 2008 provision was made through the Livelihood Empowerment Against Poverty (LEAP) programme which provided cash transfers or social grants for poor and vulnerable households including those with OVC. Since LEAP does not target HIV related OVC specifically the 2008 NASA report did not capture data on OVC supported by LEAP.

Table 5 shows spending on key intervention areas in 2007 and 2008. According to the draft report a greater proportion of funds spent on prevention in 2008 compared with 2007. A reduction on spending on Treatment, care and support was noted from 40% of funds in 2007 to only 24.6% of the finds in 2008. Overall however, treatment care and support still receives more funding probably because of the cost of the intervention. A drop in spending was also noted in the programme management and administrative strengthening.

Table 5: Total spending on key intervention areas, 2007 and 2008

Key areas of expenditure	Grand Total 2007	Percentage of total spending (%)	Grand total in 2008	Percentage of total spending
Prevention	6,339,069.00	12.09	8,550,916	22.01
Treatment Care and Support	21,026,047.00	40.09	9,554,075	24.59
Orphans and Vulnerable Children	153,233.00	0.29	425,999	1.10
Programme Management and Administrative Strengthening	18,566,509.00	35.40	11,603,866	29.87
Incentives for Recruitment and Retention of Human Resources	2,788,821.00	5.32	4,661,299	12.00
Social Protection and Social Services (Excluding OVC)	1,256,559.00	2.40	754,620	1.94
Enabling Environment and Community Development	902,332.00	1.72	2,138,620	5.50
HIV and AIDS – related Research (Excluding Operations Research)	1,412,512.00	2.69	1,161,545	2.99
Grand Total	**52,445,091.00**	100	**38,850,940**	100.00

Table 5 shows that the total amount spent on prevention was US$ 6,339,069.00 which fell short by $3 million of total required for the programme implementation in that year [41]. The total amount spent on prevention activities in 2008 compared with 2007 saw an increase from US$6,339,069.00 to US$8,550,916. Out of the total amount, funds provided for HIV and AIDS, prevention increased from 12.1% to the 22% of the total AIDS funds.

In the same period, the amount spent on treatment care and support reduced from US$21,026,047.00 to US$9,554,075, decreasing from 40.09 % to 24.6 % of the total AIDS funds. In 2007, a substantial investment was made to provide treatment care and support for PLHIV. This included the capital investments of laboratory machines, including CD4 machines. This increased amount spent on treatment care and support in 2007. The current investments are mainly for the Anti-retroviral drugs.

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. In Ghana's generalised epidemic though low risk heterosexual contact contribute 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 2008 report also indicates that spending on activities/services excluding ART for PLHIV and MARPS was 36.56% and 0.93% respectively of the total spending.

4.3 National Composite Index

The purpose of this indicator is to assess progress in the development and implementation of the national HIV and AIDS policies and strategies. This index was obtained through interviews with government officials using the national composite index questionnaire and a consensus building workshop with United Nations Agencies, Bilateral Agencies and the Civil society.

The composite index covers the following broad areas of policy, strategy and programme implementation:
Part A (respondents: Ghana AIDS Commission and MDAs)
1. Strategic plan
2. Political support
3. Prevention
4. Treatment, care and support
5. Monitoring and evaluation

Part B (respondents: by UN agencies, Bilateral Agencies, the civil society)
1. Human rights
2. Civil society involvement
3. Prevention
4. Treatment, care and support

4.3.1 Strategic Planning

Ghana's national response to HIV is spelt out in the National Strategic Framework 2006 – 2010 (NSFII), which is 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.

In addition, 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 strategic planning process has improved over the past years 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 serve as the implementation 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 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
- Technical review meeting with implementing partners and stakeholders

These working groups, 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+, Ghana Business Coalition, 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 muliti-sectoral strategy. These are Ministries of Health, Education, Manpower and Employment, Transportation, Interior (Police, 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.)
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. In 2008 and 2009 no further evaluation was done. In 2010 a comprehensive review will be undertaken to inform the development of the NSF III in 2010.

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 population include women, young people, orphans and vulnerable children, MSM, FSW and their partners, refugees, uniform 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 and Gender empowerment and gender equality.

On the strategic planning level the country continues in its quest towards Universal access to prevention, treatment, care and support services by 2010. 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.

Two reviews have been undertaken to determine the progress towards 2010 and inform programmatic decisions. The recent review indicated that in 2009, Ghana achieved and exceeded the targets for eight out of the thirteen indicators for 2008. Four indicators are lagging behind and are 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 adult and children and HIV prevalence among 15 – 24 age groups. 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]. This report has revitalised a new momentum to achieve targets.

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

- Improved information flow and quality of data used for evidence based planning
- Stronger M&E systems in place
- Improved planning using NSF II and Annual Programmes of work as guides
- More results based planning due to implementation of more GFATM projects which are performance based
- Improved quality of information provided by stakeholders
- More results oriented planning to achieve measurable targets
- Extensive stakeholder consultation and participation through the partnership forum and Technical Working groups
- Greater buy-in of development partners

The remaining challenges in strategic planning for 2007 and 2009 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

4.3.2 Political Support

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 and the Vice Chairman is the Vice President. 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 representative 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]. With a change of the government , new members of the Commission were inaugurated in August 2009.

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 reporting period, a number of new technical staff were recruited to support the secretariat.

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 was 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 2008 and 2009 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.

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

The President, Vice President and Minister spoke publicly about HIV and AIDS on a number of occasions. In 2009, the Vice President launched the World AIDS Day activities
However, stakeholders felt that in 2008 and 2009, the national leadership including the Executive, Parliament, the Judiciary branches of government, and the leadership of political parties, have not maintained the needed momentum to revitalise advocacy for HIV and AIDS. Possible reasons cited for this are discontinuation of financial for parliamentarians to undertake advocacy programmes where parliamentarians are supported to speak about HIV/AIDS, the apparent stabilization of the national prevalence and competing political issues.

The main challenges identified by respondents in the area of political support were:

- insufficient funding for activities,
- complacency on the part of individuals and Government as a result of perceived low HIV prevalence
- inadequate involvement of leaders of all political parties.

Respondents rated political support efforts in HIV and AIDS programmes in 2007 at 8 (average). In the 2009 political support was rated at 7.3. However, the scope of questions has been increased and the respondents for the two surveys were not the same.

4.3.3 Human rights

Currently, Ghana does not have a specific HIV and AIDS laws. Laws exist which protect PLHIV against discrimination, address their specific rights and needs as well as protecting vulnerable populations such as women, young people and PLHIV. However a number of laws also exist which are obstacles for successful implementation of HIV prevention and care programmes in the country.

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 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, region, 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 Wilful 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 HIVAIDS shall be a notifiable condition 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 dismal [46].

- The Police Service established under the Police Act 1970, has the statutory duty to prevent and detect crime and apprehend 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 subsidised HIV services. In the period under review through advocacy and review of programmes outcomes, HIV prevention services such as Counselling and testing and all aspects of PMTCT have been made free. Unfortunately condom is 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. 140 districts of the 170 district 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 receive, “Know Your Status (KYS)” campaigns were undertaken all over the country to ensure an increase in the counselling testing through mobile/ outreach services. This was provided in conjunction with the health service in many communities.

The country has a policy to ensure access to women 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-friences 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 nurse. 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 issue of having an explicit comprehensive HIV Law still remains under discussion [59].

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 plays an executive and advisory roles 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 340 associations were supported in the period under reveiw 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 does not seem to yield the desired impact as HIV related stigma is still high. 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 different levels ranging between 4 and 7 for 2009 (average of 5) and 5 in 2007. According to the respondents progress since 2007 were:

- Stigma reduction training has been implemented for Police, prisons, judiciary, health worked, MARPS
- Stigma reduction campaign using the mass media

Key challenges remaining were:

- Inherent stigma and discrimination by the general public.
- The large gap between the policies and laws and their enforcement
- Law and policy reforms

4.3.4 Knowledge and behaviour change

HIV epidemics are fuelled through the transmission of infection of successive generations of young people. Comprehensive knowledge on HIV is the first step for the adoption of behaviour that reduces the risk of HIV transmission. The knowledge and behaviour of most at risk populations and vulnerable 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 on HIV, comprehensive knowledge on HIV and AIDS, appropriate prevention and non-stigmatising behaviour has been lagging behind [6, 36].

Indicator No. 13: 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. In the last reporting period (2006- 2007), 25.1% of young women and 33% of young men aged 15-24 years had comprehensive knowledge (i.e. Correctly identified ways of transmitting HIV and rejected misconception about HIV transmission) of HIV and AIDS [68].

In the 2008, the GDHS showed that only 28.3% of female respondents age 15 – 24 and 34.2% of men had comprehensive knowledge in about HIV and AIDS. There has thus been little progress along this front. This is mirrored by the reported reduced resources provided to HIV prevention programmes/activities in 2006, 2007 and 2008 in favour of HIV care and treatment. Ghana, through the implementation of GFATM Round 8 grant intends to bridge this gap for effective HIV prevention interventions.

Indicator No. 14: Percentage of most at risk populations who both correctly identify ways of preventing that sexual transmission of HIV and who reject major misconception about HIV transmission

No survey was conducted to obtain data for this indicator directly, however the answers for the individual questions on misconception are available as illustrated in the table 6 below.

Table 6: Knowledge of Female sex workers in 2006 and 2007

Indicators	Seater		Roamer		% Change Δ	
Correctly identified ways of preventing sexual transmission of HIV/AIDS	2006	2009	2006	2009	Seaters	Roamers
Abstinence	48.1	30.7	29.5	20.0	+17.4	+9.5
Use of condoms	46.7	32.6	29.6	18.4	+14.1	+11.2
Being faithful to one uninfected partner	47.4	31.7	29.8	18.9	+15.7	+10.9
And reject misconceptions about transmission:						
HIV not transmitted by mosquitoes	48.6	35.3	30.6	18.6	+13.3	+12.0
HIV not transmitted through used needle	48.5	31.6	30.6	18.4	+16.9	+12.2
HIV transmitted to unborn	47.8	31.7	31.0	18.9	+16.1	+12.1
HIV not transmitted by healthy looking people	48.2	32.5	31.4	18.5	+15.7	+12.9
Disease to newborn	50.5	32.0	32.0	18.8	+18.5	+13.2

Source: Female Sex Workers Behavioural Surveillance Survey in Accra and Kumasi, Ghana, 2009 [8].

The data shows that on the whole the knowledge among sex workers knowledge is improving.

Indicator No 15: Percentage of young and men aged 15-24 who have had sexual intercourse before the age of 15

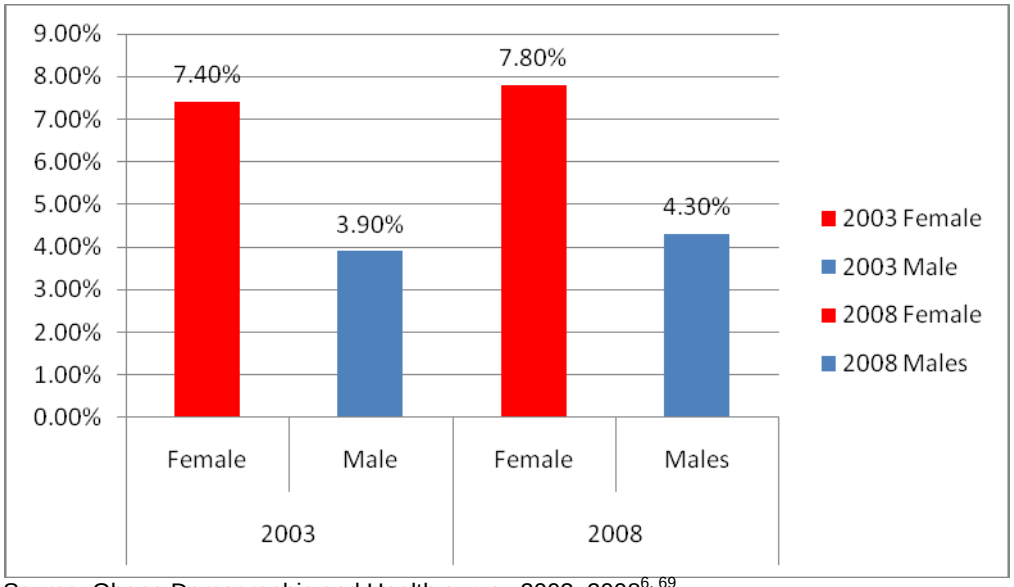
One of the HIV prevention goals is to delay sexual debut for as long as possible. This reduces the risk to HIV exposure and reduces the susceptibility to HIV infection for women. This indicator is measured in the GDHS. In 2003, 7% of women and 4% of men had sex before the age of 15 years. In the 2008 GDHS, women 7.8% and men 4.3% had sex before the age of 15 years. There has thus been little change in the age of sexual debut in this age group. The table below shows the details.

Table 7: Percentage of 15 – 24 years who have had sexual intercourse before age 15 years

Age	Females	Males
15 - 17	7.5%	4.4%
18 - 19	9.3%	2.5%
15 – 19	8.2%	3.6%
20 -24	7.2%	5.2%
15 – 24	7.8%	4.3%

Source: Ghana Demographic and Health survey 2008 [69]

Figure 9: 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]

Indicator No: 16 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 sequentially 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. 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. 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.

Table 8: Percentage of respondents 15 – 49 years which have sexual intercourse with more than one partner in the past 12 months

	2008	
Age	Female	Male
15- 49	1.0%	11.3%
15 – 19	1.2%	3.1%
20 – 24	1.6%	9.6%

25 – 29	1.7%	16.7%
30 - 39	0.5%	15.5%
40 - 49	0.2%	12.4%

Indicator No. 17: 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

Having higher risk sex and using a condom 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.

The GDHS does not utilise this indicator for both males and females. In 2008, 26.2% of male respondents aged 15- 49 years, used a condom with their last partner while, 24.4% of males aged 15 – 19 years, 49.2% of males aged 20 – 24 years, 42.8% of male respondents aged 25 -29 years, 19.6% of respondents aged 30 -39 years and 3.5% of respondent age 40 -49 years did the likewise [69]. Due to the small number of women in the same category the comparable data for female is not provided [69].

Another similar indicator measures the percentage of individuals with higher risk sex who used a condom during their last sexual act. In 2008, 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% or 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 [6]. Thus the rate of condom use has decreased slightly for females and increased slightly or remained the same for male respondents over the five year period. Table 9 depicts the percentage condom use for the different age groups. Almost all the age groups had reduced condom use in their last higher- risk with the exception of the 25 – 29 age group were condom use increased slightly.

Table 9: Percentage of the 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%

Indicator No. 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client

From the Modes of transmission survey is evident that sex workers and their partners (clients and partners) contribute about 31.1% to HIV incidence. Thus sex workers play a major role in HIV

transmission. The consistent use of condoms by the sex workers with all partners would go a long way to reduce HIV transmission. From the Behaviour surveillance study in 2009, only 4.1% of sex workers said that they did not feel the need to use condoms with their paying partners [8]. The percentage that used it during their last sexual act however was not provided.

Indicator No 19: Percentage of men reporting the use of condom the last time they had anal sex with a male partner

Most –at-Risk-Populations such as Men who have sex with men (MSM) also contribute considerable 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. Data for this indicator was not available for this reporting period.

Indicator No 20 and 21: Injecting drug users

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 behavious 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. Data is not currently available on the condom use and use of sterile equipment during this reporting period.

4.3.5 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 NSFII.

Various reviews and surveys have indicated that the HIV response in Ghana has not made the expected progress (Refer to page 43). As Ghana progresses towards achieving Universal Access by 2010, a lot needs to be done if we are to achieve our goals and/or targets set by 2010. The GDHS 2008 and the 2007 and 2009 Universal Access report have indicated the areas which need to addressed.

The prevention interventions for 2009 were designed to reduce high risk behaviour and exposure to risk, and to reduce the vulnerability of those who are unaware of their risk by raising their awareness, and "de-stigmatizing" the disease so as to increase access to prevention, treatment and care services.

Prevention Programmes for Most at Risk Populations (FSW/MSM)

The two leading CSOs working with MARP are West African Project to Combat HIV & AIDS (WAPCAS) and Academy for Education and Development/Strengthening HIV & AIDS Response Programme (AED/SHARP) in 2008 and 2009. The key behaviours being promoted were correct and consistent condom use, use of water-based, and together with condoms during each act of anal sex, HIV testing, seeking prompt STI and HIV care.

Indicator No 9: Percentage of most-at-risk populations reached with HIV prevention Programmes

In 2009, AED/SHARP concluded its interventions and WAPCAS provided a minimum package of prevention services to 16,742 females sex workers and 939 MSM in six regions of the country. The main activities under taken were included:

- Capacity Building of FSW and MSM peer educators
- BCC Material reproduction for MARPs
- Monitoring and supervision
- Outreach Activities
- Peer education within FSW & MSM communities
- Mobile CT
- MSM get-togethers/CT
- Condom promotion/sales
- Referral of clients for clinic visits

Considering the estimated number of sex workers in 2009, 47.9% of sex workers were reached with these interventions.

HIV prevention among in-school youth

The Ministry of Education Science and Sports 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.

During the year under review, the Ghana Education Service continued to implement its school based HIVALERT Model. 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 Pillar and School community –Directed Pillar. 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 nine out of ten regions and hopes toscale-up to the remaining region with funding from GFATM R8 in 2010. In 2008, 7 regional teams were trained, 19,876 peer educators, 5,053 school teachers and 767 circuit supervisors were trained.

Indicator No 11: Percentage of schools that provided life-skills based HIV education in the last academic year.

Table 10: Schools with HIV ALERT Programme

	public	private	total
Total number of schools	19,778	5,061	24,839
Schools with HIV FLHE	16,618	3.032	19,650
Percentage of schools with HIV FLHE	84.0%	59.9%	79.10%

Source. Ministry of Education Statistics 2009.

HIV prevention among out-of-school youth

Out-of-school youth have been targeted through mainstreaming HIV interventions in programmes of the Non-formal education unit of the MOESS. A number of development partners; UNICEF, UNFPA, JICA and USAID as well as District Assemblies have provided support to some NGOs, CBOs and FBOs to implement HIV prevention programmes for out-of-school youth. These programmes/activities provide life skills training, promote, abstinence, partner reduction and condom use for the sexually active. Two examples are provided below.
In 2009, the HIV & AIDS Prevention and Education (HAPE) Project targeted out-of-school youth in two regions of Ghana. The project referred a total of 1,770 people to health facilities, mobile & outreach CT services and distributed 118,449 male and female condoms through local NGOs and CBOs. In all 494 out of 520 Peer educators were trained. 97,051 were reached with HIV prevention messages individual/group discussions and 22,947 and 58,056 were reached through drama performances and film shows.

A survey conducted at the end of the project indicated that:

- The proportion of youth who reported consistent use of condom increased from 35.8 % at mid-term survey to 37 % at end-line although it showed a 1.5 percentage point decline compared with the baseline results.
- The mean age at first sex has declined from about 18 years at the baseline survey to 16.8 years at the end-line survey.
- About one-third (33.7%) of those who had sex within the last 12 months reported having multiple partners. This shows an increase of about 11 percentage points compared with the mid-term results.
- The proportion with multiple sex partners increases with age and is a habit more practiced by the out-of-school youth (34.8%) and those in the Kumasi Metropolitan Assembly (KMA) (40.5%) [12].

The survey concluded that the project impacted positively on knowledge but did not make the needed impact on attitudes and behaviours. A number of lessons have however been learnt to guide the design and implementation of similar projects in the future.

DFID Youth Project

As part of efforts to halt the spread of HIV and AIDS among youth in Ghana, a consortium of three leading NGOs in Ghana are implemented the 'Empowering young people to reduce new HIV Infections through Partnership' project. This consortium is comprised of Family Health International (FHI), Ghana Social Marketing Foundation (GSMF) International, and the Planned Parenthood Association of Ghana (PPAG).

The goal of the project is to contribute to the reduction of new infections among young people in Ghana.

The main objectives of the project were to:

1. To increase uptake of quality STI and CT services by 5% over the baseline among young people in four regions (Western, Ashanti, Eastern and Greater Accra) within 12 months
2. To increase knowledge and awareness on STI and HIV-related issues among young people in four regions (Ashanti, Eastern, Western and Greater Accra) within 12 months
3. To increase the proportion of 1,000,000 young people practising safer sex (abstinence, consistent condom use, reduction of sexual partners) by 5% over baseline in four regions(Ashanti, Eastern, Western and Greater Accra)within 12 months

The project uses multiple strategies to provide adequate and accurate information and services to young people in and out of school as well as members of selected communities. These strategies range from mass media/materials production and BCC to mobile counselling and testing (CT), integrated service delivery as well as condom promotion. To ensure access to information and services, capacities of community volunteers and local NGOs/CBOs were built.

In 2009, the project achieved the following results.

- 4,380 youth reached with information through one on one interaction.
- 13,304 reached through group discussion.
- 5,309 people participated in community durbars [12].
- 1,215 youth reached with CT services and 17 reactive cases were recorded. All reactive case referred for follow-up services.
- 422,276 pieces of condoms distribution[12].

Much has been done in HIV prevention for the youth in 2008 and 2009 to increase the coverage of services to all regions and districts of Ghana

Respondents rated NCPI score for policy effort for HIV prevention in 2007 and 2009 at 7.1 in 2005 and 6.75 respectively. Respondents thought interventions for HIV prevention had not increased as expected. This can be seen by the only slight increase in expenditure for prevention in 2008 [40]. Respondents thought that to achieve the national target much more should be done in HIV prevention programming.

It is hoped that with funding from GFATM Round 8 there will be increased funding available for HIV prevention in 2010.

Health System HIV Prevention

HIV and AIDS prevention linked to health systems continued in 2008 and 2009.Interventions undertaken to prevent the transmission of HIV included, provision of Safe blood, universal precautions in hospital settings, counselling and testing (CT) and prevention of mother to child transmission (PMTCT).

Blood Safety

The National Blood Transfusion Service (NBTS) and the Public Health Reference Laboratories (PHRL) in the Ghana Health Service continue to provide services in the country to ensure that the donated blood is screened against infectious diseases. In Ghana Blood donated is routinely screened for HIV, Hepatitis B, Hepatitis C and syphilis.

Indicator No 3: Percentage of donated blood units screened for HIV in a quality assured manner

The blood collection and screening is conducted in a decentralised manner through regional and district laboratories. In 2009, in Greater Accra 33,294 units of blood were screened in the public sector for HIV with 3.68%, (1224 units of blood) confirmed as HIV positive. Blood screened is currently conducted through the use of antibody tests and not PCR test that identify the HIV antigen.

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, counselling 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 counselling 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. In 2009, PMTCT services were provided at the national (tertiary), regional, district, health centre level facilities in both public and private health facilities. Efforts are far advanced to further decentralise PMTCT to the community level and provide PMTCT at community level through Community Based Health Planning Services (CHPS).

The number of PMTCT centres increased from 135 in 2005 to 793 functional sites by December 2009. The number of clients counselling and testing as part of ANC services has increased from 104,045 in 2007, 257,466 in 2008 and 381,874 in 2009. The number of positive PMTCT clients receiving ART has increased from 2,896 in 2007 to 4,991 in 2008 but decreased to 3,643 in

2009. The percentage of HIV infected pregnant women who received anti-retroviral drugs to reduce the risk of mother to child transmission increased from 12.6% in 2007 to 38.1% in 2008 and decreased to 28% in 2009.

Indicator No 5: Percentage of HIV-positive pregnant women who received antiretroviral medication to reduce the risk of mother-to-child transmission

Table 11: PMTCT services in 2007 to 2009

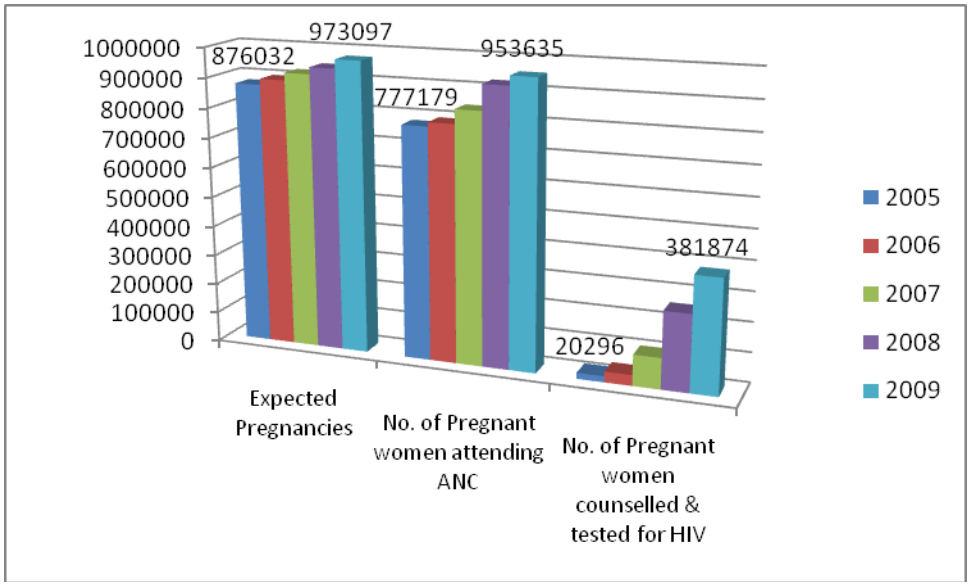
Indicator	2007	2008	2009
No of clients received PMTCT	104,045	257,466	381,874
No of clients positive	3,298	6,021	6,634
Percentage of Clients positive	3.2%	2.3%	1.7%
Clients on ART	2896	4,991	3,643
Percentage of HIV Positive clients detected through PMTCT on ART	37.6%	82.9%	54.9%
Estimated number of HIV-infected Pregnant women in the last 12 months	19918	13095	12990
Percentage of HIV infected pregnant women who received antiretroviral s to reduce the risk of mother to child transmission	12.6%	38.1%	28%

Source: National AIDS Control Programme 2007, 2008 Annual Report and 2009 statistics [72, 73]

The 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 assessing services at the end of the reporting period. In 2009 only 54.9% of PLHIV received ART compared with 82.9% in 2008.

With regard to achieving the UNGASS targets, in 2009, only 29% of antenatal clinics in the country provided PMTCT services to its clients. As can be seen in figure 10 and 11 below, only 40% of ANC clients were counselled and tested for HIV and only 28% of those estimated to be in need of ART for PMTCT received it.

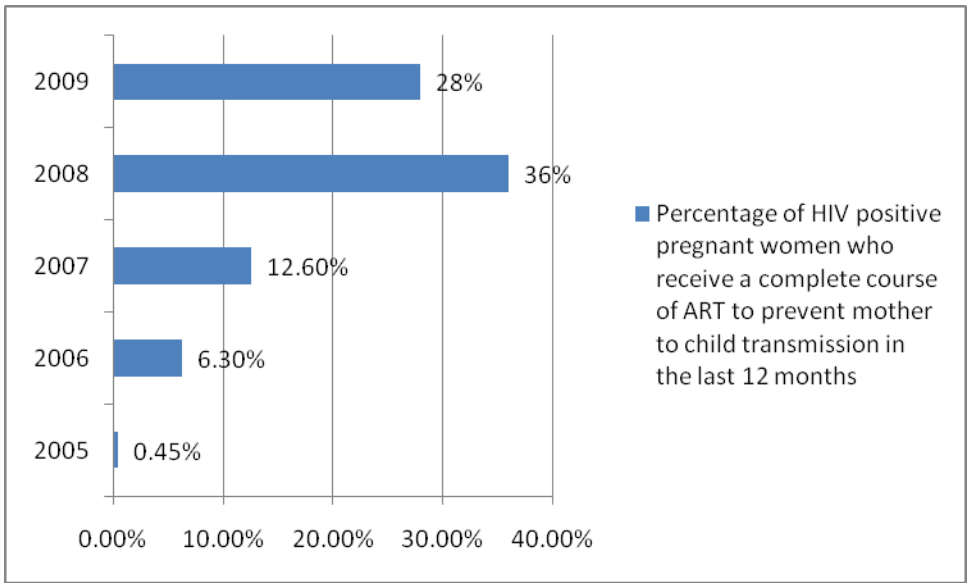
Figure 10: PMTCT Service delivery data 2005 to 2009



Source: Reproductive and Child Health Unit Report 2005-2008 and 2009 Statistics, Ghana Health Service [74] .

There is a significant gap between the country's achievements in 2009 (28%) and target (80%) for 2010. A concerted effort will thus be required to overcome the obstacles and achieve the targets for 2010.

Figure 11: Percentage of HIV positive pregnant women who receive a complete course of ART to prevent mother to child transmission in the last 12 months



Percentage of infant born to HIV- infected mothers who are infected

Provision of antiretroviral therapy during pregnancy and following birth and the use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. Substantial reductions in mother-to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis. 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. However efforts are being made through the development of guidelines and training for staff in Early Infant Diagnosis and the provision of appropriate infrastructure for testing to enable this to be monitored in the future and take appropriate programmatic action. During this reporting period therefore, this data was not collected and the indicator not measured.

Counseling and Testing (C&T)

Indicator No. 7: 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 12: Percentage of respondents 15- 49 who received an HIV test result and know their results in the last 12 months.

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 2008 [6, 69]

To address this, counselling and testing has been scaled-up up further in this reporting period. Programmatic data from the NACP indicates that by December 2009, 808 CT centres were providing CT services and each region and district undertook the 'Know Your Status Campaign'. By the end of 2009, 1,635,889 individuals had completed the counseling and testing process. In 2008 and 2009, 467,935 and 865,058 respectively were counselled and tested, 77.8% were females and 22.8% were males. There is a significant annual increase in the number of people tested. The ongoing situation where significantly more women access HIV testing than men needs to be addressed.

Table 13: The number of clients tested by Gender

Clients tested for HIV by Gender

	2007	2008	2009
Male Tested	24,433	84,690	196,342
Female Tested	137,470	383,245	686,716
Male +Ve	4,922	8,017	10,564
Female +Ve	12,082	21,025	26,008

From the results it is clear, that though there have been vast efforts 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.

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

- Utilisation of an Opt-out approach for PMTCT
- Shift of GAC:
    - - to fund fewer, larger CSOs and coalition groups with better capacity as compared to more, smaller CSOs;
    - to improve monitoring, reporting and
    - to build the capacity of smaller CSOs
- Increase in funding for prevention
- Increased focus on MARPs

The identified challenges are:

- Weak coordination and monitoring
- The need to intensify scale- up of CT
- Shortage of condoms & lubricants last year (stock out of various supplies)
- Low level of comprehensive HIV Knowledge

4.3. 6 Clinical Care and Treatment

Great strides have been made by all stakeholders in Ghana 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 2008 and 2009 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 donor partners, including DFID, USAID, World Bank and the GFATM. Health facilities providing ART increased from 3 in 2003, to 13 in 2005, 48 in 2007 and 138 by December 2009. 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 33,745 PLHIV have been put on ART since the onset of the programme in Ghana and 30,265 (90%) of these are currently still on ART.

Table 14: Annual Number of Clients Accessing ART Services

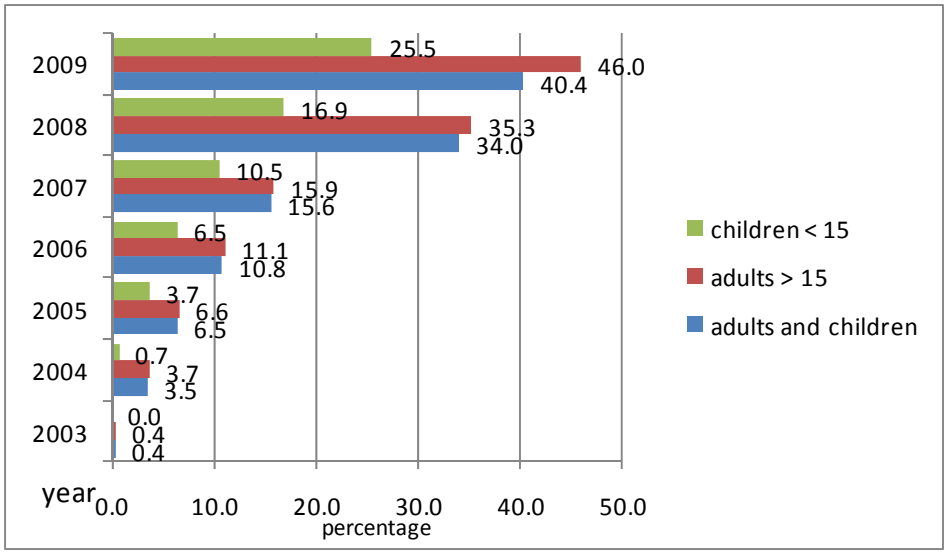
Indicator	2003	2004	2005	2006	2007	2008	2009	Total
Total Number on ART	197	1,831	2,032	3,278	6,091	10,185	10,131	33,745
Males on ART	85	764	762	1,218	2,180	3,066	3,104	11,179
Females on ART	112	1,067	1,270	2,060	3,911	7,119	7,027	22,566
15+	197	1,804	1,913	3,156	5,783	9,735	9,409	31,997
<15	0	27	119	122	308	450	722	1,748

Source: NACP Annual Report 2005 – 2008 and 2009 statistics [72, 73, 76, 77]

Indicator No 4: Percentage of women and men with advanced HIV infection receiving antiretroviral therapy

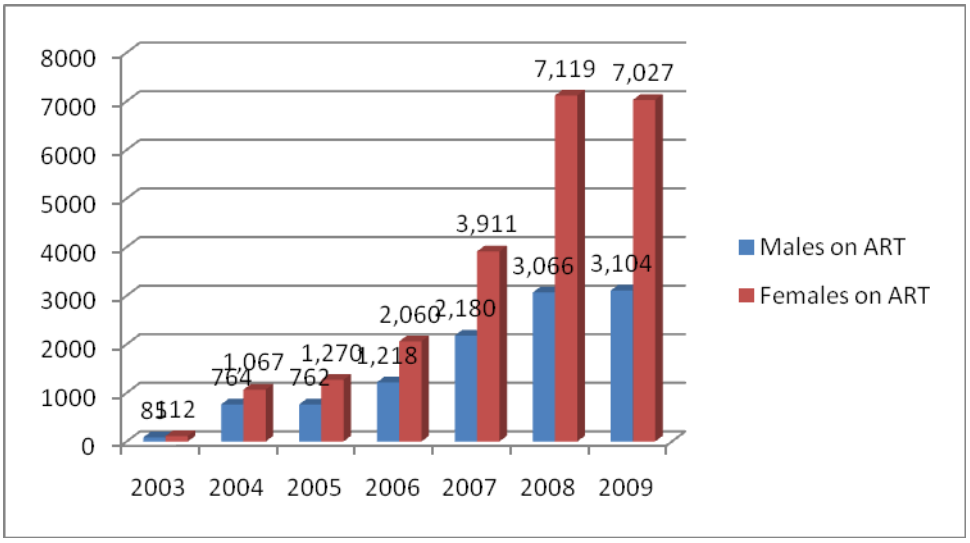
Ghana has pledged to achieve provide ART to 66% of clients who need it by 2010.By the end of 2009, much progress had been made. Figure 8 illustrates the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy. The graph shows the steady increase in overall coverage of HIV services to those who need it (adults and children) from 0.4% in 2003 to 34% in 2008 and 40.4% in 2009. The coverage of ART for children in particular has increased from 0% in 2003, to 10.5% in 2007. Since 2007, the percentage of children accessing ART services has increased more than two fold to 25.5% in 2009. The ART coverage for adults has also increased from 15.6% in 2007 to 46% in 2009. This indicates the immense progress the country has made over this reporting period.

Figure 12: Percentage of adults and children with advanced HIV on ART in 2003 to 2009



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 while only 33.1% were men. This indicates that 50% of females who need ART are accessing the service while only 39% of males who need ART have access. 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 13: The number of male and females initiating ART in 2003 to 2009



Source: NACP Annual Report 2005 – 2008 and 2009 statistics [72, 73, 76, 77]

Indicator No 24: Percentage of adult 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. In 2008 the overall value for this indicator was 89.8%.[32]

On the whole respondents scored treatment care and support 7.5 in 2007 and 8.25 in 2009. The key achievements they identified were:

- Initiation of Early Infant Diagnosis

- Adequate provision of equipment and supplies to more health facilities especially in the regions
- The initiation of 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

4.3.7 Impact Indicators

Indicator No 22: 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 sentinel survey revealed a median prevalence in this age group of 1.8% in 2008 and 2.1% in 2009. Using the definition of the indicator the overall HIV prevalence in this age group was 1.9 % in 2008 and 2.1% in 2009. Considering that a downward trend is targeted for expected in this age group more interventions specific to this age group and the youth are required to achieve the expected target.

Year	2008	2009
Median	1.8%	2.1%
Overall prevalence	1.9%	2.1%

Source: 2009 HIV Sentinel Survey Report [1, 3]

4.3.8 Impact Alleviation

Orphans and vulnerable children

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 No 10: Percentage of orphaned and vulnerable children aged 0–17 whose households

The LEAP was preceded by an initial pilot phase of 21 districts and is being rolled out to an additional 33 districts. At the end of the reporting period, 40 districts had been covered. The districts were selected based on poverty ranking, HIV/AIDS prevalence, incidence of child labour and limited access to social services. All the ten regions of the country were covered. By 2008, 4,064 OVC were reached representing 14.5 % of the beneficiary household[79]. By 2009, 10,722 OVC received support in 41 districts. This represents 7.36% of all OVC in the country.

The civil society has also contributed to some extent to the needs of OVCs. In the first half of 2009, 5244 OVCs were supported by various NGOs (Opportunities Industrialisation Centre International (OICI|), West African AIDS Foundation, WAAF, World Vision International) for nutrition, health and educational support and the Manya Krobo Queen Mother's Association [12]. However, the scale-up of OVC activities is still required to achieve the desired effect.

Indicator No 12: 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. (see table 15)

Table 15: Current school attendance among orphans and among non-orphans aged 10-14 years

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

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.

4.3.9 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 and Faith Based Organizations at all levels. Through interactions with the Ghana AIDS Commission, the civil society has played an active role in policy formulation and planning of Interventions at all levels. In 2008 and 2009 the civil society played an active role in the development of POW 2008 and 2009; took decisions in prioritising areas of intervention and refocusing on prevention interventions for 2008 and 2009 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, ISODEC, FBOs, Society of Women Against AIDS. At the district level local NGOs and CBOs are involved in HIV activities targeting specific populations.

Following the challenges identified in 2007, 2008 and 2009, 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. Out of 227 organisations 29 were selected. These organisations were assessed and prepare 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.

4.3.10 Workplace Programmes

Workplace 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 GTZ 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. Through a number of innovative Public Private Partnership Projects GTZ 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, thus broadening the scope and reducing the resistance to implementation of the activities. Specific organisations which have benefited from this are CEPS, IRS, VAT and Ghana

Water Company. 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) to support private sector enterprises to implement workplace HIV&AIDS activities. The GBCA undertook several activities to strengthen Workplace programmes in the private sector, these include peer education training and Member Information Exchange Forum.

4.3. 11 Summary of National Composite Index

Table 16: Results of National Composite Policy Index (NCPI) in 2009

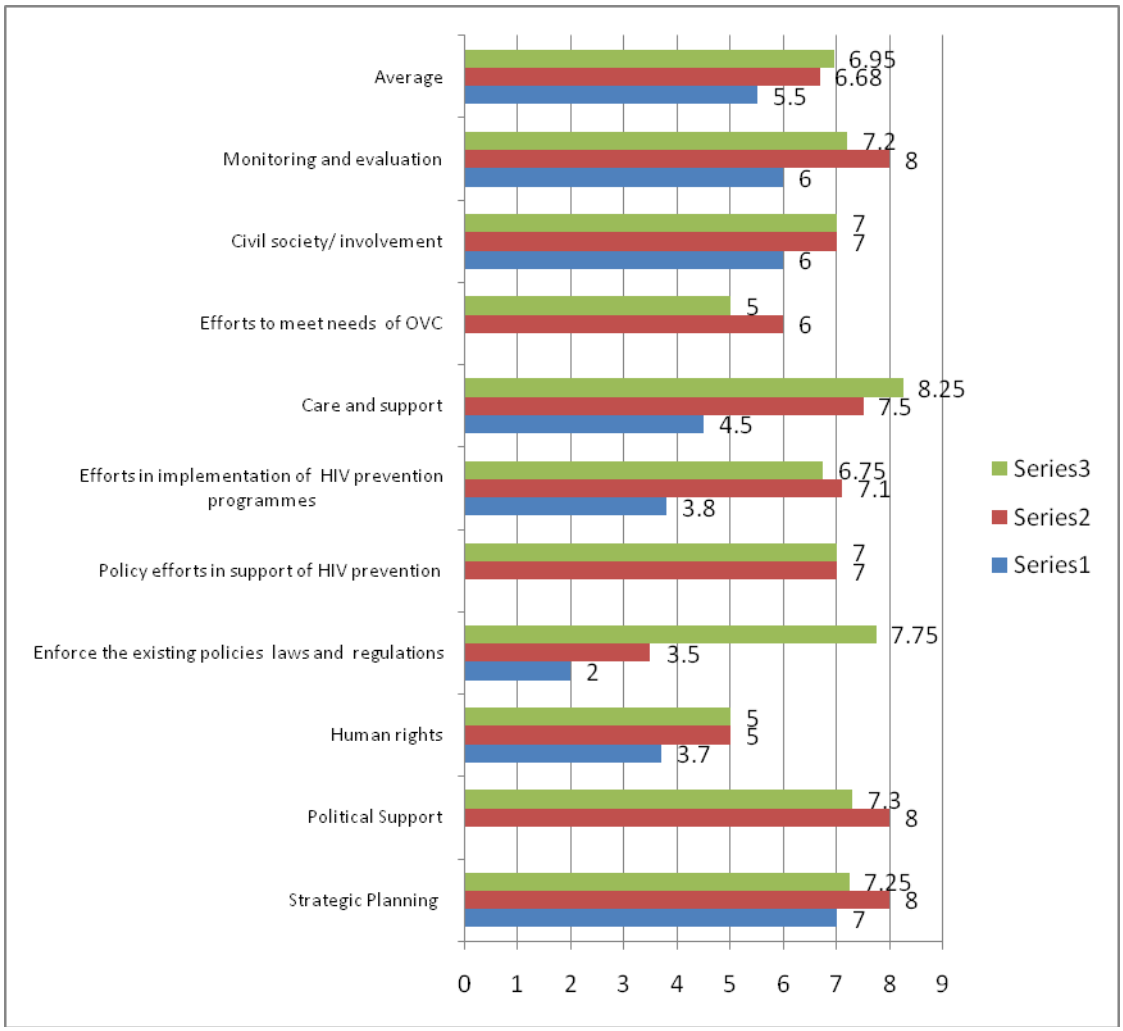
Area\Score	2005*	2007	2009
Strategic Planning	7	8	7.25
Political Support		8	7.3
Human rights	3.7	5	5
Enforce the existing policies laws and regulations	2	3.5	7.75
Policy efforts in support of HIV prevention		7	7
Efforts in implementation of HIV prevention programmes	3.8	7.1	6.75
Care and support	4.5	7.5	8.25
Efforts to meet needs of OVC		6	5
Civil society/ involvement	6	7	7
Monitoring and evaluation	6	8	7.2
Average	**5.5**	**6.68**	**6.95**

The results of the three successive UNGASS surveys 2005, 2007 and 2009 are depicted in Table 16. The scoring in 2005 is as seen in 2007. On the whole, the results show that respondents thought that the various intervention areas ranked the same as in 2007. A number of areas scored higher in 2007 than in 2009. These were Strategic planning, political support, efforts for implementation of HIV prevention programmes and monitoring and evaluation. Most of the respondents for 2009 were different from the respondents in 2009. These respondents thought that some areas were ranked too high in 2007. Human rights, civil society involvement and policy efforts in HIV prevention remained the same.

On the whole respondents thought that the exercise was quite subjective. Responses were dependant on the persons who responded, whether they worked in 2007 and 2009 and their personal views on the progress they had made in their area of intervention. There was a

challenge with the interpretation and determining whether a change of one point was actually significantly different.

Figure 14: Trend Analysis of NCPI, 2005, 2007, and 2009



4 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 the implementation of the response.

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.

GTZ 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.

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.

Public Private Partnerships and workplace programmes

In 2008 and 2009, GTZ built on the public private partnership package instituted under TAP and linked private organisation with public health institutions. Through a comprehensive workplace

programme private and public companies were engaged through training of workplace focal persons and peer educators. Educational sessions were held for all personnel and counselling and testing services were organised for the staff. Clinical care and ART were provided to staff and their dependents who were found to be HIV positive in public health institutions. Through the programme, between 2007 an 2009, in one of the organisations the acceptance rate for HIV testing was 64.8% of the staff [81]. This allowed 38 persons to be diagnosed as HIV positive and referred for treatment[81]. Through the workplace programmes, individuals who would not normally access health service are counselled and tested and have an entry point for HIV care. This is increasingly important with the emerging evidence that men do not access services as readily as their female counterparts.

5 Major Challenges and remedial actions

5.1 Progress on key challenges reported in 2007

In the 2007 UNGASS report the key challenges identified were:

- Inadequate coordination of the HIV response of the different agencies by the Ghana AIDS Commission
- Late provision of funding for MDAs and NGOs resulting in late or non implementation of planned activities.
- Reduced funding for prevention programmes
- Stock out of some HIV commodities for a period of time.
- Inadequate skilled human capacity.

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 2008 and 2009, 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.

5.2 Challenges faced throughout the reporting period of 2008 – 2009

The main challenges faced that hampered implementation of national response 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,.
- Inadequate number of skilled human resources at the lower levels of the health system and at the community level

- High human resource turn over
- Inadequate coordination and management of HIV/AIDS activities at the community level
- The low level of National commitment to HIV/AIDS activities coupled with inadequate direct government funding and high donor dependence for HIV/AIDS activities. This does not enable the country to move forward on its own agenda leading to dependence on donor priorities
- Stigma and discrimination (both perceived and actual) of PLHIV and MARPS.
- Inadequate coverage of services to all PLHIV at the community level
- Frequent drug and other commodity stock-outs
- Weak Health Information Systems
- Wide gap between the policies and laws and their enforcement
- Coordination within each sector as well as supra-ministerial coordination
- Weak health and community systems
- Inadequate M& E system in some sectors

5.3 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.
- 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.

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.
- The Country Response Information System (CRIS) should be scaled-up to all districts to provide a uniform data for the districts
- 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

6 Support from the Country's development Partners

In 2008 and 2009 development partners contributed aptly to the national response by the provision of technical and financial support to the Ghana AIDS Commission 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.

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, Royal Netherlands Embassy (RNE), GTZ, DFID, DANIDA and JICA and UN agencies; UNAIDS, WHO, UNDP, UNICEF, UNFPA, UNESCO, ILO WFP and UNHCR. 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 2008, development partners contributed $32,588,547 for the HIV response. Development partners still provide the majority of funds (83.9%) for the HIV response. Support was provided mainly to strengthen the health care system, prevention programmes, care and treatment as well as research. Table 17 below provides detailed support provided specifically for intervention programmes.

Table 17: Expenditure by partners to the HIV response

Key areas of expenditure	International Organisations	Grand total in 2008	Percentage of funds for intervention area
Prevention	6,871,268	**8,550,916**	**80.4%**
Treatment Care and Support	7,479,503	**9,554,075**	**78.3%**
Orphans and Vulnerable Children	422,218	**425,999**	**99.1%**
Programme Management and Administrative Strengthening	10,483,931	**11,603,866**	**90.3%**
Incentives for Recruitment and Retention of Human Resources	4,553,981	**4,661,299**	**97.7%**
Social Protection and Social Services (Excluding OVC)	733,772	**754,620**	**97.2%**
Enabling Environment and Community Development	1,186,724	**2,138,620**	**55.5%**
HIV and AIDS – related Research (Excluding Operations Research)	857,150	**1,161,545**	**73.8%**
Grand Total	**32,588,547**	**38,850,940**	**83.9%**

Source: National AIDS Spending Account 2008 [40]

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

7 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 2008 and 2009, the M&E unit was provided with more personnel. The Unit is led by the Acting Director of Research Monitoring and Evaluation and supported by the Research Coordinator, an Information Coordinator and Monitoring and Evaluation (M&E) Coordinator, MIS Officer, Data Analyst, two data entry assistants, and one secretary. Four additional personnel are to be recruited to support the unit in 2010.

A research monitoring and evaluation technical committee continues to support the GAC. It is comprised of GAC, academic experts, development partners, M&E specialist, MDAs, NGOs and PLHIV, USAID, 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, SHARP, GTZ and representative from PLHIV. The RM&E committee is responsible for monitoring a national set of indicators and report on of the national response.

In 2008 and 2009 a number of activities were under taken to strengthen the national M& E system.

In 2009, the 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.

In 2008, the GAC decided to use the Country Response Information System CRIS) to support national and sub-national databases. GAC in collaboration with UNAIDS in May 2008, developed the CRIS roll-out plan for implementation from 2008 – 2010. The British Government's Department for International Development (DFID) provided funding to support the CRIS roll-out plan. Activities carried out in the CRIS roll-out include ; Procurement of equipment and installing of the database, training of trainers and training of 87 M&E personnel in the use of CRIS

- **M&E Road Map**
  As part of the commitment to strengthening the monitoring and evaluation systems of the national response a Road Map for monitoring and Evaluation based on the new UNAIDS Organizing Framework for Functional National M&E Systems (12 components) was developed in 2008. A validation workshop was organized in March 2009 to solicit inputs in terms of commitments and pledges of support from partners and stakeholders to move

the Road Map implementation process forward. The document has been finalised following the validation meeting and implementation has since been on-going[12].

- **Indicator Harmonization**
  The indicator harmonization and standardization was undertaken in 2009 to streamline data collection, ease reporting burden and improve data quality and enhance data use at all levels. Through several meetings and one stakeholder consultation forum, a single set of national indicators that meets the common information needs across donors, stakeholders and covers the sub-national and programme level data needs was created. The indicators were constructed with required disaggregation, as outlined in the current UNGASS guidelines and every effort was taken to ensure that most community-based programmes and service delivery points would be able to collect the data or obtain it from already existing data sources and report appropriately [12, 78].

- **International Technical Assistance and collaboration**
  In 2008 and 2009, the GAC received technical assistance to strengthen national M& E system.

- In line with the national M&E system harmonisation process, national institutions such as GAC, UNAIDS, NACP, NMIMR, National Public Health Reference Laboratory engaged the Centres for Disease Control and Prevention (CDC) in designing SI and M&E plan for the PEPFAR Partnership Framework for Ghana.

  The Global Health Institute of University of California, San Fransisco campus (UCSF) provided technical assistance to GAC (with funding from CDC) to strengthen the national M&E system. The technical assistance covers surveillance among MARPs and the design and implementation of M&E short courses to be delivered by the School of Public Health, University of Ghana. The UCSF team provided training for national stakeholders on IBBS and mapping and size estimation of MARPs.

  Overall, respondents scored the M& E efforts of the AIDS programme in 2007 and in 2009 as 8 and 7.2 respectively.

(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
- Difficulty in obtaining reports from partners not funded by GAC.
- 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
- National integrated and costed M&E roadmap is being implemented to strengthen the national M&E system in line with the 12 Components
- 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

9 Conclusion

Overall, Ghana has maintained its achievements in the Strategic planning, policy formulation, prevention programmes, treatment and care and support, human rights issues and in monitoring and evaluation as well as civil society involvement.

Though prevention, care, treatment and support interventions have been put in place all over the country, some of the interventions still have not yet achieved their desired impact at the population level and are lagging behind national targets. Access to care and treatment services still lag behind prevention services and desired target for prevention behaviours have not yet been achieved.

This UNGASS report has provided some 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. Angela El Adas	Acting Director General	Ghana AIDS Commission
2. Dr. Richard Amenyah	Director of Technical Services	Ghana AIDS Commission
3. Mr. Kyeremeh	Acting Director, Research Monitoring and Evaluation Officer	Ghana AIDS Commission
4. Maxwell Addo	Head of Finance	Ghana AIDS Commission
Ministry of Health / GHS		
5. Dr. Nii Akwei Addo	Programme Manager	National AIDS Control Programme
6. Mr Kwadwo Asante	M&E coordinator	National AIDS Control Programme
7. Justina Ansah	Programme Manager	Blood Bank
8. Dr. Hansen Nortey	Programme Manager	National TB Programme
9. Kwame Afutu	Programme Officer	National TB Programme
Other MDAs		
10. Hilda Hagan	HIV Focal Person	Ministry of Education
11. Margaret Blankson	HIV focal Person	Ministry of Local Government and Rural Development
12. Mrs Ellen Mensah	SHEP Coordinator	Ministry of Education
13. Ms. Faustina Achaempong	Assistant Planning Officer, Secretary to HIV/AIDS Committee	Ministry of Women and Children
14. Mr Lawerence Ofori-Addo		Social Welfare Department

Person Present at of National Composite Policy Index Consensus building workshop held at UNAIDS Conf. Room – 29th January, 2010

NAME	ORGANISATION
Emmanuel Adiku	Pro-Link
Dr. Cecilia Bentsi	Ghana Coalition of NGO's in Health
Comfort Asamoah Adu	WAPCAS
Anyimadu-Amaning	GHANET
Mara Black	GHANET
Major Regina Akai-Nettey (Rtd)	QHP
Ama Nettey	WFP
Deborah Kwablah	FHI
Tawiah Agyarko-Kwarteng	World Education
Akua Ofori -Asumadu	ILO
Jacob Larbi	UNAIDS
Cecilia Senoo	SWAA Ghana
Getrude Adzo Akpalu	Public Health Consultant
Gladys Tetteh Yeboah	World Vision Gh.
Leopold Zekeng	UNAIDS
Eddie Donton	WAAF
Collins Seymah Smith	CEPEHRG
Mac-Darling Cobbinah	CEPEHRG
Claire Ryan	CEPEHRG
Esi Awotwi	UNFPA
Albert Wuddah Martey	PPAG
W. Y. Brown	ADRA
Charity Owusu Danso	NAP+ GHANA
Derek Aryee	GBCA

Expanded Technical Working Group Meeting, Validation Workshop
UNAIDS Conf. Room – 17th March 2010

	NAME	ORGANISATION
1	Getrude Adzo Akpalu	Public Health Consultant
2	Dr. Agnes Dzokoto	Public Health Consultant
3	Charity Owusu Danso	NAP+ Ghana
4	Jacob Larbi	UNAIDS
5	James Rosen	FUTURES
6	Dr. John David Dupree	NGO Consultant
7	Rhehab Chimzizi	NSH/TBCAP
8	Kenneth Yeboah	Consultant
9	Desmond Williams	CDC
10	Laura Shelby	CDC
11	Prince Lamtey	Department of Social Welfare
12	Elsie Ayeh	UNAIDS
13	Kyeremeh Atuahene	GAC
14	Derek Aryee	GBCA
15	Kwaku Osei	UNAIDS
16	Emmanuel Obeng	ADRA
17	Jones Blantari	Ghana Police
18	Lucy Owusu Darko	OICI
19	Hilda Hagan	MOE
20	Akua Ofori -Asumadu	ILO
21	Sally Ann Ohene	WHO
22	Josephine Amenuvor	
23	Kinsley Odum Sam	SWAA Ghana
24	Felix Asante	ISSER, UG
25	Gladys Tetteh Yeboah	World Vision Gh.
26	Daniel Omane	US Peace Corps
\27	D. Opam Adjei	Network of NGOs
28	Kofi Lucas	Network of NGOs
29	Otema Ohene – Asare	Ghana Coalition of NGOs in Health
30	Frank Lartey Jnr	NYC
31	Owiredu Samuel Hanson	CEPEHRG
32	Daniel Owusu Boatey	GH. TUC
33	Christopher Conduah	NDPC
34	Jane Ansah	Military Hospital
35	Henry Nagai	FHI
36	Betty Adu	West African AIDS Foundation
37	Vincent Anane	West African AIDS Foundation
38	Belynda Amankwa	WAAF
39	Josephine Nartey	UNIFEM
40	Anita D'Almeida	Danish Embassy
41	Holger Till	GTZ
42	Dan Norgbedzie	CCM Sect.
43	Jennifer Antwi	USG-state
44	Clive Ashby	GAC
45	Ayugane Theophilus	EKN
46	Leopold Zekeng	UNAIDS
47	Peter Wondergen	USAID
48	Victoria Alhassan	Prisons

49	Richard Amenyah	GAC
50	Jane Mwangi	UNICEF
51	Joyce Steiner	Christian Council

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:

Dr. Angela ElAdas, Acting Director General Ghana AIDS Commission

Postal address:

Ghana AIDS Commission,
P.O. Box 5169
Cantoments, Accra Ghana

Tel: 233-21-78262/ 782263

Fax: 233-21-782264

Email: Aeladas@ghanaaids.gov.gh

Date of Submission: 29th March 2010

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.)

A stakeholder workshop was held on 28th January 2010 with participants from the UN, and civil society 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 second validation workshop was held on 17th March 2010 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. Concerns were raised and addressed at that meeting.

The main concerns were that the results of the NCPI were subjective. Participants involved in the NCPI for previous years had changed. Many of the respondents had not been at their post in 2007 and could not objectively compare 2007 with 2009. Other respondents would consider their work they had done and scored high in 2009, where other scored low.

In addition some respondents felt due the change in some of the questions some of the areas were not comparable. This came out in the validation meeting. On the whole respondents thought that NCPI was a very subjective exercise.

Respondents for the National Composite Index Part A

Organization	Names, Positions	Respondents for Part A				
		A.I	A.II	A.III	A.IV	A.V
Ghana AIDS Commission	1. Angela El Adas - Acting Director General	X	X			
Ghana AIDS Commission	2. Richard Amenyah 3. Director of Technical Services			X	X	
Ghana AIDS Commission	4. Kyeremeh Atuahene Acting Director, Research Monitoring and Evaluation Officer					X
MOH/ NACP	5. Dr. Nii Akwei Addo Programme Manager	X	X	X	X	X
NACP	6. Mr Kwadwo Asante M&E coordinator					X
National Blood Transfusion Unit	7. Justina Ansah Programme Manager			X		
National TB Programme	8. Dr. Hansen Nortey, Deputy Programme Manager				X	
Ministry of Education	9. Hilda Hagan , HIV Focal Person					
Ministry of Local Government and Rural Development	10. Margaret Blankson HIV focal Person	X	X	X		
Ghana Education Service	11. Ellen Mensah SHEP Coordinator			X		
Ministry of Women and Children Affairs	12. Ms. Faustina Achaempong Assistant Planning Officer, Secretary to HIV/AIDS Committee			X		
Social Welfare Department	13. Lawrence Ofori- Addo Coordinator LEAP			X		

Respondents for the National Composite Index Part B

Name	Organization	Respondents to Part B			
		B.I	B.II	B.III	B.IV
WAPCAS	1. Comfort Asamoah Adu	X			
ILO	2. Akua Ofori -Asumadu	X			
Public Health Consultant	3. Getrude Adzo Akpalu	X			
CEPEHRG	4. Mac-Darling Cobbinah	X			
UNFPA	5. Esi Awotwi	X			
CEPEHRG	6. Claire Ryan	X			
GHANET	7. Anyimadu-Amaning		X		
GHANET	8. Mara Black		X		
UNAIDS	9. Jacob Larbi		X		
SWAA Ghana	10. Cecilia Senoo		X		
ADRA	11. W. Y. Brown		X		
Private sector	12. Mercy Bannermann		X		
PPAG	13. Albert Wuddah Martey		X		
FHI	14. Deborah Kwablah			X	
World Education	15. Tawiah Agyarko-Kwarteng			X	
World Vision Gh.	16. Gladys Tetteh Yeboah			X	
CEPEHRG	17. Collins Sermah Smith			X	
Ghana Coalition of NGO's in Health	18. Dr. Cecilia Bentsi			X	
	19. Emmanuel Adiku			X	
WFP	20. Ama Nettey				X
NAP+ GHANA	21. Charity Owusu Danso				X
GBCA	22. Derek Aryee				X
WAAF	23. Eddie Donton				X
QHP	24. Major Regina Akai-Nettey (Rtd)				X

National Composite Policy Index questionnaire

I. STRATEGIC PLAN

1. Has the country developed a national multi-sectoral strategy/action framework to combat AIDS	**Yes,**	**National Strategic Framework I 2001-2005** **National Strategic Framework II 2006 -2010**
1.1 How long has the country had a multi-sectoral strategy/action framework	**10 years**	

1.2 Which sectors are included in the multi-sectoral strategy/action framework with a specific HIV budget for their activities?

Sector	Strategy/ Action framework	Earmarked budget
Health	**Yes**	**Yes**
Education	**Yes**	**Yes**
Labour	**Yes**	**Yes**
Transportation	**Yes**	**Yes**
Military/Police	**Yes**	**Yes**
Women	**Yes**	**Yes**
Young People	**Yes**	**Yes**
Other Tourism Trade union congress Head of civil service Ghana Employers Association Ministry of Justice Ministry of Agriculture Ministry of Manpower Ministry of Local Government and Rural Development Trade and Industry	 **YES** **YES** **YES** **YES** **YES** **YES** **YES** **YES** **YES**	 **YES** **YES** **YES** **YES** **YES** **YES** **YES** **YES** **YES**

The earmarked budget is available through Ghana AIDS Commission. Proposal are submitted by the Ministry to GAC who review and approve the proposal and budgets.

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	**Yes**
b. Young women/ young men	**Yes**
c. Injecting drug users	**No**
d. Men who have sex with men	**Yes**
e. Sex workers	**Yes**
f. Orphans and other vulnerable children	**Yes**
g. Other Specific vulnerable sub-population (clients of sex workers, refugees, cross-border populations)	**Yes**
Settings	
h. Workplace	**Yes**
i. Schools	**Yes**
j. Prisons	**Yes**
Cross-cutting issues	
k. HIV/AIDS and poverty	**Yes**
l. Human rights protection	**Yes**
m. PLHIV involvement	**Yes**
n. Addressing stigma and discrimination	**Yes**
o. Gender empowerment and / or gender equality	**Yes**

1.4 Were target populations identified through a process of a needs assessment or needs analysis?	**YES**	**2004, Joint Programme Review** **2007 Joint Programme Review**
1.5 What are the target populations in the country	**General Population** **Youth (in and out of school)** **Women** **Children** **Female Sex Workers** **Clients of sex workers** **Men who have sex with men** **Prison inmates** **PLHIV** **Orphans and Vulnerable children** **Employees (private and public sector)** **STI clients** **Uniformed service personnel** **Displaced persons and Refugees**	
1.6 Does the multisectoral strategy/action framework include an operational plan	**Yes**	**Programme of Work** **Annual Programme of Work**
1.7 Does the multisectoral strategy/action framework or operational plan include:		

Formal programme goals Clear target and or milestones Detailed budgets of costs per programme area Indication of funding sources Monitoring and Evaluation Framework	**Yes** **Yes** **Yes** **Yes** **Yes**	
1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multi-sectoral strategy/action framework?	**Active involvement**	**The civil society is part of the committees within the Ghana AIDS Commission involved in the joint programme review and involved in the development of the strategic framework. They form part of the review and development teams as well as being respondents during the review.**
1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?	**Yes**	**These partners were part of the process**
1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework	**Yes**	**All partners aligned and harmonized their programmes with strategic framework.**

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c)Poverty Reduction Strategy Papers, d) Sector Wide Approach?	**Yes**
Poverty Reduction Strategy Papers	**Yes**
United Nations Development Assistance Framework	**Yes**
Sector Wide Approach	**Yes**

2.1 IF YES, which specific HIV-related areas are included in one or more of the development plans

HIV prevention	**Yes**
Treatment for opportunistic infections	**Yes**
Antiretroviral therapy	**Yes**
Care and support (including social security services)	**Yes**
HIV impact alleviation	**Yes**
Reduction of gender inequalities as they relate to HIV prevention/ treatment care and support	**Yes**
Reduction of income inequalities as they relate to HIV prevention/ treatment care and support	**Yes**
Reduction of stigma and discrimination	**Yes**
Women's economic empowerment (access to credit, access to land, training)	**Yes**
Other	

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?	**No**	
4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?	**Yes**	
4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage reach a significant proportion of one or more uniformed services?		
Behaviour Change Communication	**Yes**	**Prisons, Police, Military, CEPS**
Condom Promotion	**Yes**	**Prisons, Police, Military, CEPS**
HIV testing and Counselling	**Yes**	**Prisons, Police, Military, CEPS**
STI services	**Yes**	**Prisons, Police, Military, CEPS**
Antiretroviral Treatment	**Yes**	**Police, Military,**
Care and Support	**Yes**	**Police, Military,**
Others: Programmes for wives and families	**Yes**	

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory)/

HIV testing is generally voluntary for uniformed services. However, It is mandatory in the following circumstances; for recruitment into the forces/ service, for medical examination prior to peace keeping and prior to taking up post-graduate education.

However in the Military testing prior to peace keeping mission is mandatory but is supported with counselling services

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?
YES

5.1 In Yes, for which populations

a. Women	**YES**	
b. Young people	**YES**	
c. Injecting drug users		**NO**
d. Men who have sex with men		**NO**
e. Sex workers		**NO**
f. Prisons inmates	**YES**	
g. Migrant/mobile populations	**YES**	
h. Other PLHIV	**YES**	

If yes briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly comment on the degree to which these laws are currently implemented:
A number of institutions are in place to enable the laws be enforced. These include the Ghana Police Service, the Domestic Violence and Victims support Unit, which apprehend perpetrators. The Judiciary, the legal aid which provide legal services and Commission of Human Rights and administrative justice which can provide avenues for addressing human rights violations.

These laws are being implemented to some extent but this is not at all levels and for all population groups,

6. Does the country have laws or regulations or policies that present obstacles to effective HIV prevention, treatment care and support for most-at-risk populations or other vulnerable subpopulations? **YES**

6.1 In Yes, for which populations

a. Women		**NO**
b. Young people		**NO**
c. Injecting drug users	**YES**	
d. Men who have sex with men	**YES**	
e. Sex workers	**YES**	
f. Prisons inmates		**NO**
g. Migrant/mobile populations		**NO**
h. Other PLHIV		**NO**

If yes briefly describe the content of the laws, regulation or policies.
Law on drug trafficking
Criminal code. Criminalises sex work and the having carnal knowldege

Police arrest women because they carry condoms in their bags. This prevents condom promotion. Sex workers adn MSM are driven underground and difficult to target.

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?	Yes	National AIDS Control Programme, Ghana National ART Scale up Plan 2006-2010, Towards Universal Access to antiretroviral therapy, January 2006 Another Universal Access review was conducted in November 2009
7.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly	Yes	Annual Programmes of work have been revised. Resources have been mobilised for PMTCT to ensure that the target is achieved
7.2 Have the estimates of the size of the main target population sub-groups been updated?	Yes	National AIDS Control Program, Ghana Health Service Technical Report Estimates and Projections of National HIV prevalence and Impact in Ghana using Sentinel Surveillance Data adjusted with DHS+ Data. Technical updates for the estimates are done annually Size estimation for MARP is yet to be undertaken this year.
7.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?	Yes	
574 Is HIV and AIDS programme coverage being monitored?	Yes	
IF YES, is coverage monitored by sex (male, female)?	Yes	
IF YES, is coverage monitored by population sub-groups?	yes	This is done for adults and children
IF YES, which population sub-groups	Children , Adults , MARPS, in the general population and youth	This is informs program planning and allocation of resources

IF YES, is coverage monitored by geographical area?	Yes	Site, district , regional levels The information is used for local planning and national programme planning
IF YES, at which levels (provincial, district, other)?	Regional, District and site levels	
5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?	Yes	

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?

2009	8

Comments on progress made in strategy planning efforts since 2007:

- Planned activities have been on track,
- NSF has guided the national response
- Greater involvement of the development partners
- Greater involvement of the decentralised agencies
- Remaining challenges Resource mobilization (difficulty in obtaining total funding from partners and central government)

- Improved information flow and quality of data used for evidence based planning
- Stronger M&E systems in place
- Improved planning using NSF II and Annual Programmes of work as guidance
- More results based planning due to implementation of more GFATM projects which are performance based
- Improved quality of information provided by stakeholder
- More results oriented planning to achieve measurable targets
- Extensive stakeholder consultation and participation through the partnership forum Global Business coalition and Technical Working groups
- Greater buy-in of development partners

The remaining challenges in strategic planning 2009 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
- Inadequate M& E system in some sectors

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic for a at least twice a year?		
President/ Head of Government	**No**	**Not high this year**
Other High Officials	**Yes**	**Vice President has spoken about HIV four times this year (2007)**
Other Officials in regions and districts	**YEs**	**Parlaimentarians involved in Advocacy**
2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?	**Yes**	
2.1 If YES, when was it created?	**2000**	
2.2 If Yes, who is the chair	**President**	
2.3 if Yes, does it have a terms of Reference	**Yes**	
Have active Government Leadership and participation	**Yes**	
Defined membership	**Yes**	

How many member Including civil society If yes how many PLHIV How many Private sector	**47** **Yes** **14** **Yes** **1** **Yes**	
Have an Action plan	**Yes**	
Functional Secretariat	**Yes**	
Meet quarterly	**Yes**	
Review action on policy decision regularly Review action on policy decisions Actively promote policy decisions Pro vide opportunity fir civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting	**Yes** **Yes** **Yes** **Yes** **Yes**	

3. Does your country have a mechanism that promotes interaction between government, PLHIV, the private sector and civil society for implementing HIV/AIDS strategies/programmes? Representatives for various bodies in the three areas are represented on the GAC sub-committees and work together to develop and monitor the implementation of activities. They play an active role in the committees These are: • Technical Working Groups: TWG on MARPs, ART, Research, Monitoring and Evaluation, Expanded TWG and	**Yes**	

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 • Technical review meeting with implementing partners and stakeholders Challenges : Coordination of a large multi secotoral Approach, with different organisations		
4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society I n the past year?	**30%**	**How difficult to track**
5 What kind of support does GAC provide to implementing partners of the national program, particularly to civil society organizations		
Information on priority needs and services	**Yes**	
Technical Guidelines/ materials	**Yes**	
procurement and distribution Drugs/ other supplies	**Yes**	**Drugs provided by NACP/MOH**
Coordination with other implementing partners	**Yes**	
Capacity building	**Yes**	
Others Policy direction Finances (resource mobilisation		
6. Has the country reviewed national policies and legislation to determine which, if any are inconsistent with the National AIDS Control Policies?	**Yes**	
6.1 If yes were policies and legislation amended to be consistent with the National AIDS Control Policies	**NO**	**No Laws have not been amended, dialogue and advocacy is on going for addressing MSM, CSW and IDU.**

Overall, how would you rate the political support for the HIV/AIDS programmes in 2007 and 2005
2009 Poor Good 0 1 2 3 4 5 6 7 **8** 9 10 **Achievements:** Vice-president launching World AIDS Day in 2009 Resource allocation for commission and redemption of pledges **Challenges** Greater invlovemnt of all political leaders Greater involvement of sector ministries Resource needs

III PREVENTION

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?	**Yes**
1.1 If yes what key messages are explicitly promoted	X
a. Be sexually abstinent	X
b. Delay sexual debut	X
c. Be faithful	X
d. Reduce the number of sexual partners	X
e. Use condom consistently	X
f. Engage in safe® sex	X
g. Avoid commercial sex	X
h. Abstain from injecting drugs	X
i. Use clean needles and syringes	
j. Fight against violence against women	X
k. Greater acceptance and involvement of PLHIV	X

l. Greater involvement of men in reproductive health programmes	X
m. Males to get circumcised under medical supervision	
n. Know your HIV status	X
o. Prevention of Mother to child transmission	X
Other Blood safety - make sure blood is screened and safe Donate to save a life	X
1.2 In the last year, did the country implement an activity or programme to promote accurate HIV/AIDS reporting by the media?	Yes

2. Does your country have a policy or strategy promoting HIV/AIDS related reproductive and sexual health education for young people?	Yes	
2.1 Is HIV education part of the curriculum in Primary Secondary Teacher training	 Yes Yes Yes	
2.2 Does the strategy/ curriculum provide the same reproductive and sexual heat education for young men and young women	Yes	
2.3 Does the country have an HIV education strategy for out-of school young people	Yes	Not as comprehensive as in school youth
3 Does your country have a policy or strategy to promote IEC and other preventive health interventions for vulnerable populations?	Yes	
If Yes, which sub-populations and what elements of HIV prevention for the policy strategy address		

	IDU	MSM	Sex Workers	Clients sex workers	Prison inmates	Other sub-populations
Targeted information on risk reduction and HIV education		**X**	**X**	**X**	**X**	Migrant populations, uniformed services Refugees

Stigma and discrimination reduction		X	**X**	**X**	**X**	**X**
Condom promotion		**X**	**X**	**X**	**X**	**X**
HI V testing & counselling		**X**	**X**	**X**	**X**	**X**
Reproductive health, including STI prevention & treatment		**X**	**X**	**X**	**X**	**X**
Vulnerability reduction (e.g. income generation)	N/A	N/A	**X**	N/A	N/A	**X**
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringes exchange		N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of prevention in 2009?
2009 Poor Good 0 1 2 3 4 5 6 7 8 9 10 **Achievements** Know your status improving prevention programmes, increasing overage of PMTCT **Challenges** Low in depth / comprehensive HIV knowledge Condom use is low

4. Has the country identified the districts (or equivalent geographical/ decentralized and level) in need of HIv prevention programmes?

YES

If yes how were the specific needs determined. From the Joint Programme reviews and programme evaluation and studies such as the GDH, BSS and HSS

If yes to what extent have the following HIV programmes been implemented in identified districts in need?

HIV prevention programmes	This majority og people in need have access		
	Agree	Don't Agree	N/A
Blood safety	X		
Universal precautions in health care settings	X		
Prevention of mother to child transmission	X		
IEC on risk reduction	X		
IEC on stigma discrimination	X		
Condom promotion	X		
HIV testing and counselling	X		
Harm reduction for IDU		X	N/A
Risk reduction of MSM		X	X
Risk reduction of SW		X	
Reproductive health services including STI prevention and treatment	X		
School based AIDS education for young people	X		
Programmes for out of school young peole		X	
HIV prevention in the workplace		X	
Others HIV prevention in the prisons	X		

Overall, how would you rate efforts in the implementation of HIV prevention programmes in 2007 and 2005?
2009 Poor Good 0 1 2 3 4 5 6 **7** 8 9 10 **Achievements** • Expanded services for prison services • MSM services expanded • Cross border activities **Challenges:** • Scaling up services for MARPS • Resources • Inadequate human resources

IV. Care and Support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, (Comprehensive care includes, but is not limited to, VCT, psychosocial care and home and community-based care? **Yes**

1.1 if yes does it give sufficient attention to barriers for women and children and most at risk populations?

Yes

2. Has the country identified the specific needs of HIV and AIDS treatment, care and support

Yes

If yes to what extent have the following HIV and AIDS treatment, care and support services

Through review of programmatic data and results from HIV sentinel surveillance.

HIV treatment , care ad support services	The majority of peole in need have access		
	Agree	Don't agree	N/A
Antiretroviral therapy		X	

Nutritional care		X	X
Paediatric AIDS treatment		X	
Sexually transmitted Infection Management	X		
Psychological support for PLHIV and their families	X		
Home Based Care		X	
Palliative care and treatment of common HIV related infections	X		
HIV testing and counselling for TB patients	X		
TB screening for HIV infected people		X	
TB preventive therapy for HIV infected people			N/A
TB infection control in HIV treatment and care facilities			X
Co-trioxazole prophylaxis I HIV infected people	X		
Post exposure prophylaxis	X		
HIV treatment service in the workplace		X	
HIV care and support in the workplace	X		
Other programmes Care for OVC		X	

3. Does the country have a policy for developing / suing generic drugs or parallel of drugs for HIV?

Yes

4. Does the country have access to regional procurement and supply management mechanism for critical commodities, such as antiretroviral drugs, condoms and substitution

No

Overall, how would you rate efforts in the implementation of HIV treatment care and support programmes in 2009
2009 Poor Good 0 1 2 3 4 5 6 7 **8** 9 10 **Achievements**

- ARV available in each region
- 140 districts having ARV services

Challenges:

- Difficulty of implementing ART in new districts without appropriate health infrastructure and human resources

5. Does the country have a policy or strategy to address the additional HIV or AIDS- related needs of orphans and other vulnerable children (OVC) Yes

If yes , is there an operational definition for OVC	Yes	
If yes does the country have a national action plan specifically for OVC	Yes	
If yes, does the country have an estimate of OVC being reached by existing interventions	Yes	
If yes what percentage of OVC is being reached	7.36%	

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

Overall, how would you rate efforts to meet the needs of OVC?
Poor Good 0 1 2 3 4 **5** **6** 7 8 9 10 **Achievements** Increased coverage for OVC through the national LEAP proramme **Remaining challenges** Scaling up services

V. Monitoring and Evaluation

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

Yes

The National Monitoring and Evaluation Plan 2006- 2010

1.2 IF YES, was it endorsed by key partners in evaluation? **Yes**

1.3. Was the M&E plan developed in consultation with civil society, PLHIV?

Yes

1.4 if yes have key partners aligned and harmonised their M&E requirement Yes. A comprehensive harmonisation exercise has been undertaken with all stakeholder and indicators have been harmonised

2. Does the M&E plan include?

A data collection and analysis strategy. If yes does it address.	Yes	
Routine programming	Yes	
Behaviour surveillance	Yes	
Evaluation studies	Yes	
HIV surveillance	Yes	
A well- defined standardized set of indicators	Yes	
Guidelines on tools for data collection	Yes	
A strategy for assessing quality and accuracy of data	Yes	
A data dissemination and use strategy	Yes	

3. Is there a budget for the M and E plan?

Yes for the period initially 2006 – 2010

What percentage f the budget is M&E 12% in 2009

If yes, has funding been secured?

Yes

Is M& E expenditure being monitored

Yes through NASA

Are M & E Proprieties determined through a national m& E Assessment YES

Based on 12 components for the organisation as a functional national M&E system

Briefly describe

One national M&E assessment is conducted one a year. Use 12 component to assess aspects of M&E system including national sub-nation and Implementing partners M7E systems. This year GFATM M&E system strengthening tools will be used

4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes

4.1 IF YES,

Based in NAC or equivalent? **Yes**

Based in Ministry of Health? **Yes** No

Elsewhere? Yes **No**

4.2 If yes how many and what type of permanent and temporary professional staff are working in the M&E Unit

Permanent staff	6 staff , 4 will be added this year	
Direction of Policy Planning Research Monitoring and Evaluation	Full Time	2000
Acting Director of research Monitoring and Evaluation	Full time	2008 Formerly M& E coordinator

M and E Coordinator	Full time	2002
MIS Officer	Full time	2005
2 Data entry assistants	Full time	2008
Secretary	Full time	2005
Temporary staff		

5.3 If yes, are there mechanisms in place to ensure that all major implementing partners submit their report to this Unit or Department for review and consideration in the country's national reports? **Yes**

Comments:

A national data base exists. Data is channelled through partners to GAC where data is entered in the data base the data base. Currently CRIA is beib used as aplatform at the national and sub- national level in 20 districts

The mechanism does not work fully. There are challenges in obtaining reports from those not funded by GAC

- Challenges with human resources at the national level
- Not all Implementing patterns freely share their data
- Timely reporting
- Data gaps
- Data quality

5. Is there a committee or working group that meets regularly coordinating M&E activities, including surveillance?

Yes, meets regularly bi-monthly meetings

5.1 Does it include representation from civil society, PLHIV?

Yes

These include FHI, WAPCAS, QHP SHARP, UN agencies, Accademia and research entities

6. To what degree (Low to High) are UN, bi-laterals, other institutions sharing M&E results?

Low High

0 1 **2** 3 4 5

Yes

6. Does the M&E Unit manage a central national database?

Yes

6.2 IF YES, what type is it? A simple database using access with key indicators

6.3. Is there a functional Health Information System?

National Level **Yes**

Sub-national (regional) **Yes**

10. Is there a function Education System?

National Level	**Yes**
Sub-national	**Yes**

If yes, please specify the level, i.e., district

6.4. Does your country publish at least once a year an evaluation report on HIV/AIDS, including HIV surveillance reports?

Yes

7. To what extent strategic information is used in planning and implementation?

Low High

0 1 2 3 **4** 5

What are examples of data use?

Programmatic data and research data are used to prioritise areas for the annual programmes of worjk. The APOW is now more evidence based. . The upcoming NSF i going to be more evidence based.

Main challenges Data quality at the lower levels is often a challenge

Resource allocation

Low High

0 1 2 3 4 **5**

- Targeted population identified and prioritised the following year

- At national level?	**Yes**
Number trainers	At least 50
At sub-national level?	Over 250
Including civil society?	Yes 100-120

Were M& E capacities conducated other than training? Yes

- onsite support visits were provided
- Quarterly meetings
- International conference
- Mentoring exchange
- Technical Assistance form CDC

Overall, how would you rate the monitoring and evaluation efforts of the HIV/AIDS programme?
2009 Poor Good 0 1 2 3 4 5 6 **7** 8 9 10 Achievements National Data bases in process Standard tools for data collection National M&E road map launched

Capacity Building Standard curriculum fir M&E with SOPH for ongoing M&E training   Challenges High human resource turnover rate Operational manuals have been developed, training for district and regional level staff has been conducted, planning processes have been strengthened

PART B

I. Human Rights

1. Does your country have laws and regulations that protect people living with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?	**Yes**
If yes specify	
If yes for which sub-populations	
women	**Yes**
Young people	**Yes**
IDU	**No**
MSM	**No**
Sex workers	**No**
Prison inmates	**No**
Migrant populations	**No**

Other PLHIV	**NO**
If yes, what mechanism are in place to ensure the laws are implemented The Domestic Violence Unit for enforcement to prevent domestic violence The Commission on Human Rights and Administrative Justice, provides an avenue to seek redress for human rights violations Legal aid scheme: ensures that the poor have legal support Labour commission to seek redress for work related in justices Briefly comment on the degree to which they are currently implemented The laws are implemented to a large extent.howevefr it is not universal at al levels	
3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?	**Yes**
If yes for which populations?	
MSM	**Yes**
Sex workers	**Yes**
Prison inmates	**Yes**
Injecting drug users	**Yes**
Describe the contents of the laws • 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 commercial sex work 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.	

4 Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy/strategy? If yes briefly describe this mechanism The National HIV/AIDS and STI Policy. This policy particularly mentions protection of human rights it is premised on Ghana 's constitution: • Ghana's Constitution 1992: This protects persons against discrimination and upholds basic 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, region, 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.	**Yes**
5 Is there a mechanism to record, document and address cases of discrimination experienced by PLHIV and or most at risk populations CHRAJ DOVVSU FIDA HRAC CDD NLC	**Yes**
Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation? PLHIV form part of the Ghana AIDS commission and are represented on all the committees National TWG task teams Programme Implementation M&E PLHIV have received a large amount of support for implementation of activities PLHIV form part of the PLHIV PLHIV are part of the CCM	**Yes**
7 Does your country have a policy to ensure equal access, between men and women, to prevention and care?	
HIV prevention services	**Yes/** **No**
Antiretroviral treatment	**No**
HIV related care and support interventions	**No**
Counselling and Testing, PMTCT are free condoms are at a cost ART is highly subsidised	

Care and support is mainly free , hospital care is not free	
8. Does the country have a policy to ensure equal access to women and men to prevention, treatment, care and support? I n particular, to ensure access for women outside the context of pregnancy and childbirth. Enshrined in the HIV Policy, The Domestic Violence Act and the gender Policy	**Yes**
9. Does your country have a policy to ensure equal access to prevention and care for most-at-risk population? Only for vulnerable populations	**No**
9.1 Are there differences in approaches for different most at risk populations	**No**
10 Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?	**Yes**
11. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?	**Yes**
11.1 IF YES, does the ethical review committee include civil society and PLHIV?	**No**
12. Does your country have the following monitoring and enforcement mechanisms? Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commission, watchdogs, and ombudspersons which consider HIV –related issues within their work	**Yes**
Focal points within governmental health and other departments to monitor HIV- related human rights abuses and HIV- related discrimination in areas such as housing and employment	**Yes**
Performance indicators or benchmarks a) compliance with human rights standards in the context of HIV efforts	**Yes**
b) reduction of HIV –related sigma and discrimination	**No**
13 In the last two years, have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work	**Yes**
14 Are the following legal support services available in your country?	**Yes**
Legal and systems for HIV/AIDS casework	**Yes**
State support to private sector laws firms or university based centres to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination	**Yes**
Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights	**Yes**

15 Are there programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance? If yes what types of Programmes		**Yes**
Media	**Yes**	
School Education	**Yes**	
Personalities	**Yes**	
Other workplace programmes **Health care workers**		

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS 2009?
2009 Poor Good 0 1 2 3 **4** **5** **6** 7 8 9 10 Achievements : discussion on the media, stigma reduction trainings, for Police , prisons Judiciary, HCW, Informal sector, MARPS(FSW/MSM) Challenges : stigma still exist
Overall, how would you rate the efforts to enforce the existing policies, laws and regulations?
2009 Poor Good 0 1 2 3 4 **5** 6 7 8 9 10 Relevant Polices and instiutions in place: DOVSU and legal aid systems are being used to enforce laws and regulation. Challenges: Large gap between enforcement and the polices

II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

Low **High**

0 1 2 **3** 4 5

The CSO do not have a common front and thus do not have much influence. Currently umbrella organisations are being formed to address this.

2. To what extent civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low **High**

0 1 2 3 **4** 5

3. To what extent are the services provided by civil society to areas of prevention and care and treatment and support included?

In both the National Strategic plans and reports

Low **High**

0 1 2 3 **4** 5

In the national budget

Low **High**

0 1 2 **3** **4** 5

4. To what extent 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

CSO are members of the TWG and are stakeholder involved in developing the NSF an M&E plan.

M& E capacity is low across board.
Challenges exist with:

- Coordination of M&E,
- M&E Tools not harmonised
- Developed tools are not being used

5. To what extent is the civil society sector representation in HIV related efforts inclusive of its diversity

Low **High**

0 1 2 3 **4** 5

Lack of an enabling environment

7. 5. To what extent is the civil society sector 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

- Global funds are inadequate for CSOs
- MSHAP funds are is low and irregular
- Source for technical support limited/procedure cumbersome/information on source and type of support are inadequate.

	< 25%	**25 – 50%**	**51- 75%**	**>75%**
Prevention for youth			X	
Prevention for most-at-risk-populations **IDU** **MSM** **FSW**	X			 X X
Testing and Counselling		X		
Reduction of Stigma and Discrimination				X
Clinical services (ART/OI)*	X			
Home-based care		X		
Programmes for OVC**		X		

Overall, how would you rate the efforts to increase civil society participation in 2005 and 2007?
2009 Poor Good 0 1 2 3 4 5 6 **7** 8 9 10 Achievements • Participation in MSHAP (Large CSOs) and the Global Fund • Individual support by some key donors Key Challenges • Resources not reaching CSOs adequately • Lack of a united front with regards to CSOs • Lack of Capacity to support the system

III PREVENTION

1. Has the country identified the districts (or equivalent geographical/ decentralized and level) in need of HIV prevention programmes?

YES

Several studies were conducted

- BSS for FSWs by SHARP, in 2009 (drop in infection rates, increase in knowledge)
- Progress report on universal access, in 2009 identifying needs for adolescents
- GDHS 2008 and HSS 2009; low prevalence with pockets of high prevalence targeted for increased prevention programmes

If yes to what extent have the following HIV programmes been implemented in identified districts in need?

Prevention programmes are being scale-up

- PMTCT opt out policy has helped to increase numbers reached
- Global Fund Round 8 is focusing a lot more on prevention and there is an increase in budget and more inclusion of civil society groups
- CT seen as a key entry point to prevention. Shift in more CT being community based than static
- Targeting both in school and out of school youth
- Increasing condom use amongst MARPs
- IEC also being scaled up

HIV prevention programmes	The majority of people have access		
	Agree	Don't agree	N/A
Blood safety	X		

Universal precautions in health care settings	X		
Prevention of mother to child transmission	X		
IEC on risk reduction	X		
IEC on stigma discrimination	X		
Condom promotion	X		
HIV testing and counselling	X		
Harm reduction for IDU		X	
Risk reduction of MSM	X		
Risk reduction of SW	X		
Reproductive health services including STI prevention and treatment		X	
School based AIDS education for young people	X		
Programmes for out of school young people	X	X	
HIV prevention in the workplace		X	
Others	X		

Overall, how would you rate efforts in the implementation of HIV prevention programmes in 2007 and 2005?
2009 Poor Good 0 1 2 3 4 5 6 **7** 8 9 10

Key achievements

- PMTCT opt-out/ provider initiated policy has helped to increase numbers reached
- Global Fund Round 8 is focusing on prevention, this provides added funds and will ensure the inclusion of civil society groups
- CT seen as a key entry point to prevention. Shift in more CT to mobile and outreaches has increased access to counseling and testing
- Targeting both in school and out of school youth
- Increased focus on MARPs; Increasing condom use amongst MARPs
- Shift of GAC to fund few, larger CSOs and coalition groups with better capacity as compared to smaller CSOs; improves monitoring, reporting, building capacity of smaller CSOs

Remaining Challenges

- Coordination and monitoring still a bit weak
- Scale up of ART
- Need to intensify scale up of CT
- Shortage of condoms & lubricants last year (stock out of various supplies)
- Though awareness is still very high, the content of the message is inadequate (misconceptions, etc)

VI. Care and Support

2. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, (Comprehensive care includes, but is not limited to, VCT, psychosocial care and home and community-based care? **Yes**

Through Needs assessments and review of programmatic data and past programmes

a. CT, PMTCT, ART/OI, TB/HIV (needs analyses)

b. Lessons learnt from Clinical statistics

c. Lessons learnt from the START programme at Atua, Agormanya

d. Lesson learnt from activities of traditional practioners

e. Lessons learnt from Paediatric clinics and departments

1.1 if yes does it give sufficient attention to barriers for women and children and most at risk populations?

Yes

2. Has the country identified the districts(or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support **Yes**

If yes to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts in need.

ART	Agree	140 out of 170 districts with treatment facilities All regions have ART services in regional hospitals and the teaching hospitals
Nutritional Care	Don't Agree	Most Districts don't have comprehensive nutrition services for HIV and AIDS
Pediatric AIDS Treatment	Don't Agree	Weakness in the quality of care and commodity availability. However staff have been trained and guidelines have been developed to a large extent (Gaps remain EID etc)
STI Infection Management	Agree	Systems need to be strengthened. Guidelines available. Widely disseminated? Integrated?
Psychosocial support for people living with HIV and their families	Don't Agree	Service needs strengthening.
Home-based care	Don't Agree	Available in pocket. Coverage not up to 50%.
Palliative Care and treatment of common HIV-related infections	Agree	Integrated in ART and OI treatment
HIV testing and counseling for TB patients	Agree	Integrated into service

TB screening for HIV infected people	Agree	Service is integrated
TB Preventive therapy for HIV infected people	Don't Agree	Not part of National Policy. Concerns about drug resistance?
TB infection control in HIV treatment and care facilities	Agree	Policy is supportive. Screening of HIV+ clients in facilities.
Cotrimoxazole prophylaxis in HIV infected people	Agree	Included in guidelines
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape	Agree	Limited to certain settings, esp health. Gaps remain esp. rape.
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't Agree	Service limited to a few well resourced companies
HIV Care and Support in the workplace	Don't Agree	Service Limited to a few well resourced companies
Stigma reduction and Infection prevention in health care facilities	Don't Agree	Some headway, 38 out of 40 trained by QHP
Integrating FP/HIV	Don't Agree	Weak. Pilot projects exist.

Overall, how would you rate efforts to meet the in the implementation of HIV care, treatment and support programmes in 2009?

2009 Poor Good

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

Key Achievements

- Early Infant Diagnosis
- Scale up to more facilities esp in the regions
- Equipment supply to facilities

- TB/HIV

Key Challenges

- Coverage of service to PLHIV
- Lack of Human resource and mal-distribution
- Drug and other commodity Stock-outs
- Health Information Systems

3. Does the country have a policy or strategy to address the additional HIV or AIDS- related needs of orphans and other vulnerable children (OVC) Yes

If yes , is there an operational definition for OVC	Yes	
If yes does the country have a national action plan specifically for OVC	Yes	
If yes, does the country have an estimate of OVC being reached by existing interventions	Yes	
If yes what percentage of OVC is being reached	2.4%	

How would you rate the efforts to meet the OVC in 2009?

2009 Poor Good

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

Key Achievements

- Queen Mothers programmes
- Improved regulation of Orphanages

Key Challenges

- Not reaching sufficient coverage of OVCs

ANNEXE 3: Guidelines for UNGASS Report

The following provides the full template of the narrative part of the Country Progress Report and detailed instructions for completion of the different sections included in it. It is highly recommended that the UNGASS indicator data are submitted through the Country Response Information System (CRIS) to enhance the completeness and quality of the data and to facilitate trend analysis. A data file (CRIS or the Excel template included on the Guidelines CD-ROM) is required to be sent at the same time as the file containing the narrative Country Progress Report.

UNGASS COUNTRY PROGRESS REPORT

[Country Name]

Reporting period: January 2008–December 2009

Submission date: [fill in the date of the formal submission of the country report to UNAIDS by e-mail]

I. Table of Contents

[Instructions: Fill in]

II. Status at a glance

[Instructions: This section should provide the reader with a brief summary of

(a) the inclusiveness of the stakeholders in the report writing process;

(b) the status of the epidemic;

(c) the policy and programmatic response; and

(d) UNGASS indicator data in an overview table]

III. Overview of the AIDS epidemic

[Instructions: This section should cover the detailed status of the HIV prevalence in the country during the period January 2008–December 2009 based on sentinel surveillance and specific studies (if any) for the UNGASS impact indicators. The source of information for all data provided should be included.]

IV. National response to the AIDS epidemic

[Instructions: This section should reflect the change made in national commitment and programme implementation broken down by prevention, care, treatment and support, knowledge and behaviour change, and impact alleviation during the period January 2006–December 2007.

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programmes, verifiable behaviour change and HIV prevalence as supported by the UNGASS indicator data. Where relevant, these data should also be presented and analysed by sex and age groups (15–19, 20–24, 25–49). Countries should also use the National Composite Policy Index data (see Appendix 7) to describe progress made in policy/strategy development and implementation, and include a trend analysis on the key NCPI data since 2003, where available. Countries are encouraged to report on additional data to support their analysis and interpretation of the UNGASS data.]

V. Best practices

[Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learned with other countries.]

VI. Major challenges and remedial actions

[Instructions: This section should focus on:

(a) progress made on key challenges reported in the 2005 UNGASS Country Progress Report, if any;

(b) challenges faced throughout the reporting period (2006-2007) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and,

(c) concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets.]

VII.Support from the country's development partners

[Instructions: This section should focus on (a) key support received from and (b) actions that need to be taken by development partners to ensure achievement of the UNGASS targets.]

VIII. Monitoring and evaluation environment

[Instructions: This section should provide (a) an overview of the current monitoring and evaluation (M&E) system; (b) challenges faced in the implementation of a comprehensive M&E system; and (c) remedial actions planned to overcome the challenges, and (d) highlight, where relevant, the need for M&E technical assistance and capacity-building. Countries should base this section on the National Composite Policy Index.]

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS