

# **NATIONAL HIV and AIDS, STI POLICY**

**February 2013**

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## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIS	Aids Indicator Survey
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBO	Community-Based Organisation
CHBC	Community Home-Based Care
CHRAJ	Commission on Human Rights and Administrative Justice
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
CSW	Commercial Sex Workers
DAC	District AIDS Committee
DFID	Department for International Development
DHS	Demographic and Health Survey
DPAC	District Population Advisory Committee
eMTCT	Elimination of Mother-To-Child Transmission
EPP	Estimation and Projection Package
FBF	Fortified Blended Food
FBO	Faith-Based Organisation
FP	Family Planning
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GoG	Government of Ghana
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Viruses
HIV SS	HIV Sentinel Survey
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IUD	Intrauterine Device
JUTA	Joint UN Team on AIDS
LEAP	Livelihood Empowerment Against Poverty
LESDEP	Local Enterprises and Skills Development Programme
LTFU	Loss To Follow-Up
MARPs	Most-At-Risk Populations
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MICS	Multiple Cluster Indicator Survey

MLGRD	Ministry of Local Government and Rural Development
MMDA	Metropolitan, Municipal and District Assemblies
MoYS	Ministry of Youth and Sports
MoE	Ministry of Education
MoELR	Ministry of Employment and Labour Relations
MoFA	Ministry of Food and Agriculture
MoF	Ministry of Finance
MoH	Ministry of Health
MSM	Men Who Have Sex With Men
MTCT	Mother-To-Child Transmission
MTP	Medium-Term Plans
NACP	National AIDS and STI Control Programme
NDPC	National Development Planning Commission
NDPF	National Development Policy Framework
NGO	Nongovernmental Organisation
NHIS	National Health Insurance Scheme
NPC	National Population Council
NSF	National HIV & AIDS Strategic Frameworks
NSP	National HIV & AIDS Strategic Plan
NSPS	National Social Protection Strategy
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PC	Programmes Committee
PEP	Post-Exposure Prophylaxis
PLHIV	Persons Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
PrEP	Pre-Exposure Prophylaxis
RH	Reproductive Health
RTUF	Ready-To-Use Therapeutic Food
RPAC	Regional Population Advisory Committees
STI	Sexually Transmitted Infection
TB	Tuberculosis
TC	Testing and Counselling
UNAIDS	Joint United Nations Programme on HIV and AIDS
VTC	Voluntary Testing and Counselling
WHO	World Health Organisation

## PREFACE

This document is the revised National HIV and AIDS, STI Policy for Ghana. It has been revised by the Ghana AIDS Commission in collaboration with the Ministry of Health, National AIDS and STI Control Programme (NACP) of the Ghana Health Service and key stakeholders, taking into account recent developments in the national and global response. The document provides useful information on the status of the epidemic, its consequences and interventions necessary to adequately respond to the epidemic and the policies and organisational structures that have been put in place to address the epidemic comprehensively.

Ghana's HIV response has made significant progress towards the achievement of universal access to HIV and STI services. Progress has been made to make treatment available to persons living with HIV (PLHIV), address stigmatisation and discrimination and eliminate mother-to-child transmission (MTCT) of HIV. Currently, the national adult HIV prevalence has stabilised at 1.5%, declining from 2.7% in 2005. By the end of 2011, the estimated number of persons living with HIV was 225,478, of which 65,087 were on treatment.

As we pride ourselves on these successes and the potential of our shared future, challenges still exist. Challenges exist in mobilising adequate funding to address livelihood enhancement and improve the quality of life of PLHIV.

New infections are recorded daily, especially among people in the sexual and reproductive age group, notably youth and key populations. This has the potential to undermine efforts to achieve the developmental goals of Ghana.

However, there is much that we can do to change the course of the epidemic in our country. Sexual transmission of HIV remains the predominant mode of transmission in Ghana. Key populations are highly exposed to HIV infection due to risky sexual behaviour, stigmatisation and discrimination. Key interventions such as behaviour change communication will seek to sustain the very high level of awareness. They will improve the comprehensive knowledge of HIV among the general and key populations, promote safe behaviour to prevent HIV and STI infection and improve treatment, care and support services.

PLHIV also have an important role to play to reduce the spread of HIV and other STIs. They can help prevent further infections and can improve the quality of their own lives through positive behavioural change.

The Government is therefore pleased to introduce this important and far-reaching *National HIV and AIDS, STI Policy* to address the very serious health and developmental challenges posed by HIV and AIDS. This policy will provide the framework for Ghana's strategy to reduce by half, new infections and to eliminate mother-to-child transmission of HIV by 2015. The policy will optimise, sustain and scale up treatment, care and support for PLHIV and leverage treatment as a prevention strategy. It will mitigate the socio-economic impact of HIV on PLHIV and orphans and vulnerable children (OVC).

It is expected that this National Policy will evolve over time with new scientific knowledge, information and experience gained under the leadership of the Ghana AIDS Commission (GAC). Changes in our

societal attitudes and behaviours will also be critical. Policies and guidelines on HIV and AIDS, STIs will therefore be revised periodically to ensure that they reflect needs.

This document will be widely circulated to stakeholders, including key Ministries, Departments and Agencies (MDAs), Nongovernmental Organisations (NGOs), Civil Society and the Private Sector. It will also be distributed to Decentralised Institutions, such as Regional Co-ordinating Councils and Metropolitan, Municipal and District Assemblies (MMDAs) and religious groups. Institutions of learning and development partners will also be included in the distribution. The Ghana AIDS Commission established under the *Ghana AIDS Commission Act, 2002* (Act 613) is responsible for the co-ordination of this policy.

Given the multisectoral nature of the response to HIV in Ghana and the GAC's mandate to co-ordinate, monitor and evaluate all HIV and AIDS activities. GAC will be strengthened and given a free hand to implement this policy. This policy is however directed to each person and I call upon the leaders in our society to do their part to attain the goals of zero new infections, zero AIDS-related deaths and zero discrimination towards the achievement of a generation free of HIV in Ghana.

**His Excellency, John Dramani Mahama**

**President of the Republic of Ghana and Chairman of Ghana AIDS Commission**

## ACKNOWLEDGEMENTS

The Ghana AIDS Commission acknowledges the contributions of each person who, in diverse ways, contributed to the successful revision of the *National HIV and AIDS, STI Policy*. The inputs and contents of this policy were derived from several participatory consultations held with key stakeholders during the revision process.

We wish to express our gratitude to the Ministry of Health and other various organisations that contributed towards the revision of the 2004 policy. We also wish to extend our sincere appreciation to the members of the Programmes Committee (PC) and Policy Task Team of the Ghana AIDS Commission, Hon. Muntaka Mohammed Mubarak (Chairman, Select Committee on Health) and Dr. Nii Akwei Addo (Programmes Manager, National AIDS and STI Control Programme) for their active participation and support during the process of development.

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We also wish to thank the U.S. Agency for International Development (USAID) and its co-operating agency, Futures Group, which leads the Health Policy Project, the Department for International Development (DFID), the Joint UN Team on AIDS (JUTA) and other partners who contributed financially, as well as those who made their key personnel and technical resources available to the process.

We also acknowledge the contributions of others who supported the process of developing this policy in diverse ways, including the MDAs, the community-based organisations (CBOs), faith-based organisations (FBOs), NGOs and individual members of the communities from each region of the country.

Guided by this policy, we now have a common responsibility to combine our individual and collective resources to ensure its effective implementation.



## EXECUTIVE SUMMARY

The first 42 cases of AIDS were recorded in Ghana in 1986. By the end of 2011, an estimated 225,478 persons were living with HIV, of which 65,087 were on treatment. Currently, the national adult HIV prevalence has stabilised at 1.5%, declining from 2.7% in 2005. It is also estimated that 12,077 new infections occurred in 2011, including 1,707 in children.<sup>1</sup>

The main determinants of the spread of HIV in Ghana are the physiological, social, cultural and economic circumstances that have a disproportionately negative impact on the ability of key and vulnerable populations to adopt protective behaviours and access HIV and AIDS, STI services. These circumstances create a reservoir of infection that sustains the epidemic by contributing to low condom use, incorrect and inconsistent condom use, multiple and concurrent sexual partners, stigma and discrimination, issues about gender, gender-based violence and the disproportionate number of females vis-à-vis males who are infected and will determine the direction of the HIV epidemic in Ghana.

HIV negatively impacts life expectancy, health, education and the economy. It has dire social and psychological impacts on both the infected and affected. Thus, HIV transmission and the ability to cope with its consequences cannot be isolated from the social, cultural, demographic, economic and political conditions in a country. An effective national response to the epidemic must be holistic and multisectoral. HIV and AIDS contribute significantly to morbidity and mortality rates in Ghana.

In Ghana, HIV awareness is almost universal, although comprehensive knowledge is low. In spite of the fact that the epidemic has stabilised and there is high political commitment, there are numerous challenges to implement and roll out national policy and guidelines at local levels. For example, leadership and governance are weak at the district and sub-district levels, where much of the intervention takes place. Human resources for health and physical infrastructure are also inadequate at this level. There is limited access to services for those in need, especially for key and vulnerable populations.

This revised *HIV and AIDS, STI Policy* is guided by dictates of the 1992 Fourth Republican Constitution and other government policies, international conventions and protocols, including the Millennium Development Goals (MDGs).

The policy outlines guidance on human rights and legal and ethical issues. It supports a conducive legal framework with political, economic, social and cultural responses. It advocates for an HIV and AIDS prevention law and information to the public about their health rights in the Patient's Charter of the *Public Health Act, 2012* (Act 851).

The policy provides that discrimination against a person infected or affected by HIV or AIDS is prohibited. This extends to the workplace. Public and private institutions are to have workplace HIV and AIDS policies. Legal proceedings may be instituted for discrimination by the Commission on Human Rights and Administrative Justice (CHRAJ), public interest organisations and the Legal Aid Scheme. The right to privacy and confidentiality is safeguarded in the policy, subject to certain exceptions. The consent of an individual is required for a medical or behaviour change intervention.

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<sup>1</sup>Ghana AIDS Commission. *Ghana Country AIDS Progress Report*. 2012, p. 27.

A mandatory medical examination is not to be part of the pre-employment or pre-enrolment to an educational institution, or be part of a pre-marital regime. Mandatory testing is however to be conducted in procedures for the transfer of body parts or fluids and where a person is charged with a criminal offence. The criminalisation of key and vulnerable populations is unacceptable. Instead, referrals should be made to care and support services with education on safe sex.

Law enforcement should support non-adversarial interactions. The policy supports non-custodial sentencing to keep key and vulnerable populations out of prison and stipulates that a full range of HIV services should be provided to infected and non-infected prison populations.

Cultural practices that are inimical to HIV prevention should be proscribed by law, supported with educational campaigns to encourage people to discontinue these practices.

The *Criminal Offences Act, 1960* (Act 29) should be used to prosecute the offenders of wilful transmission under the circumstances provided in the policy.

Harassment should not be used to deliver effective HIV and AIDS services and public morality laws should focus on offences committed in public.

The policy also gives guidance to HIV prevention, treatment, care and support and sexually transmitted infections (STIs) since prevention is important to the reversal of the devastating effects of the HIV epidemic.

The overall goal of the policy on prevention is to halt and reverse the spread of HIV infection in the general population and in key and vulnerable populations. It also seeks to promote the elimination of mother-to-child transmission in the country.

Various strategies implemented together will achieve this goal. Some of the strategies are behaviour change communication (BCC) and information, education and communication (IEC) campaigns; HIV testing and counselling (HTC); elimination of mother-to-child transmission (eMTCT); blood and tissue transfusion safety; universal precautions; and post-exposure prophylaxis (PEP). Other strategies are prevention of STIs; use of preventive commodities; interventions for key populations; pre-exposure prophylaxis (PrEP); treatment as prevention (TasP); male circumcision; gender-based violence prevention and response strategies and HIV and AIDS surveillance.

Reduced HIV and STI-related morbidity and mortality in infected men, women and children remain the rationale for the provision of treatment, care and support services. This policy aims to promote the use of effective medicines, antiretroviral therapy (ART), adequate nutrition, psycho-social and other support and home-based care to achieve its goal.

Aspects of the policy deal with the mitigation of social and economic effects of HIV and AIDS, STIs. The policy addresses HIV-related stigma and discrimination, together with issues of sexuality, gender, differences in cultural practices and the socio-economic status of the infected and affected. The main object of mitigation is to reduce HIV and AIDS-related stigma and discrimination towards persons infected or affected by HIV and AIDS, especially key and vulnerable populations and draw attention to the compelling public health rationale to overcome stigmatisation and discrimination in society, especially at the individual, household and community levels. Key mitigation efforts include the reduction of stigma and discrimination against PLHIV and key and vulnerable populations. They are also to address the impact of gender norms and stereotypes and the impact on households and caregivers, especially women, children and the aged. They are to provide access to basic needs for

PLHIV and OVC. This policy also identifies a role for government and nongovernmental and private sectors to mitigate stigma and discrimination through information, collaborative multisectoral advocacy, policy and monitoring.

In terms of health systems strengthening, this policy seeks to ensure that strategies, resources and inputs for HIV and AIDS are integrated within the health system to enhance overall efficiency. This includes the mobilisation of resources and the equitable and sustainable funding of the health sector in alignment with existing health sector policies and strategies in the areas of leadership and governance, human resources for health, physical infrastructure, health service delivery, health management information systems, health technologies and health financing.

The stewardship of the Ministry of Health (MoH), “outsourcing,” partnerships and accountability systems are to be rationalised under leadership and governance at each level. Human resource and infrastructure development emphasise bridging equity gaps, while policy on service delivery addresses demand and access to quality “patient-centred” health services at each level, with appropriate referral systems. High-quality pharmaceuticals and devices—in line with strategies on procurement, supply and commodity security and monitoring for antimicrobial resistance, including antiretrovirals (ARVs)—are proposed. The policy on health financing seeks to mobilise funding, focusing first on local resources, including private sector participation. In view of Ghana’s attainment of lower middle-income status, the creation of an HIV and AIDS fund for HIV prevention programmes is proposed and an enhanced health management information system (HMIS) that links monitoring and evaluation, research and information and communication technology (ICT) for effective and timely information for decision making is proposed.

In terms of community systems strengthening (CSS), the policy also promotes the development of informed supportive communities where community and health actors work together to manage systems to contribute to the long-term sustainability of health and other interventions so as to deal effectively with the HIV epidemic. Programmes in the community should be evidence-informed, cost-effective, sustainable, and include counselling, legal support, policy advocacy and home-based care. Community networks, linkages and partnerships should operate to reduce stigma and discrimination and promote health. The GAC should collaborate with public and private partners to provide services.

Community systems strengthening interacts with health systems strengthening (HSS) to support positive behaviour change for disease prevention and treatment and improve access to healthcare, while HSS makes healthcare more accountable to the public and responsive to the needs of patients and communities. The GAC should develop guidelines for community-based HIV intervention that support the regularisation of NGOs and CBOs with independent audits.

The policy provides guidance to the public and private sector and outlines specific responsibilities. The public sector, for example, has the responsibility to provide an enabling policy environment to achieve the nation’s development goals and objectives. The national population and development agencies, the public sector and MDAs are important in the HIV response of the country and therefore should contribute to the national HIV response at multiple levels. Key line ministries have been identified as critical to successfully mainstreaming HIV in the public sector and are therefore expected to incorporate HIV concerns into their core business. Almost all the major MDAs and government co-ordinating bodies, including GAC, the National Development Planning Commission (NDPC) and the National Population Council (NPC), have key roles to play.

Private sector organisations and enterprises are mandated to develop and implement workplace policies and programmes for the management of HIV and AIDS, STIs in line with the National Workplace HIV Policy. These will include the implementation of HIV and AIDS, STI prevention education for workers, condom distribution and protection of the rights of PLHIV at the workplace. The private sector is also mandated to mobilise local private sector financial and other resources for HIV and AIDS, STIs education for the workforce and surrounding communities and to integrate HIV and AIDS, STIs into training courses for workers and managers, where appropriate. The policy provides a code of ethics for the media, civil society and faith-based organisations in relation to PLHIV and STIs.

In line with each of the outlined stipulations in the policy, research, monitoring and evaluation are key to effective planning, co-ordination and the implementation of the *National HIV and AIDS, STI Policy*.

Funding mechanisms have been outlined for internal and external funds. Adequate and sustainable funding for HIV programmes is the core of the national response. The policy on funding mechanisms seeks to mobilise funding that will be adequate and dynamic to meet the changing circumstances and expansion of prevention programmes. Funding mechanisms should lead to predictable financial resources and accountability for the resources mobilised on a long-term basis. An HIV and AIDS fund with legal backing should be established.

In view of the need for a dynamic response to the HIV epidemic and STIs, policies and guidelines on the subject will therefore be revised periodically to ensure that they reflect the needs and changes in societal attitudes and behaviour.

It is expected that this National Policy will evolve over time with new scientific knowledge, information and experience gained under the leadership of the Ghana AIDS Commission.

# 1. INTRODUCTION

## 1.1. Country Context

This introduction to the revised *National HIV and AIDS, STI Policy* focuses on the country context, Ghana's demographic situation, the history of the HIV epidemic and the national response to the epidemic and challenges. These will serve as background and context to formulate a viable HIV and AIDS, STI policy.

The total population of Ghana was 24.6 million<sup>2</sup> in 2012. Males constitute 48.5% of this population, with a sex ratio of 94 males per 100 females. Children under age 15 account for 40% of the population, while older persons (65 years and over) form 4.7% of the population. An estimated 24.1% of the total population is between ages 15–24.<sup>3</sup> A significant proportion of the population (56%) resides in rural areas. Although mortality has decreased over the years, life expectancy at birth is currently estimated at 61.45 years.<sup>4</sup> The decline in the maternal mortality rate from 451<sup>5</sup> in 2008 to 350<sup>6</sup> per 100,000 live births in 2010 is not sufficient. There have been significant reductions in neonatal mortality (from 41 to 30), infant mortality (from 77 to 50) and child mortality (from 155 to 80) per 1,000 live births between 2004 and 2008.<sup>7</sup> The total fertility rate is currently 4.0 children per woman.

### 1.1.1. HIV in Ghana

Since the first 42 cases of AIDS were recorded in Ghana in 1986, a cumulative total of 225,478<sup>8</sup> people living with HIV was estimated at the end of 2011. The last population-based survey on HIV prevalence carried out in Ghana was the Ghana Demographic and Health Survey (GDHS) of 2003. Results of the GDHS 2003 indicated that 2% of adults ages 15–49 were HIV positive (2.7% of women and 1.5% of men). HIV prevalence in Ghana has been estimated based on sentinel surveillance of pregnant women attending antenatal clinics since 2003. An estimation and projection package (EPP) modelling done in 2008 estimated the national HIV prevalence among adults to be 1.9% (range of 1.7% to 2.2%), with urban and rural prevalence estimated at 2.3% and 1.7%, respectively. The trend in the national median HIV prevalence since 2003 shows three peaks: 2003 (3.6%), 2006 (3.2%) and 2009 (2.9%). A linear trend analysis shows that HIV prevalence since 2003 has decreased and stands at 2.1% as of 2011. Currently, the national adult HIV prevalence has stabilised at 1.5%, declining from 2.7% in 2005.

Although the HIV prevalence is low, it varies across the 10 administrative regions and is notably higher among key population segments—men who have sex with men (MSM), female sex workers (FSWs), people who inject drugs (PWID), prisoners, clients of FSW and sexual and needle sharing partners of PLHIV. In 2011, prevalence among FSWs was 11.1%<sup>9</sup> and MSM 17.5%.<sup>10</sup> An estimated

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<sup>2</sup>2010 Population and Housing Census.

<sup>3</sup>UN Population Statistics.

<sup>4</sup>*Ghana Demographics Profile*. 2012. Retrieved from [http://www.indexmundi.com/ghana/demographics\\_profile.html](http://www.indexmundi.com/ghana/demographics_profile.html).

<sup>5</sup>WHO, 2008.

<sup>6</sup>*National Strategic Plan*. 2010, p. 16.

<sup>7</sup>Ministry of Health, 2008.

<sup>8</sup>HIV Sentinel Survey (HIV HSS), 2011.

<sup>9</sup>Ghana AIDS Commission. *Ghana Country AIDS Progress Report*. 2012, p. 12.

40.6% of new infections occurred among the key populations.<sup>11</sup> In Ghana, in addition to the key populations referred to above, vulnerable populations include the poor, migrant and displaced populations, women and youth—especially orphans and vulnerable children (OVC) and the aged. It is also estimated that 12,077 new infections occurred in 2011, including 1,707 infections in children.<sup>12</sup> The key determinants of the spread of HIV in Ghana are:

- Physiological, social, cultural and economic circumstances that have a disproportionately negative impact on the ability of key and vulnerable populations to adopt protective behaviours and access HIV and AIDS, STI services;
- Low condom use;
- Incorrect and inconsistent condom use;
- Multiple and concurrent sexual partners;
- Stigma and discrimination; and
- Issues regarding gender, gender-based violence and the disproportionate number of females vis-à-vis males who are infected.

### 1.1.2. Impact of the Epidemic

HIV negatively impacts life expectancy, health, education and the economy. It has dire social and psychological impacts on both the infected and affected. Thus, HIV transmission and the ability to cope with its consequences cannot be isolated from the social, cultural, demographic, economic and political conditions in a country. An effective national response to the epidemic must be holistic and multisectoral. HIV and AIDS contribute significantly to morbidity and mortality rates in Ghana.

HIV negatively impacts social systems because of the tremendous strain on these systems to cope with such a large number of orphans and provide them with the needed care and supervision. At the family level, there is increased burden and stress on the extended family. This surge in the number of orphans is especially difficult in major urban centres, where traditional family structures are not as strong as in the rural areas.

HIV and AIDS are also major threats to the world of work because of their depletion of the workforce in important sectors in terms of numbers, skills and personal productivity. Additionally, the issue of HIV and AIDS is creating unwarranted stigmatisation and discrimination aimed at workers and people living with and affected by HIV and AIDS.<sup>13</sup>

## 1.2. National HIV and AIDS, STI Response

Ghana's HIV epidemic is classified as a low prevalence epidemic, with pockets of high prevalence in certain populations. According to the 2011 *HIV Sentinel Survey Report*, the estimated adult national HIV prevalence in Ghana remains at 1.5%. The surveillance data since 2003 continue to show a declining trend in HIV prevalence.

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<sup>10</sup>Ghana AIDS Commission. *Ghana Country AIDS Progress Report*. 2012, p. 12.

<sup>11</sup>Ghana AIDS Commission. *Ghana Country AIDS Progress Report*. 2012, p. 24.

<sup>12</sup>Ghana AIDS Commission. *Ghana Country AIDS Progress Report*. 2012, p. 27.

<sup>13</sup>*National Workplace HIV Policy*. 2004.

Ghana has made significant progress towards achieving universal access to HIV services through the implementation of the *National HIV & AIDS Strategic Frameworks* (NSF I and NSF II) and through the medium-term plans (MTP 1 and 2) developed by the National AIDS and STI Control Programme (NACP), which earlier drove the health sector response.

There are established co-ordination and partnership arrangements for public, civil society and private sector institutions. Development partners are co-ordinated within the context of the Partnership Forum guided by the *Paris Declaration on Aid Effectiveness* and the *Accra Agenda for Action*.

In line with efforts to continue and sustain this progress, GAC, in collaboration with key partners and stakeholders, has developed a new *National HIV & AIDS Strategic Plan 2011–2015* (NSP 2011–2015) to direct the implementation of the national HIV and AIDS response over the next five years.

The *NSP 2011–2015* emphasises intensification of HIV prevention to reduce new HIV infections by 50% and also provides a broad framework towards the virtual elimination of mother-to-child transmission (MTCT) of HIV.

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

- Technical working groups on key populations, ART, research, monitoring and evaluation, communication and an expanded technical working group;
- Task teams, such as gender and HIV, stigma reduction, prevention of mother-to-child transmission (PMTCT), decentralised response and World AIDS Day planning committees;
- The Partnership Forum; and
- Technical review meetings with implementing partners and stakeholders.

There are several other sector-level and workplace policies, plans and programmes that have been established over the last 10 years to guide stakeholders in the implementation of HIV interventions. At the regional and district levels, GAC has established multisectoral HIV and AIDS committees with the Regional Ministers and District Chief Executives as chairpersons. These committees co-ordinate HIV interventions at the decentralised level.

### 1.3. Challenges

There are numerous challenges to implement and roll out national policy and guidelines at local levels. For example, leadership and governance are weak at the district and sub-district levels, where much of the intervention takes place. Human resources for health and physical infrastructure are also inadequate at these levels. There is limited access to services for those in need, especially for key and vulnerable populations. Other identified key challenges include:

- Policy gaps in the private sector response;
- Slow uptake of workplace HIV programmes by formal and informal establishments;
- Weak capacity by Civil Society Organisations (CSOs) networks and umbrella organisations to effectively coordinate the large number of CSOs to implement HIV responses at national, regional and district levels;

- The absence of a GAC Secretariat at the decentralised level, coupled with high turnover of HIV focal persons;
- Lack of a resource mobilisation strategy;
- Weak mechanisms to coordinate funding; and
- Accountability.



## 2. THE POLICY FRAMEWORK

### 2.1. Guiding Principles

#### 2.1.1. Alignment with Existing Documents

This revised *HIV and AIDS, STI Policy* is premised on and complementary to the following:

- 1992 Fourth Republican Constitution, which provides fundamental rights to each person in the *Ghana Shared Growth and Development Agenda (2010–2013)*;
- Revised Population Policy (1994);
- Public-Private Partnership Policy (MoT/MoFEP);
- Intervention/population-specific policies, which set detailed standards, protocols, outcomes and quality indicators for interventions and populations;
- *National HIV & AIDS Strategic Plan (2011–2015)*, which identifies a detailed national action plan, strategies and performance indicators; and
- Millennium Development Goals (MDGs).

It is also based on the principles of social justice and equity, which includes equitable people-oriented development, derived from the recognition that adequate healthcare is an inalienable right of each person in Ghana, including those infected and affected by HIV and AIDS, STIs and also based on the assumption that appropriate legislation will be enacted and administrative guidelines made to complement the provisions in this policy.

#### 2.1.2. Alignment with International Conventions and Protocols

In addition, this policy takes account of international human rights conventions, treaties and protocols ratified by the Republic of Ghana. Commitments made and the goals agreed upon at various international fora that outlined the profound concerns about the devastating impact of HIV and AIDS, STIs on socio-economic development also have been taken into consideration. Strategic programmes of action and declarations for the response to the epidemic were also considered. These include:

- *UN Convention on Economic, Social and Cultural Rights (1976)*;
- *African Charter on Human and People's Rights*, which affirms the right to the highest attainable standard of health;
- Key actions for the further implementation of the *Programme of Action* of the International Conference on Population and Development adopted at the United Nations (UN) in Cairo on 13 September 1994, which for the first time agreed on specific goals for the reduction of HIV infection, especially among adolescents;
- Political Declaration and further action and initiatives to implement the *Beijing Declaration and Platform for Action* of 1995;
- Political Declaration and further action and initiatives to implement commitments made at the World Summit for Social Development, 1 July 2000 and the *United Nations Millennium Declaration* of 8 September 2000, which enjoined member countries to halt and begin to reverse the spread of HIV infection by 2015;

- United Nations General Assembly Special Session on HIV and AIDS, June 2001; and
- *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases* and the *Abuja Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, 27 April 2001, which considered AIDS as a state of emergency in Africa.

### **2.1.3. Public Health and Human Rights**

This revised *National HIV and AIDS, STI Policy* is built on a foundation of public health safety and human rights as provided in the *Public Health Act 2012* (Act 851) and the proposed *HIV and AIDS Control and Prevention Law*, which stipulates that:

- The highest attainable standard of physical and mental health is an inalienable right of each person in Ghana, including key and vulnerable populations at risk for or infected with HIV, other STIs, or tuberculosis;
- A human rights-based approach requires the education of the population on their rights and the establishment of systems for redress when rights are abused;
- A public health response is grounded on scientific evidence and international best practice and prioritises finite resources for individuals and interventions that will achieve the highest impact on HIV and AIDS;
- A public health response recognises the need to serve each individual, regardless of their risk or the source of infection;
- A public health response prioritises minimising harm and disease transmission and utilises judicial and legal approaches as mechanisms for referral to services rather than punishment;
- Social justice and equity—every person in Ghana is equal under the law; and
- Equitable, people-oriented development.

### **2.1.4. Integration and Holistic Programmes with Key and Vulnerable Populations**

This policy seeks to integrate holistic approaches to address the needs of key and vulnerable populations. Particular priorities will be identified to serve individuals with compounded vulnerabilities.

### **2.1.5. Community, Prison and Detention Settings**

The principles identified in the revised *National HIV and AIDS, STI Policy* apply equally in community and prison or detention settings. Prisoners and service personnel are to be provided with essential services within their stipulated jurisdictions.

### **2.1.6. Overarching Principles**

The overarching principles of protection, confidentiality, consent, non-disclosure and data protection are enshrined in this policy and applicable throughout. Mandatory testing or compulsory testing and treatment are prohibited unless as part of a stipulated medical procedure, further explained in subsequent chapters. This policy encourages human rights and evidence-informed, results-oriented, gender-sensitive and responsive programmes and interventions.

## 2.2. Rationale of the National HIV and AIDS, STI Policy

The rationale of the *National HIV and AIDS, STI Policy* is to provide guidance to other HIV-related policies, interventions and programme design and implementation in Ghana. It is applicable to each sector and is expected to provide guidance for legislation, strategic plans, action plans and intervention-specific standards and protocols. The essence of the policy is to reduce the impact of HIV and AIDS, STI-related morbidity and mortality in the country in the interest of public health, safety and human security.

## 2.3. Goals and Objectives

The overall goal of the revised *National HIV and AIDS, STI Policy* is to create a favourable environment for every aspect of HIV and AIDS, STI prevention, care and support. The main objectives of the policy are to set standard parameters for the national response to HIV and AIDS to:

- Halt and reverse the incidence of new infections with an ultimate aim to achieve zero new infections;
- Eliminate MTCT of HIV;
- Reduce HIV-associated morbidity and mortality to ensure the continued survival of men, women and children infected with the virus;
- Identify components that ensure that the basic human rights of each person in Ghana—especially persons infected and affected by HIV—are respected, protected and upheld;
- Alleviate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels by reducing HIV-related stigma and discrimination through the provision of information, basic needs and legal and community safety nets for PLHIV, OVC and key and vulnerable populations;
- Ensure the integration and alignment of policies, strategies and resources for HIV within a responsive health system and other sectors to enhance overall efficiency while equity and sustainability of funding and other resources are addressed;
- Ensure that access to social and economic opportunities remains open to PLHIV and key and vulnerable populations;
- Provide multisectoral and multidisciplinary guidance on coordinating programmes and resources for implementation, research, monitoring and evaluation of HIV and AIDS, STI interventions; and
- Ensure that HIV and AIDS prevention and control are pursued actively from a gender-sensitive perspective.

## 3. HUMAN RIGHTS, LEGAL AND ETHICAL ISSUES

### 3.1. Introduction

Human rights violations and related stigma and discrimination of persons infected with and affected by HIV is pernicious and pervasive. A conducive legal framework, free from discrimination, that supports political, economic, social and cultural responses, together with other strategies to address HIV, is the approach favoured by the Government of Ghana (GoG) to promote and protect the rights and empowerment of PLHIV, as well as key and vulnerable populations. The right to health is inalienable and unequivocal.

### 3.2. HIV and AIDS Prevention and Control Law

Legislation should be enacted to create a favourable environment to comprehensively deal with HIV and AIDS, STI-related prevention, care and support. The object of the legislation should be to promote a healthy lifestyle and behavioural change through effective information, education and communication (IEC) efforts and the promotion and protection of the rights of PLHIV and key and vulnerable populations.

### 3.3. Public Health Legislation

The *Public Health Act, 2012* (Act 851) provides for optimum healthcare, dependent on collaboration between health workers, patients and society. Its Patient's Charter should be used as a guide to promote the responsibility of the patient for personal and communal health through preventive and curative health strategies.

The public health response must be grounded in scientific evidence and international and national best practices and should prioritise resources that will achieve the highest impact on HIV and AIDS.

### 3.4. Protection from Discrimination

Government and relevant agencies should ensure compliance with this HIV policy and legislation related to discrimination against persons infected, perceived to be infected, or affected by HIV. Awareness of an individual's right not to be discriminated against must be created by the relevant stakeholders.

Legal proceedings must take into consideration the need to maintain the confidentiality of HIV status in cases concerned with PLHIV.

A person who has died of an AIDS-related condition, or who is perceived to be HIV positive, is not to be denied burial services on grounds of HIV status.

### 3.5. Right to Employment

The *Labour Act, 2003* (Act 651) excludes the Armed Forces, Police Service, Prison Service and Intelligence Agencies specified under the *Security and Intelligence Agencies Act, 1996* (Act 526) and prohibits discrimination against an employee based on gender, race, colour, ethnic origin,

religion, creed, social or economic status, disability, or politics.<sup>14</sup> It is inclusive of HIV and AIDS and must be enforced.

Public and private institutions are to have workplace HIV and AIDS, STI policies in accordance with the 10 guiding principles of the *National Workplace HIV and AIDS, STI Policy*.

Citizens of Ghana who seek to emigrate for employment should not be prevented from emigrating from this country on the basis of their real or perceived HIV status.<sup>15</sup>

### 3.6. Legal Representation for Anti-discrimination Matters

The Commission on Human Rights and Administrative Justice (CHRAJ) may remedy or call for the correction and reversal of instances of abuse of power and human rights through fair, proper and effective means.<sup>16</sup> A public interest organisation may represent an individual or group of PLHIV and key and vulnerable populations where discrimination has been demonstrated. CHRAJ and the Legal Aid Scheme should develop guidelines to provide assistance to PLHIV and key and vulnerable populations who require the services of CHRAJ.

Information obtained in the process of providing HIV-related services to individuals engaged in high-risk behaviour that may be considered criminal should be considered private and maintained as confidential.

### 3.7. Confidentiality

Each person should enjoy their right to privacy and confidentiality regarding their HIV status. Information about the HIV status of a person should not be disclosed without the informed consent of the PLHIV, except:

- Where provided by law;
- To a healthcare provider who is directly involved in providing healthcare to that person, where knowledge of the patient's HIV infection is necessary to make a clinical decision in the best interest of the person;
- For the purpose of an epidemiological study, where the release of information cannot be expected to identify the person to whom it relates; and
- In a court order, where the information contained in the medical file is directly relevant to the proceedings before the court.

A PLHIV cannot be forced to declare his or her HIV status except where required by law. The disclosed or perceived HIV status of a person should not be the basis of any discrimination or violation of the person's rights.

Those who have been infected with HIV through conduct considered or perceived to be illegal should be able to seek healthcare without fear of being reported to a law enforcement agency or official.

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<sup>14</sup>Section 14 of Act 651.

<sup>15</sup>Article 8 of the International Labour Organisation (ILO) text of the *Recommendations Concerning HIV & AIDS and the World of Work*. June 2010.

<sup>16</sup>Section 7(d) CHRAJ Act, 1993 (Act 456).

A healthcare provider may inform the partner of a person under the direct care of the healthcare provider of the patient's HIV-positive status only if all of the following conditions are met:

- The healthcare provider reasonably believes in good faith that the partner is at significant risk of transmission of HIV from the person;
- The PLHIV has been counselled to inform the partner;
- The healthcare provider is satisfied that the PLHIV will not inform the partner;
- The healthcare provider has informed the PLHIV of the intention to disclose their HIV-positive status to the partner; and
- The disclosure to the partner is made in person and with appropriate counselling or referrals for counselling.

Despite the provision of this policy, or any law on wilful transmission, a healthcare provider shall, in the best interest of the PLHIV, not inform a partner—particularly in the case of a woman—where there is a reasonable apprehension that the information may result in violence, abandonment, or actions that may have a severe negative effect on the physical or mental health and safety of the HIV-positive person, the person's children, or someone who is close to the person.<sup>17</sup>

In the cases of persons in detention, any information on the health status and healthcare procedures of a PLHIV should be treated with confidentiality.

Where the sharing of information with other professionals is required for official purposes, it is the responsibility of the professional making the disclosure to ensure that the other colleague appreciates that the information is being imparted in strict professional confidence.

The right to privacy of the individual or group of persons as regards HIV and AIDS should be respected in the print and electronic media.

Data on HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality in accordance with the *Data Protection Act 2012* (Act 843).

### 3.8. Consent of Individuals for Medical or Behaviour Change Intervention

This policy stipulates that the informed consent of individuals is a prerequisite for any medical intervention. In accordance with the best practice internationally,<sup>18</sup> informed consent must:

- Provide full information on the medical intervention;
- Include the right of a person to refuse or withdraw from a medical intervention at any time;
- Relate specifically to the treatment or intervention required;
- Be given voluntarily;
- Be either verbal or written; and

<sup>17</sup>Retrieved from [http://data.unaids.org/pub/Manual/2007/20071128\\_ipu\\_handbook\\_en.pdf](http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf), pp. 90–91.

<sup>18</sup>UN General Assembly *Report of the Special Rapporteur* on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009.

- Not be obtained through misrepresentation, coercion, or fraud.

Medical consent for a child, a person under the age of 18 years, or a mentally incapacitated individual must be obtained through a legal guardian, parent, partner, or next of kin. Where it is impracticable or undesirable to obtain this consent because a child is between the ages of 16 and 18 years, a medical practitioner may institute the necessary care and intervention in the best interest of the individual. Adolescents have a right to access appropriate health information and counselling services regardless of parental consent, particularly information and counselling services concerned with sexual and reproductive health.<sup>19</sup> The reproductive health policy applies to this policy.

Women have the right to HIV-related services that are non-coercive and respectful of privacy, confidentiality and autonomy—including the right to consent or refuse services without being required to consult any other person or family member. The disclosure of HIV-related information with personally identifying information must require informed consent.

### 3.9. Mandatory Medical Examination

HIV testing must be conducted with the consent of the individual. Mandatory testing is not to be part of a pre-employment examination for any public or private position, including enlistment into the security services and pre-enrolment to an educational institution, or to be conducted prior to any form of marriage. Mandatory testing is not to be a prerequisite for entry into or travel out of the country or for the provision of healthcare, insurance coverage, or any other service.

Mandatory testing or confinement is not to be carried out on the mere suspicion that a person is a sex worker or a member of a vulnerable group.

Despite this, procedures that involve the transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplants, require mandatory screening for HIV and other blood-borne viruses of any blood that is destined for transfusion or for the manufacture of blood products.<sup>20</sup>

A person charged with a sexual offence, such as rape, defilement and incest under the *Criminal Offences Act, 1960* (Act 29) may be mandatorily tested by order of a court.

Existing guidelines related to peacekeeping operations by the security services that can be interpreted to allow for mandatory testing of the armed forces, peacekeepers and police should be reviewed and revised to conform to UN Peacekeeping Guidelines. The focus should be changed to the availability of HIV testing and counselling and engagement should be based on the assessment of fitness to perform duties, regardless of HIV status.<sup>21</sup>

### 3.10. Criminalisation of Key and Vulnerable Populations

Healthcare providers, general medical care actors and beneficiaries of HIV prevention drug treatment, harm reduction and non-medical service providers who provide assistance to key and vulnerable populations should not be considered as accomplices in the prosecution of key and vulnerable populations.

<sup>19</sup>United Nations General Assembly, 2009, p. 14.

<sup>20</sup>Retrieved from <http://www.who.int/hiv/pub/vct/counselingtestingtoolkit.pdf>.

<sup>21</sup>Retrieved from <http://uniformservices.unaids.org/country/Peacekeeping/DPKO%20testing%20policy.pdf>.



People engaged in the distribution of educational materials about disease transmission risks, drug treatment and harm reduction should not be considered as aiding and abetting criminal offences.

The following circumstances are inadmissible as evidence of criminalised behaviour:

- The presence of disease or mode of transmission;
- The possession of condoms or other harm reduction, safer sex, or educational materials;
- Information provided in the process of reporting blackmail, bribery, coercion, extortion and harassment; and
- Information provided in the process of filing a discrimination complaint or domestic violence charge.

### 3.11. Prison and Detention Settings

The full range of HIV services should be provided to infected and non-infected persons who are incarcerated. The Prison Service should ensure that it has a clear policy related to HIV that determines this level of access.

### 3.12. Cultural Practices Inimical to HIV Prevention

The Government should take steps to engage traditional authorities and relevant stakeholders to reform customary practices and acts of stigma and discrimination that lead to gender inequality or exacerbate HIV risk, such as female genital mutilation and scarification.

### 3.13. Wilful Transmission

This policy supports the use of existing standards of evidence, international best practice standards and a range of offences under the *Criminal Offences Act, 1960* (Act 29) and the *Domestic Violence Act, 2007* (Act 732) to prosecute offenders for the wilful transmission of HIV. Criminal law should not be used, at least in the following circumstances, by the prosecution for a conviction of wilful transmission:<sup>22</sup>

- When there is no transmission or significant risk of transmission;
- When the alleged perpetrator does not know if he or she is living with HIV;
- When the person involved does not understand HIV transmission;
- When the person disclosed his or her HIV positive status to his or her sex partner, or has reason to believe in good faith that his or her status is already known to the partner;
- In the case of nondisclosure of HIV status because of fear of violence or other negative consequences of disclosure;
- When reasonable measures have been taken to reduce the risk of transmission, such as condom use; and
- When the parties involved previously agreed on a level of mutually acceptable risk.

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<sup>22</sup> UNAIDS *Criminalisation of HIV Transmission Policy Brief*. 2008.



### **3.14. Harassment of Key Populations**

Bribery, coercion, extortion and harassment are not only illegal, but also counterproductive to efforts to deliver effective HIV and AIDS prevention, care and treatment services. Law enforcement performance assessment and promotion is not to be dependent on targeting marginalised, key, or vulnerable populations. The government should consider legal reform to prevent loitering laws from being used against key and vulnerable populations. Public morality laws should focus on offences committed in public and those that force unsuspecting individuals to participate in activities against their will.

### **3.15. Insurance**

A person's HIV status must not be a barrier or put him or her at a disadvantage to obtain personal or group health insurance. HIV prevention, treatment and management of opportunistic infections (OIs) of PLHIV available in Ghana should be covered by the National Health Insurance Scheme (NHIS).

## 4. PREVENTION OF HIV AND STI INFECTIONS

### 4.1. Introduction

Prevention is fundamental to the reversal of the devastating effects of the HIV epidemic. The overall goal of the policy on prevention is to halt and reverse the spread of HIV infection in the general population and in key populations and to achieve the elimination of MTCT in Ghana.

Some of the strategies to be used in prevention include behavioural change communication and information, education and communication campaigns, HIV testing and counselling (HTC), eMTCT, blood and tissue transfusion safety, universal precautions and post-exposure prophylaxis (PEP). Other strategies are prevention of STIs, use of preventive commodities, interventions for key populations, pre-exposure prophylaxis (PrEP), treatment as prevention, male circumcision and HIV and AIDS, STI surveillance.

These strategies have varied levels of success and need to be implemented together in different combinations to achieve the overall goal of a sustained reduction in new infections.

### 4.2. Elimination of Mother-to-Child-Transmission<sup>23, 24, 25</sup>

Transmission of HIV from mother to child can occur during pregnancy, during delivery, or through breastfeeding. Mother-to-child transmission of HIV represents a major cause of morbidity and mortality among children less than five years old.

Under this policy and in view of the desired objective of saving children's lives and reducing the impact of HIV on families and communities, the use of ART to reduce the risk of MTCT is to be promoted.

The Government should ensure that eMTCT programmes are available to every pregnant woman living with HIV. These programmes include behaviour change communication (BCC), HIV testing as part of routine antenatal services, psycho-social support, follow-up services and nutritional support for malnourished mothers. Infant feeding options should be integrated into maternal and child health services. Integration of eMTCT services into family planning (FP) services is to be pursued. Special efforts should be made to target men with information on family planning/reproductive health (FP/RH), HIV and AIDS, STIs and to ensure that they support their partners during pregnancy, labour and after the birth of the child.

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<sup>23</sup>MoH. *National Guidelines for Prevention of Mother to Child Transmission of HIV*. August 2010.

<sup>24</sup>Retrieved from [http://www.aidstar-one.com/sites/default/files/AIDSTAR-One\\_GBV\\_Guidance\\_lowres.pdf](http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_GBV_Guidance_lowres.pdf).

<sup>25</sup>MoH. *National Reproductive Health Service Policy and Standards*. 3<sup>rd</sup> Edition in development (2<sup>nd</sup> Edition-2003).

### 4.3. HIV Testing and Counselling<sup>26, 27, 28, 29</sup>

Good quality testing and counselling (TC) for HIV should be made available and accessible to each person seeking these services. Adequate information must be provided prior to testing and post-test counselling should be provided when test results are received. Clients who test positive must be made fully aware through counselling of their responsibility to prevent onward transmission to others. TC should also be promoted as a major entry point into care and treatment services.

Under each of the following recommended modalities, TC must be confidential, accompanied with counselling and only conducted with consent so that it is informed and voluntary:

- **HIV Testing and Counselling (HTC):** HTC primarily involves individuals actively seeking HIV testing and counselling at facilities offering the service. HTC should be offered especially in non-health settings, such as the community, mobile and stand-alone services and during pre-marital counselling and in walk-in health settings where people go to learn their status.
- **Routine testing:** Routine testing is a form of provider-initiated testing and counselling, which is recommended to persons attending healthcare or community facilities by a healthcare provider or equivalent as a standard component of medical care. Routine testing may take the form of including HIV testing as a component of regular panels of tests—for which the patient may choose to “opt out”—or suggestions by the healthcare provider to add HIV testing to routine medical testing—for which the patient must choose to “opt in.” Populations that may lack the ability to fully negotiate in healthcare settings such as adolescents, key and vulnerable populations, should be offered “opt in” opportunity to ensure that consent is truly achieved, as the basic conditions of confidentiality, consent and post-test counselling and referral remain the same as for other HIV testing. Populations to be offered routine testing include:
  - Pregnant women;
  - Key populations;
  - Patients in the emergency rooms of hospitals;
  - In-patients (both children and adults);
  - Adolescents attending adolescent-friendly services;
  - Clients accessing STI services;
  - Patients with TB;
  - Individuals who have experienced potential occupational or sexual exposure; and
  - Any other identifiable groups likely to have a high prevalence of HIV.
- **Diagnostic testing:** Diagnostic testing refers to HIV testing offered to patients with HIV-related symptoms and signs for the purpose of arriving at a diagnosis for patient management.
- **Mandatory testing:** Mandatory testing is only supported in the following circumstances:

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<sup>26</sup>Guidance on Provider-initiated HIV Testing and Counseling in Health Facilities. 2007. Retrieved from <http://www.who.int/hiv/pub/vct/pitc2007/en/>.

<sup>27</sup>UNAIDS/WHO. *Policy Statement on HIV Testing*. Retrieved from <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf>.

<sup>28</sup>Retrieved from <http://www.cdc.gov/hiv/topics/testing/>.

<sup>29</sup>NACP. *National Guidelines for Development and Implementation of HIV Counseling and Testing*. 2008.

- Blood donated for transfusion;
- Donors and recipients of body fluids or parts; and
- Individuals charged with rape, defilement and incest.

Mandatory testing is not supported for individuals solely on public health grounds.

**Test results:** Test results are confidential and are only to be released to the individual who was tested or to the individual who was authorised to provide consent. Exceptions to this general rule are detailed in Chapter Three. No person should be denied an opportunity or stigmatised on account of a positive test result.

**Linkages to treatment, care and support:** As much as possible, each person testing positive for HIV should be linked to treatment, care and support services.

**Commercial home self-test kits for HIV:** When innovative technologies result in the availability of these tests, they may be used after they have been evaluated and licensed by the Ministry of Health (MoH) or its accredited agency.

**Testing:**

- A screening facility should apply the prescribed national protocol for HIV testing and screening provided by the MoH/Ghana Health Service (GHS);
- For epidemiological purposes, two positive antibody tests of different antigenic properties should be considered confirmative of HIV infection, as spelled out in the national guidelines;
- HIV screening kits/reagents for use in the country should first be evaluated and licensed by the MoH or its accredited agency;
- Subsequent lots/batches of these reagents should undergo periodic quality assurance tests before they are used;
- The MoH should regulate the activities of diagnostic laboratories that screen and test for HIV and STIs, monitor compliance and ensure that appropriate sanctions are applied, if and when necessary; and
- The MoH should facilitate testing in the community as well as in healthcare settings.

#### 4.4. Blood and Tissue Transfusion Safety<sup>30</sup>

The virtual elimination of blood-transmissible HIV infection should be facilitated by ensuring that health facilities obtain blood for transfusion that is screened for HIV and other transmissible infections and obtained from reputable sources, including the National Blood Transfusion Service.

In line with this policy of elimination of blood transmissible HIV infection, blood transfusion and tissue transplantation should involve mandatory testing. A client who tests positive during blood donation and tissue transplantation should be linked to treatment, care and support services. More comprehensive guidelines are outlined in the *National Blood Policy for the Health Sector*.

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<sup>30</sup>MoH. *National Blood Policy for the Health Sector*. February 2006.

## 4.5. Universal Precautions

Universal precautions are an integral part of good health practice. This policy endorses and encourages specific and appropriate measures to protect healthcare workers against the risk of infection and reduction of nosocomial transmission at each level. The policy supports the development, dissemination and use of protocols in health facilities and the training of healthcare workers (HCW).

Healthcare institutions should provide equipment and materials for the proper observation of universal safety precautions and procedures within the institution. Healthcare workers should have access to free PEP in the event of occupational exposure.

Healthcare workers should observe universal safety precautions and procedures in the management of their patients, handling of corpses and disposal of body fluids, other potentially infectious materials and medical waste.

Traditional and alternative healthcare providers who use invasive procedures, such as circumcision, skin piercing, scarification and blood-letting operations, should be educated on universal precautions and enabled to keep within the legal framework. They should also use standard sterilisation and disinfection procedures. This policy promotes the inclusion of safety precautions as part of pre- and in-service education for each category of health worker.

Universal precautions should also be disseminated widely at workplaces.

## 4.6. Post-Exposure Prophylaxis<sup>31, 32, 33</sup>

PEP should be offered to persons who have been exposed to the virus in either occupational or non-occupational circumstances and who have been put at risk as a result of the exposure. PEP consists of a comprehensive set of services given to prevent an infection from developing in an exposed person and includes counselling and risk assessment, HIV testing and counselling and short- or long-term ARVs with support and follow-up.

The following categories of persons may benefit from PEP: health workers; security services personnel at accident scenes; rape, defilement and incest survivors; people who experience occupational exposure; isolated or incidental injection drug use and consensual sexual exposure. Individuals who seroconvert should have access to comprehensive care and ART services as outlined in the *Workplace and HIV & AIDS Policy and Technical Guidelines for the Health Sector* and also *Guidelines on Antiretroviral Therapy*.

## 4.7. Behaviour Change Communication

A comprehensive BCC strategy that includes IEC is considered central to efforts to reduce the spread of HIV and the management of AIDS. BCC and IEC messages should therefore include information for the general population and information targeted at specific populations. The BCC strategy will be guided by the following basic principles:

<sup>31</sup>GHS/NACP. *Guidelines for Antiretroviral Therapy in Ghana*. September 2011.

<sup>32</sup>*Workplace HIV & AIDS Policy & Technical Guidelines*.

<sup>33</sup>*Post-exposure Prophylaxis to Prevent HIV Infection*, Joint WHO/ILO Guidelines. 2007. Retrieved from <http://www.who.int/hiv/pub/guidelines/PEP/en/>.

#### **4.7.1. Basic Principles of BCC Strategy**

Each person should be given access to BCC and IEC on HIV and AIDS, STIs, which:

- Take into account age, key cultural and family values, sexual orientation and gender specificities;
- Are appropriately informed by HIV-related ethical and human rights issues;
- Provide information that is scientifically accurate and evidence informed;
- Are developed using participatory methods so that they are appropriate for key populations, the vulnerable and the general population; provide families, schools and religious and traditional bodies and other relevant organisations with information and support the development of communication skills to enable discussions on HIV and AIDS, STIs without hindrance;
- Challenge stigma and discrimination in any form;
- Will be integrated into the spheres of social, economic and religious activities of individuals, communities and organisations;
- Recognise the critical role that the media, (both traditional and modern, has to play to inform and educate the public about practices that either promote or hinder the spread of HIV and AIDS, STIs; and
- Ensure that behaviour change interventions emphasise and aim at a progressive transition from general awareness to knowledge of a person's sero-status and ultimately to know how personal protection and the protection of others is ensured.

#### **4.7.2. Role of Mass Media in the Implementation of BCC and IEC programmes**

The mass media should initiate and support appropriate and effective HIV and AIDS, STI awareness, behaviour change, care and coping strategies. Mass media practitioners should be provided with the latest information to enable them to give up-to-date and accurate reports on HIV and AIDS.

Mass media practitioners should be encouraged to be circumspect and to adhere to journalistic ethics in the dissemination of information on HIV and AIDS, STIs in order to avoid the reinforcement of negative stereotypes, sensationalism, or stigma. The GAC should work with the National Media Commission to enforce these rules.

The GAC, in collaboration with other relevant bodies, should promote the widest possible media coverage of HIV and AIDS, STIs activities.

### **4.8. HIV Preventive Commodities**

HIV preventive commodities are essential to prevention interventions. These include male and female condoms, lubricants and any other commodities with a clear role in prevention, based on sound scientific evidence.

#### **Condoms and Lubricants**

The use of condoms and lubricants in the prevention of HIV and STIs is recommended. These commodities should be made affordable and accessible to members of the public, including key

populations and should be distributed widely in the public and private sectors at free or low cost and without restrictions on age or sexual behaviour.<sup>34</sup>

The quality of these commodities should be monitored regularly by the MoH or its accredited agencies.

#### 4.9. Sexually Transmitted Infections

Sexual transmission of HIV remains the predominant mode of transmission in Ghana. Epidemiological and biological studies provide evidence that, on the individual level, STIs and HIV are co-factors for HIV acquisition and transmission, especially for specific STIs that cause genital ulcer disease. STI clients have a higher prevalence of HIV infection.

This policy seeks to strengthen and complement the *Reproductive Health Service Policy and Standards (NRHSP-S)*, *Adolescent Reproductive Health Policy*, *National Reproductive Tract Infection Policy Guidelines* and *Sexually Transmitted Infections, Guidelines for Management*.<sup>35, 36, 37</sup>

In particular, this policy emphasises new areas, such as screening for Hepatitis B, immunisation against Hepatitis B and treatment for each client with reproductive tract infections and STIs. It also emphasises the screening and management of reproductive tract neoplasm, particularly cancer of the cervix and anus due to oncogenic human papilloma viruses (HPV).

#### 4.10. Interventions for Key Populations

Key populations are more likely to be exposed to HIV infection due to sexual behaviour and high HIV prevalence within their social networks. The HIV prevalence in these groups is much higher than the general population and they contribute a significant proportion of new HIV infections.<sup>38</sup> Based on 2010 data, approximately 41% of HIV infections are attributable to most-at-risk populations, MARPs, also known as key populations, with significant transmission among FSWs, their non-paying partners and clients and the primary sex partners of clients of non-paying partners.<sup>39</sup> There is therefore a need for targeted prevention interventions to reduce HIV prevalence.

Key populations should have access to information, prevention, treatment and mitigation services and the protection of human rights. Services available should be accessible, acceptable and affordable to key populations to encourage continuous engagement.

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<sup>34</sup>UNAIDS. *Making Condoms Work for Prevention*, pp. 18-20.

<sup>35</sup>MoH. *National Reproductive Tract Guidelines*. 2004.

<sup>36</sup>NACP. *Sexually Transmitted Infections, Guidelines for Management*. 2008.

<sup>37</sup>WHO. *Global Strategy for the Prevention and Control of Sexually Transmitted Infections: 2006–2011. Breaking the Chain of Transmission*. Retrieved from [http://whqlibdoc.who.int/publications/2007/9789241563475\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241563475_eng.pdf).

<sup>38</sup>GAC. *National Strategic Plan for Most at Risk Populations 2011–2015*.

<sup>39</sup>UNAIDS, *New Infections by Mode of Transmission in West Africa. A Multi Country Analysis*. 2010. UNAIDS: Dakar, Senegal.



### 4.11. Treatment as Prevention

This policy recognises the prevention benefits of effective treatment. Under the circumstances, treatment programmes will be assisted to develop strategies for demand creation, retention in care and adherence to ART, especially in hard-to-reach, key and vulnerable populations.

Treatment as prevention should be prioritised and applied when the evidence of its efficacy as a public health strategy to prevent infection is unequivocal and can be applied in the local context.

### 4.12. Pre-Exposure Prophylaxis

The use of ART by the negative partner in discordant, monogamous, heterosexual relationships and in other heterosexual relationships has resulted in a reduction in transmission to the negative partner in some but not all of the studies conducted in this area.

The use of ARVs for PrEP should be prioritised and applied when the evidence of its efficacy as a public health strategy to prevent infection is unequivocal and can be applied in the local context.

### 4.13. Male Circumcision

Male circumcision has been recognised as an intervention to prevent HIV transmission. Even though male circumcision is widely practised in Ghana, it is not applied by 100% of the male population. Where practised, it is recommended that male circumcision be continued. Where not practised, the policy encourages its adoption so as to reduce the risk of HIV transmission.

### 4.14. HIV and AIDS, STI Surveillance

#### 4.14.1. Definition of AIDS

For the purpose of AIDS surveillance, the expanded World Health Organisation (WHO) AIDS case definition is used.<sup>40</sup>

#### 4.14.2. Epidemiological Surveillance

This policy supports epidemiological surveillance by the MoH/NACP, GAC and other organisations to monitor the trends of the HIV epidemic throughout the country. The HIV Sentinel Survey (HIV HSS), an unlinked anonymous screening in selected sites among sentinel groups, should be supported until such time that better scientific protocols become available.

- **Notification and Reporting**

In view of the wider public health ramifications, notification of STIs and HIV is mandatory, using the decentralised local government system. AIDS case reporting should be undertaken using the Universal Case Reporting System and the Integrated Disease Surveillance Report (IDSR). The Universal Case Reporting System should also be used to report on STI syndromes and diagnosis, where applicable;

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<sup>40</sup>Expanded WHO AIDS Case Definition. 1994.



- **Deaths, HIV and AIDS-related Mortality**

As a matter of policy, a medical practitioner should state the contribution of HIV infection and AIDS to the death of a person when a death certificate is prepared. This should be in addition to any other medical condition the deceased may have had. This should be based on the *Registration of Births and Deaths Act, 1965* (Act 301); and

- **HIV and AIDS, STI Prevention and Control Law**

Further information on surveillance under the law is detailed in the chapter on human rights, legal and ethical issues.

#### **4.14.3. Behavioural Surveillance**

Behavioural surveillance should be conducted periodically among identifiable groups to monitor the impact of interventions in order to direct appropriate policy and programme modifications.

## 5. TREATMENT, CARE and SUPPORT

### 5.1. Introduction

The continual survival of persons living with HIV remains the rationale for the provision of treatment, care and support services. This policy aims to reduce HIV- and STI-related morbidity and mortality in infected persons through the use of effective medicines, ART, adequate nutrition and psycho-social and other support, as well as home-based care.

The policy seeks to provide universal access to these services and maintain the effectiveness by responding to new evidence as and when it becomes available. HIV treatment, care and support services are also an important extension of prevention. This is because treatment, if implemented judiciously, tends to result in reduced risk of transmission and by extension, a reduction in new infections.

This thematic area addresses the following: service delivery models, qualification for treatment and monitoring of patients in care and co-infections. Others are traditional remedies and alternative therapies, psycho-social support, nutrition, home-based care and social protection.

### 5.2. Treatment

This policy is to ensure that comprehensive, cost-effective and affordable care is made accessible to each PLHIV. The package will include the management of opportunistic diseases and antiretroviral therapy.

Treatment should be available without discrimination as to the source or behaviour that resulted in HIV infection and is to be provided without any pre-condition related to the person's behaviour, legal or otherwise.

### 5.3. Monitoring

This policy promotes the monitoring of patients under care in accordance with the national guidelines to prevent treatment-related toxicity, reduce loss to follow-up (LTFU) and slow the emergence of drug-resistant HIV strains. The monitoring of patients on antiretroviral drugs may be clinical, laboratory based and by defaulter tracing.

### 5.4. Co-infections

PLHIV co-infected with TB, hepatitis and other infections, which when untreated adversely affect the response to ART, should be offered specific treatment regimens in addition to ART, as specified in the national guidelines.<sup>41</sup> Individuals with co-infections should be prioritised for treatment and not denied treatment based on the presence of co-morbidities such as substance addiction and hepatitis B.

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<sup>41</sup>GHS. *Guidelines for the Management of Opportunistic Infections*. September 2011.

## 5.5. Traditional Remedies and Alternative Therapies

Under the existing practice within the health delivery system, after a clinical diagnosis of HIV and AIDS, STI has been made and confirmed, many people seek alternative or traditional medicine. Some of the traditional remedies have biological modifying properties and relieve symptoms, which some traditional and medical practitioners' mistake for a cure for HIV and AIDS. It is important for PLHIV to have the right to choose the type of treatment they want, but they should be given accurate information on orthodox, traditional and spiritual treatment to enable them make informed choices.

An enabling environment should be provided for the *Traditional Medicine Practice Act 2000 (Act 575)*, that provides the legal framework for the practice of traditional medicine in Ghana to be fully operationalised.

This policy promotes the education of traditional healthcare providers who use invasive procedures such as circumcision, skin piecing, scarification and blood-letting operations to enable them keep within the legal framework and use standard sterilisation and disinfection procedures.

Individuals who make claims of a cure for HIV and AIDS, STIs should be assisted by the MoH and accredited agencies to substantiate their claims in an acceptable scientific manner according to clearly laid down criteria. No product should be marketed and dispensed until the validation and certification by the appropriate authorities has been made by the Food and Drugs Authority.<sup>42</sup> Traditional medical practitioners should therefore not advertise drugs and claims of a cure for HIV until they have been certified by the appropriate agencies.

Traditional medical practitioners are encouraged to refer PLHIV, especially those on ART, to health facilities for care in order to reduce the development of drug resistance.

## 5.6. Care and Support

The policy encourages the creation and functioning of support groups, community home-based care groups and other organisations of people living with or affected by HIV.

### 5.6.1. Service Delivery Models

Under this policy, healthcare facilities should be equipped to offer services for the management of opportunistic infections according to the national guidelines. Healthcare facilities should provide integrated services or establish referral and co-ordination mechanisms with relevant providers.

### 5.6.2. Psycho-social Support

Counselling is an integral component of comprehensive healthcare. It enables the client to talk about, share, cope and deal with issues and decisions related to HIV and AIDS, STIs in an atmosphere of acceptance and trust. This policy advocates the fullest possible counselling for those infected or affected and for caregivers. An institution that offers HIV and AIDS, STI counselling should ensure that each counsellor, including PLHIV, is given appropriate training that is inclusive of understanding the specific needs and effective approaches to serve key and vulnerable populations.

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<sup>42</sup>Public Health Act, 2012 (Act851)

### 5.6.3. Nutrition <sup>43</sup>

Due to the complex interactions between nutrition and HIV and the increased risk of opportunistic infections, food insecurity and malnutrition, the provision of adequate food and nutrition is a critical need for people living with or affected by HIV and tuberculosis. Nutrition assessment, counselling and support that includes food assistance to PLHIV will help to promote adherence to antiretroviral treatment and ensure that the nutritional status of this vulnerable, at-risk population does not decline further. Household members and caregivers of food-insecure PLHIV may also benefit from a household ration to ensure that PLHIV obtain the needed nutrition for their regimen.

In order to sustain the improved nutritional status of PLHIV who are phased out of the food assistance programmes due to the improvement in their nutritional status, PLHIV should be linked with community-based food security and economic strengthening opportunities such as income-generation activities. The following additional policies are recommended in the national nutritional policy:

- Nutritionally vulnerable groups, the aged, PLHIV and those in emergency situations should receive improved care and access to adequate and safe diets.
- Nutrition support should be fully integrated into the routine package of services available to PLHIV and TB patients. PLHIV and TB patients should be targeted to receive nutrition assessment, counselling and support based on their nutritional status.
- Severely malnourished adults living with HIV or TB should be monitored weekly and bi-weekly and should receive nutrition supplements, such as ready-to-use therapeutic foods (RTUF) with or without fortified blended food (FBF).
- Moderately malnourished PLHIV should also receive FBF and their food-insecure households should be offered assistance.
- Infants and children who have severe or moderate acute malnutrition and are exposed to HIV or are infected, should be managed for acute malnutrition in accordance with treatment protocols for the management of children with acute malnutrition. Operational research will be conducted to inform the treatment protocol for the target group.
- This policy enjoins the MoH to provide leadership for the integration of nutrition in other health programmes, such as those focused on HIV and AIDS, integrated management of childhood illness (IMCI), maternal health and school health.

Further information on nutritional care and support for PLHIV can be found in guidelines produced by the Ghana Health Service.

### 5.6.4. Home-Based Care

In accordance with the *National Home-based Care Policy and Guidelines*, community home-based care (CHBC) services should be provided to PLHIV who require this intervention.<sup>44</sup> The GAC will liaise with partners and communities to leverage funds for CHBC.

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<sup>43</sup>GHS. *National Policy on Nutrition, 2012. Guidelines on Nutritional Care and Support for People Living with HIV and AIDS*. 2006.

<sup>44</sup>GAC. *Home-based Care Policy. 2012*, in preparation.

#### **5.6.5. Social Protection**

PLHIV, OVC and vulnerable caregivers should be assisted to benefit from the Social Protection Strategy that targets vulnerable and poor people, the aged, persons with disabilities, PLHIV, OVC and lactating and pregnant PLHIV, among others.<sup>45</sup>

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<sup>45</sup>GoG, MMYE. *National Social Protection Strategy*. 2007.

## 6. MITIGATION OF SOCIAL AND ECONOMIC EFFECTS OF HIV AND AIDS

### 6.1. Introduction

The spread and impact of HIV in Ghana has been influenced by the socio-cultural, economic and legal environments. Individuals, households, extended families, communities and public and private sector institutions have each been affected by HIV. This is reflected in the rising numbers of PLHIV and OVC that has increased the burden for caregivers and increased the vulnerability of households to effectively cope with the many challenges of the HIV infection.<sup>46</sup>

Stigma and discrimination, together with issues of sexuality, gender and differences in cultural practices and socio-economic status across regions, continues to undermine efforts to address the HIV and AIDS epidemic. Unequal gender relations, which include gender-intensified situations and gender-imposed constraints, call for a holistic approach for change in the nature of development beyond mere gender, sexuality and vulnerability of women. This should involve each sector of the economy and address barriers presented by masculine and feminine gender norms and stereotypes.<sup>47</sup>

In the past, the international community has focused mainly on HIV prevention in developing countries, but there is now a global consensus that a strategic approach to the HIV epidemic must integrate prevention, care and support with mitigation.<sup>48</sup>

The goal for mitigation is to alleviate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels. Key mitigation efforts include:

- The reduction of stigma and discrimination against PLHIV, key and vulnerable populations;
- Addressing the impact of gender norms and stereotypes;
- Addressing the impact on households and caregivers; and
- Access to basic needs for PLHIV, orphans and vulnerable children.

### 6.2. Reduction of Stigma and Discrimination

A major objective of mitigation is to reduce HIV-related stigma and discrimination towards persons infected or affected by HIV and AIDS, as well as key and vulnerable populations and draw attention to the compelling public health rationale to overcome stigmatisation and discrimination against them

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<sup>46</sup>Ghana AIDS Commission. *National HIV & AIDS Strategic Plan 2011–2015. Towards Achieving Universal Access to Comprehensive HIV Services*. December 2010.

<sup>47</sup>Seeley, J., R. Grellier and T. Barnett. August 2004. "Gender and HIV/AIDS Impact Mitigation in sub Saharan Africa – Recognizing the Constraints." *Journal of Social Aspects of HIV/AIDS* 1(2): 87–98.

<sup>48</sup>Berkman, Alan, Jonathan Garcia, Miguel Munoz-Laboy, Vera Paiva and Richard Parker. 2005. "A Critical Response to the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries." *Am J Public Health* 95: 1162–1172.

in society. This policy seeks to mitigate stigma and discrimination through information, collaborative multisectoral advocacy, policy and monitoring.<sup>49</sup>

### **6.2.1. Information**

The goal is to provide accurate information, address fears, misconceptions and myths about HIV and AIDS. It is also to increase the understanding of the consequences of stigma and its effects on HIV vulnerability.

The Government should ensure that each person has equal access to culturally acceptable and age-appropriate formal and non-formal HIV and AIDS, STI information and education programmes that are adequate and sound. This should include free and accurate information on mother-to-child transmission, breastfeeding, treatment, nutrition, change of lifestyle and safer sex and the importance of respect and non-discrimination of persons living with HIV and STIs, as well as key and vulnerable populations.

This policy advocates that age-appropriate, sound adolescent sexual and reproductive health education that includes HIV and AIDS, STI be integrated into school curricula as subjects that undergo regular student assessment.

### **6.2.2. Collaborative Multisectoral Advocacy**

The goal of advocacy is to build and strengthen the commitment of each stakeholder to reduce HIV-related stigma and discrimination.

Under this policy, public and private sector leadership should develop sector-specific stigma and discrimination mitigation strategies and speak out publicly against stigma and discrimination of PLHIV and key and vulnerable populations.

### **6.2.3. Policy**

The goal of this policy is to strengthen and utilise legal and policy resources to support a rights-based response to HIV-related stigma and discrimination.

The Government should ensure that existing laws and policies provide protection against HIV-related stigma and discrimination. The general population should be educated on their rights. Systems should also be established to provide redress when rights are abused.

It should be an offence to incite hatred or contempt, or ridicule PLHIV or key and vulnerable populations.

### **6.2.4. Monitoring**

The Government should conduct periodic population-based surveys to measure levels of HIV-related stigma and establish systems to provide regular reporting of cases of discrimination.

## **6.3. Addressing the Impact of Gender Norms and Stereotypes<sup>50</sup>**

Throughout prevention, care and treatment programmes, providers should incorporate understanding and approaches to address the impact of gender norms on health seeking, decision making,

<sup>49</sup>South Africa Department of Health. *Stigma Mitigation Framework*. 2010. Retrieved from <http://hivstigma.clientdemo.co.za/resources/legislation,-policy-and-guidelines/south-african-resources/stigma-mitigation-framework.aspx>.

<sup>50</sup>Retrieved from [http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/).

behaviour change and access. HIV and AIDS, STI programmes should integrate messages and approaches with programmes that address gender-based violence, education and economic security.

The Government should:

- Collect and use sex and age-disaggregated data to monitor and evaluate the impact of programmes on different populations;
- Ensure meaningful participation of women, men, PLHIV, key and vulnerable populations in the planning, design and monitoring of programmes; and
- Support programmes with partners that strengthen the role of parents and guardians to shape positive attitudes and the behaviour of children and young people as regards sexuality and gender norms in the context of HIV and AIDS, STIs.

#### 6.4. Addressing the Impact on Households and Caregivers<sup>51, 52</sup>

AIDS-affected households face increased expenses, including healthcare, food, transportation and burial costs. They also face decreased income, as AIDS often claims lives of men and women in their most economically productive years. HIV and AIDS alter family structures because when adults die, children become household heads and take care of other orphaned children. The majority of older caregivers are women who face serious financial, physical and emotional stress due to their belated caregiving responsibilities.

Under this policy, the government should provide concrete support for older people, such as social pensions. Healthcare providers should be trained on gerontological, ageing and issues of ageing, aspects of HIV and AIDS, STIs, to enable them provide psychological and medical support for older people living with sick family members. Also, older people should be included in HIV and AIDS, STI education training programmes.

The Government should ensure that community home-based care is an integral and budgeted element of the National HIV and AIDS Strategic Plan, including direct assistance to families affected by HIV and AIDS. This policy recommends political and financial support for community mobilisation efforts to increase access to HIV information and support services.

The Government should ensure that caregivers have information on HIV prevention, treatment, care and support, as well as access to training and referral back-up support. Basic supplies and resources to support children orphaned and made vulnerable by AIDS are required. These resources should be tailored to those most likely to provide care, with a strong focus on women, including older women and girls.

Caregivers should have access to affordable basic shelter, land to grow crops or raise animals and other income-generating opportunities, including microcredit programmes to improve their quality of life.

Providers should address the overall health and specific psycho-social needs of caregivers, in particular older women and young girls, through the provision of counselling and other assistance.

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<sup>51</sup>Retrieved from

[http://data.unaids.org/pub/factsheet/2006/20060719\\_gcwa\\_fs\\_support\\_women\\_caregivers\\_en.pdf](http://data.unaids.org/pub/factsheet/2006/20060719_gcwa_fs_support_women_caregivers_en.pdf).

<sup>52</sup>Retrieved from <http://www.who.int/ageing/projects/hiv/en/index.html>.



Organisations and individuals working with caregivers should be involved in the design, implementation and monitoring of HIV prevention, treatment, care and support programmes at the national and community level.

Programmes should encourage and support men and boys to share the responsibility of caring for PLHIV.

### 6.5. Access to Basic Needs for PLHIV and OVC

The objective of provision of basic needs for PLHIV and OVC should ensure legal and appropriate social and community safety nets for them and other persons made vulnerable by HIV and AIDS. Basic needs for PLHIV include psycho-social support, health, food and nutrition, shelter and income. In addition, OVC require education and protection.

Government and partners should support the development of adequate, accessible, sound and effective HIV and AIDS, STI information, education, treatment and support programmes by and for vulnerable populations, which should actively be involved in the design and implementation of the programmes.

The capacity of the Government and other stakeholders should be improved to promote the rights and well-being of OVC and other groups made vulnerable by HIV, such as caretakers.

The Government should ensure that HIV infected and affected persons and OVC have access to appropriate legal, social and community protection schemes and safety nets outlined in the *National Plan of Action for Orphans and Vulnerable Children*<sup>53</sup> and the *National Social Protection Strategy (NSPS)*, such as Livelihood Empowerment Against Poverty (LEAP), the Local Enterprises and Skills Development Programme (LESDEP) and provisions under the NHIS.

Priority should be given for legal aid and support to PLHIV and OVC.

This policy recommends that education should be made available to OVC, especially girls.

Resources should be identified to address barriers such as tuition, cost of books, supplies and uniforms. Girls should not be expelled from school because of pregnancy.

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<sup>53</sup>Ministry of Employment and Social Welfare and Employment and UNICEF. *Ghana National Plan of Action for Orphans and Vulnerable Children June 2010–2012*.

## 7. HEALTH SYSTEMS STRENGTHENING

### 7.1. Introduction

To enhance the overall efficiency of the health sector response to HIV and AIDS, strategies, resources and inputs must be integrated within the health system. A strengthened health system is a prerequisite for improved health outcomes. Health systems strengthening refers to an array of initiatives or strategies that improve the functions of a health system and lead to better health outcomes. In strengthening Ghana's health system, systemic barriers or factors that may limit the achievement and sustainability of Ghana's overall HIV and AIDS, STI response objectives must be identified and addressed. This is based on the six health system strengthening building blocks identified by WHO—leadership and governance, human resources for health and physical infrastructure, health service delivery, health management information system, health technologies and health financing.

This policy seeks to ensure that strategies, resources and inputs for HIV and AIDS are integrated within the health system to enhance overall efficiency of health outcomes. The strategies include resource mobilisation, equitable and sustainable funding of the health sector in alignment with existing health sector policies and strategies.

### 7.2. Leadership and Governance

The Government should take the leadership role in the development of strategic health plans, identification and implementation of interventions and the policy changes required to achieve the mission and vision of the MoH, particularly in relation to the overall national HIV response. Leadership development should be systematically pursued at each level of the health service to facilitate the attainment of sustainable national HIV response.

The MoH, through the National AIDS and STI Control Programme, must provide prevention, treatment, care and support services, as well as strategic information such as surveillance data for action.<sup>54</sup>

The GAC should provide an enabling policy environment that enjoins accountable and performance-oriented institutions to provide effective, collaborative partnerships for HIV and AIDS, STI within the health sector and with other MDAs, the private sector, nongovernmental organisations (NGOs) and communities. The GAC should ensure transparency and accountability of key actors through monitoring and supervision. It should focus on the involvement of a wide range of partners in the decision making process in the best interest of PLHIV and key populations.

The MoH should partner with stakeholders and foster multisectoral collaboration to improve health and non-health aspects of development in the HIV and AIDS, STI setting.

### 7.3. Human Resources and Physical Infrastructure

Recruitment, training, retention and development of adequate numbers of staff with fair and equitable distribution are required to ensure an effective and efficient national HIV response. In this regard, a

<sup>54</sup>NACP, GHS. *2011 HIV Sentinel Survey Report*. 2012.

comprehensive health worker retention policy must be developed by the Ministry of Health and implemented in partnership with the private sector, CSOs and NGOs.

This policy supports evidence-based research to assess the capability of training and deploying lower cadres in the health sector to deal with PLHIV and key populations without compromising quality or increasing risk to clients and patients.

To serve the best interest of PLHIV and key populations, the Government should ensure that training curricula for law enforcement, the judicial service, the Prison Service and teachers are strengthened to include the following:

- Ethics and human rights, including consent and confidentiality;
- Stigma and discrimination;
- Domestic and gender-based violence;
- Human sexuality and reproductive health;
- The specific needs of key and vulnerable populations;
- Referral mechanisms between law enforcement and medical and harm reduction services; and
- HIV and AIDS, STI, TB and drug dependence.

In line with MoH policies and strategic plans on infrastructure, there should be a systematic way to increase the construction of new structures, rehabilitate and upgrade old ones, making them functional to support health service delivery.

#### **7.4. Health Services Delivery**

Health services and access to quality health services must be available at each decentralised level. The full range of evidence-based services should be available at one site, if possible, or at different places through effective referral systems by the establishment of strong linkages among the different service providers and services such as HIV and AIDS, STI, TB, family planning, PMTCT, child health, psycho-social support and other health services.<sup>55</sup>

Under this policy, the Government should facilitate universal access to HIV prevention, testing, treatment, care and support services to each person who needs them, including antenatal care and PMTCT for pregnant women. The percentage of women who access these services should be monitored to determine universal access in accordance with the practice to prepare reports on clinical areas periodically.

A systematic approach towards integrated HIV/TB/RH and other services should be undertaken throughout the country and primarily at the level of service provision.

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<sup>55</sup>Retrieved from [http://www.ghanahealthservice.org/documents/MainTextTechnical\\_Policy\\_Guidelines TB/HIV](http://www.ghanahealthservice.org/documents/MainTextTechnical_Policy_Guidelines_TB/HIV), 31 Jan 2007.pdf.

## **7.5. Health Technologies/Procurement and Supply Management**

Government and relevant agencies must ensure the equitable and timely access to essential medical products, vaccines and technologies of assured quality, safety and efficacy that are scientifically sound and cost-effective for PLHIV and key populations.

The National Essential Medicines Policy should ensure access to standard-of-care therapies for HIV and AIDS, STIs, TB and OIs.

Co-ordinated Health Commodity Security Strategies should be implemented with co-ordination by stakeholders through inter-agency co-ordination mechanisms. These strategies should include financial sustainability plans to deal with the AIDS response. Regular information on commodity security should be provided by the Ministry of Health to the Inter-agency Task Team for informed decision making.

Policies and strategies should be developed by relevant state agencies to implement a robust system that carries out appropriate studies to monitor the emergence of antimicrobial drug resistance, including resistance to ARVs, as well as drug potency and efficacy assay. These policies and strategies should address sub-standard drug production and distribution, as well as counterfeit medicines and test devices for condoms and other devices.

## **7.6. Health Financing**

The Government has an explicit responsibility to reduce out-of-pocket expenditures over time, especially for PLHIV and key populations.

The Government should develop sustainability plans as to how existing programmes and plans can be implemented without development partner support. New and existing projects or programmes that rely on development partner funds should develop financial sustainability plans and implement them.

Advocacy should also be heightened to include ARVs and family planning services and commodities in the NHIS Package. Efforts should be made to ensure that measures are put in place to facilitate local production of ARVs through partnerships between the public and private sector.

Advocacy should be heightened for the establishment of the HIV and AIDS Fund, which when established and in operation, will provide long-term sustainable funding for the national response.

## **7.7. Health Management Information Systems (HMIS)**

Health information systems should be computerised and web-based. Capacity should be developed for their use on a large scale.

A policy framework should be developed for multisectoral co-ordination mechanisms to guide the investment and development of health information systems.

A national monitoring and evaluation plan based on data needs and sources should be developed for HIV and AIDS.

Monitoring and evaluation functions should be strengthened and integrated into the national managerial process through the implementation of effective information systems.

The Government should establish mechanisms to review the utility of current indicators for planning, management and evaluations processes and adapt and modify them accordingly.

#### **7.7.1. Research**

Population-based surveys should be conducted by relevant agencies at specified times to augment service data. These should include the:

- Ghana Demographic and Health Survey (GDHS);
- Integrated Bio-Behavioural Surveillance Survey (IBBSS);
- HIV Sentinel Survey (HIV SS);
- Multiple Cluster Indicator Survey (MICS); and
- AIDS Indicator Survey (AIS)

## 8. COMMUNITY SYSTEMS STRENGTHENING

### 8.1. Introduction

HIV prevention requires a process that strengthens community systems. Community systems promote the development of informed supportive communities for PLHIV and key populations and community-based structures that enable them to contribute to the longer-term sustainability of health and other interventions. Community systems strengthening (CSS) permits the development of an enabling and responsive environment in which these contributions can be effective to deal with the HIV epidemic.

### 8.2. Enabling Environment and Advocacy

Community actors, women, youth organisations and health actors should work together to develop and manage systems that they will use jointly to deliver activities and services for communities. This will result in outputs that lead to health outcomes and other outcomes that will contribute to improvements in health.

Key actors in community systems include traditional rulers, faith-based organisations, volunteers, NGOs and CBOs. Other key actors include health personnel who provide treatment, community health interventions and health promotion. Key sector players are from education, commerce, economic development, labour, justice and uniformed service sectors.

### 8.3. Community Activities and Services

Programmes in the community should be evidence informed, cost-effective and sustainable and should be in line with universal access requirements. They include counselling, legal support, policy advocacy and home-based care in accordance with the *National Home-based Care Policy and Guidelines*. Legal support for PLHIV and key populations should make use of the Legal Aid Scheme under the *Legal Aid Scheme Act, 1997* (Act 542) and private legal support from public interest lawyers.

The GAC should collaborate with public and private legal aid services to mount legal aid clinics for key and vulnerable populations. Other activities for collaboration with partners include stigma reduction programmes, treatment literacy and education to alleviate discrimination.

### 8.4. Community Networks, Linkages, Partnerships and Co-ordination

Community networks should provide health services that include treatment, community health interventions, reduction of stigma and discrimination and health promotion.

Partnerships should encourage activities that indirectly relate to health but improve the enabling environment for health, such as advocacy campaigns to promote literacy rights for access to information and gender awareness programmes.

For successful community engagement, networks, linkages, coalitions and partnerships are encouraged. This will result in shared approaches, advocacy initiatives and appropriate representation of community needs in a co-ordinated and collaborative environment. This should be done through the District AIDS Committees (DACs), with the assistance of the social services sub-committees of the district assemblies, in collaboration with CHRAJ. Strengthened formal and informal relationships

will lead to a more effective use of resources and avoid duplication. Linkages and partnerships should collect data on abused PLHIV and key populations from the Domestic Violence and Victims Support Unit (DOVVSU) and district assemblies for GAC to compile for the Ghana Statistical Service.

### **8.5. Resources and Capacity Building**

Project funds for specific operational activities and services in communities should include operational and core funding, as well as material resources for infrastructure, information, essential medical and other commodities and technologies. Capacity-building programmes for stakeholders engaged in CSS programmes should include training for management, accountability leadership and income-generating projects. Regularising the legal status for NGOs and CBOs, where applicable and independent audits of finances should be encouraged and supported. Capacity for project design, the preparation of business plans and increased transparency and accountability through stakeholder meetings with community members should be the standard approach.

GAC should develop guidelines for community-level HIV prevention in order to facilitate the systematic development of CSS programmes and implement joint community-level prevention strategies. They should be multisectoral, inclusive of government, nongovernmental and for-profit enterprises; sensitive to community transmission dynamics; and should optimise existing resources.

### **8.6. Output of Strengthened Community Systems**

Strengthened community systems should cause improved outcomes for health and well-being, respect for people's health, other rights and protection from social and financial risk. Effective community systems should result in improved responsiveness and effectiveness of interventions by communities in health, social support, education and other services.

CSS will improve access to and the utilisation of formal health services and will also increase community engagement in health and social care, advocacy, health promotion and health literacy. CSS should lead to health monitoring, home-based and community-based care and be strongly supported as a policy intervention that will improve decentralisation and involvement of the grass roots in the prevention of HIV.

## 9. PUBLIC SECTOR POLICY, ROLES AND RESPONSIBILITIES

### 9.1. Introduction

The public sector has the responsibility to provide an enabling policy environment to achieve the nation's development goals and objectives. The national population and development agencies (NDPC, NPC) and other public sector institutions are important in the national HIV response and therefore should contribute to multiple levels. Key line ministries have been identified as critical to successfully mainstream HIV in the public sector and are therefore expected to incorporate HIV issues into their core business. Specific MDAs responsible for youth, the aged, women and children and the poor and destitute, including the mentally and physically challenged, should develop HIV interventions strategies and programmes to mitigate the effects of HIV and AIDS, STIs on these populations, using national guidelines. Each of the MDAs should integrate gender issues in HIV-related strategies and interventions.

Generally, MDAs should:

- Provide relevant policy guidelines on HIV and AIDS, STI prevention to guide implementation of activities at different levels;
- Plan for and allocate resources for the implementation of HIV and AIDS, STI prevention activities for staff, as well as for target groups reached through the routine activities of the MDAs;
- Implement, co-ordinate and monitor HIV and AIDS, STI prevention activities; and
- Utilise mechanisms and instruments that are available for the co-ordination and evaluation of the national response to the HIV and AIDS, STI epidemic.

### 9.2. Role of Coordinating Bodies and Key Ministries, Departments and Agencies (MDAs)

#### 9.2.1. The Office of the President and Parliament

##### 1. The Office of the President should:

Provide high-level advocacy, political leadership and adequate funding for the national response through GAC and ensure the involvement of each sector of government.

##### 2. Parliament should:

- Provide overall gender-sensitive legislative and political support, pass Bills that are responsive to the dynamics of HIV and AIDS, STIs, to provide legislation for new areas and reform existing laws to facilitate the implementation of this policy;
- Spearhead and mobilise social support for HIV and AIDS, STI activities, both within Parliament and at the constituency level;
- Engage in policy dialogue towards the eradication of discriminating and stigmatising provisions that affect PLHIV and key and vulnerable populations;



- Initiate the review of laws in population and reproductive health, including HIV and AIDS, STIs and ensure that the resources required are made available to observe and enforce these laws; and
- Provide high-level advocacy in support of programmes by NGOs and CBOs for key and vulnerable groups in their constituencies.

### **9.2.2. The Ghana AIDS Commission**

The Ghana AIDS Commission, as the supra-ministerial body with multisectoral representation, is mandated to provide effective leadership in the response to HIV and AIDS, STIs and to coordinate the interventions of stakeholders through joint planning, monitoring, evaluation and advocacy.

The functions of the Commission are to:

- Formulate comprehensive national policies and strategies and establish programme priorities that relate to HIV and AIDS;
- Provide high-level advocacy for HIV and AIDS, STI prevention and control;
- Provide effective leadership in national planning and the co-ordination of support services;
- Expand and co-ordinate the total national response to HIV and AIDS, STI;
- Mobilise, control and manage resources and monitor their allocation and utilisation;
- Foster linkages among stakeholders;
- Promote research, information and documentation on HIV and AIDS, STIs; and
- Monitor and evaluate ongoing HIV and AIDS, STI activities.

### **The Secretariat of GAC**

The Secretariat of the Ghana AIDS Commission is responsible for co-ordination, management of funds, monitoring and supervision of the national HIV and AIDS, STI-related policies, strategies, plans and communication, including social mobilisation. It should be supported by the activities of the National AIDS/STI Control Programme, which should provide critical technical leadership in areas such as surveillance, laboratory services, blood safety, care and support for PLHIV and research.

### **9.2.3. Regional, Metropolitan, Municipal and District (MMDAs) AIDS Committees on HIV and AIDS, STIs**

The Regional, Metropolitan, Municipal and District AIDS Committees are to co-ordinate, monitor and supervise HIV and AIDS, STI activities at their respective levels and implement national policies formulated by GAC.

Regional AIDS Committees and MMDAs are to be chaired by Regional Ministers and Metropolitan, Municipal and District Chief Executives, respectively.

The composition of the regional and MMDAs AIDS Committees should reflect that of the national body to include MDAs, NGOs, religious bodies, youth and women's organisations, the private sector, PLHIV and research institutions. At the MMDA level, they should be empowered to support community-level activities and be responsible for community systems strengthening.

### **Training and Institutional Capacity Building**

The availability of trained personnel for the management of the components of HIV and AIDS, STI prevention and care programmes is a prerequisite for any successful control of the epidemic in Ghana. In this respect, the Government should:

- Ensure the effective transfer of skills and the institutionalisation of in-country capacity development in HIV and AIDS, STI advocacy;
- Decentralise expertise in support of multisectoral decision making at each levels;
- Ensure the integration of the national HIV and AIDS, STI response in pre-service and educational training programmes of MDAs and NGOs; and
- Promote the regular update of the knowledge of physicians, nurses/midwives and other health professionals to ensure the optimal management and care for HIV and AIDS, STI cases.

GAC is mandated to provide leadership, co-ordination and management of the national HIV response. GAC should ensure that stakeholders, partner MDAs, the private sector, CSOs, the media and development partners align their programmes to its strategic plans.

#### **9.2.4. The National Development and Population Agencies**

**1. The National Development Planning Commission (NDPC)** is mandated to advise the President of the Republic on national development policy and strategy. It is also responsible for the co-ordination of the decentralised planning system. The NDPC has therefore provided the *National Development Policy Framework* (NDPF) to reflect HIV and AIDS. The *NDPF* is implemented through development plans prepared by the Ministries, Departments and Agencies, as well as through the MMDAs in relation to planning guidelines issued by the NDPC. Each MDA therefore has a unique response to achieve the outcome and impact targets determined by the *NSP (2011–2015)*. However, some MDAs are recognised as critical for and key to the improvement of the public sector contribution to the national HIV response and their expected roles to combat HIV and AIDS, STI are stipulated in this policy. Key MDAs should identify strategies to mainstream and co-ordinate an HIV response, either through direct service delivery or through referral systems in their medium-term development plans. These strategies will include information on:

- Environments and circumstances where HIV-risk behaviour takes place;
- MDA-specific responses to reduce risk and provide services;
- MDA-specific strategies for referral and co-ordination of services; and
- MDA-specific strategies to protect the human rights of key and vulnerable populations

#### **2. National Population Council**

The NPC should:

- Promote the integration of HIV and AIDS, STI issues into national population programmes; and
- Advocate for and support the effective co-ordination and implementation of HIV and AIDS, STI policy and programmes. In this regard, the Regional Population

Advisory Committees (RPACs) and District Population Advisory Committees (DPACs) that are multisectoral in nature will be proactive and work with GAC and other partners to harmonise HIV and AIDS, STI programmes at the regional and district levels.

#### **9.2.5. The Ministries, Departments and Agencies**

MDAs are encouraged to design, implement, monitor and evaluate sector-specific HIV and AIDS, STI prevention, care and support programmes for their employees. The key line Ministries include, but are not restricted to:

##### **1. Ministry of Health (MoH)**

The MoH and GHS should take the lead role in HIV and AIDS, STI interventions and programmes. Specifically, MoH will function as the “technical lead ministry” in HIV and AIDS, STI prevention and care to:

- Lead the development and refinement of strategies for prevention and care in the areas of HTC, antiretroviral therapy, PMTCT, provision of care and support to PLHIV, counselling and home-based care, among others. MoH/GHS should collaborate with the GAC, MDAs, NGOs and the private sector to carry out this mandate;
- Provide technical support to GAC and other ministries and sectors as they develop and implement their AIDS prevention and care activities;
- Continue with the implementation of health sector-based interventions to prevent the sexual, blood-borne and mother-to-child transmission of HIV in particular and of STIs in general;
- Promote the proper use of both the male and female condoms;
- Set guidelines in HIV counselling for prevention and testing; and
- Provide appropriate health facility-based care for persons with HIV-related conditions and AIDS, including counselling and home-based care and support.

MoH/GHS should therefore have the authority to provide HIV prevention, treatment and care services for every person in the country. The health sector should mainstream HIV into its core business. The National AIDS and STI Control Programme of the MoH/GHS should coordinate the national HIV response within the public, private and NGO/FBO health sectors, while the GHS should provide HIV prevention, treatment, care and support services through public health facilities nationwide.

##### **2. Ministry of Local Government and Rural Development (MLGRD)**

As a key stakeholder, the MLGRD should:

- Promote and ensure decentralisation and mainstreaming of HIV and AIDS, STI interventions and programmes at each decentralised level, the Regional Co-ordinating Council and Metropolitan, Municipal and District Assemblies, with the meaningful involvement of PLHIV and key populations;
- Facilitate the implementation of HIV and AIDS, STI prevention and care activities, in collaboration with GAC and through the Regional Co-ordinating Councils, District Assemblies and various extension and outreach services for other target groups;

- Ensure that sufficient financial resources, manpower and other resources are available for the implementation of the intensive and extensive prevention programmes needed to slow down the epidemic, within available resources and as reflected in the HIV and AIDS, STI Plans, integrated into the Medium-Term Development Plan (MTDP);
- Mobilise the community through existing and new structures for its involvement at each stage of the development and implementation of HIV and AIDS, STIs prevention and care programmes and activities; and
- Ensure co-ordination and provide leadership for programmes at the district level.

### 3. Ministry of Employment and Labour Relations (MoELR)

MoELR should be adequately resourced to deal with the poor, OVCs, young girls and boys, the aged and the destitute and physically challenged who are infected or affected by HIV and AIDS and other STIs. The sector already administers the NSPS, with its sub-component, the LEAP programme. The LEAP programme in turn has many other sub-components, which are implemented by other sector ministries. One such sub-component is the national OVC Support Programme administered by the Department of Social Welfare (DSW) through the OVC-related section of the *National Plan of Action for Social Protection*. These and other projects, which will benefit those infected and affected by HIV and AIDS, STIs, should be resourced by the government when development partner support pulls out.

### 4. Ministry of Education (MoE)

MoE, utilising official information provided by the appropriately designated institution(s), should integrate instruction on the causes, modes of transmission, consequences, means of prevention and control of HIV and AIDS and other sexually transmitted diseases in subjects taught in public and private schools at primary, secondary and tertiary levels and include them in informal, non-formal and indigenous learning systems.

The formulation and adoption of the appropriate course content, scope and methodology at each educational level should be determined after consultation with the relevant stakeholders, with meaningful involvement and participation of PLHIV and key and vulnerable populations.

The course content should include sexual and reproductive health rights and gender equality issues, as well as the acceptance of PLHIV and members of key and vulnerable populations.

The MoE should ensure that each teacher or instructor of an HIV and AIDS prevention and control course is properly trained, duly qualified and adequately resourced to teach the course.

The MoE's sectoral HIV activities are to be guided by an Educational Sector HIV and AIDS, STI Policy and Workplan and will also:

- Involve parents, through parent-teacher associations and other appropriate mechanisms, in discussions on school-based HIV and AIDS, STI education and other programmes or activities;
- Ensure that other services related to HIV and STIs control and care are accessible to students in need; and

- Collaborate with relevant MDAs to develop and strengthen HIV and AIDS, STIs programmes for young people.

#### **5. Ministry of Food and Agriculture (MoFA)**

With its widely dispersed country-wide network of extension field workers, MoFA should use its auspices to provide HIV prevention information and education to its constituents. The sector should link up with other MDAs.

#### **6. Ministry of Gender, Children and Social Protection**

Ministry of Gender, Children and Social Protection and MoH, in collaboration with key national and local stakeholders and with the meaningful involvement of PLHIV, should develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of women and girls in the context of HIV, especially as regards gender-based violence. The Ministry should integrate gender in HIV-related strategies and interventions. The Ministry's Department of Children (DoC) should coordinate and monitor the child-related activities of various agencies, in the home, schools, remand homes and police facilities. It should also share administrative responsibility with MoELR for OVC support programmes and projects.

#### **7. Ministry of Chieftaincy and Traditional Affairs**

Chieftaincy is one of the most important and revered traditional institutions in Ghana. Chiefs and traditional rulers are the custodians of cultures and norms, some of which have some profound bearing on behaviours that influence contracting and transmitting HIV and how we relate to people living with or affected by HIV. Traditional belief systems, gender and power relations and sexual mores and behaviours have the power to influence the course of the HIV epidemic in the country. The Ministry of Chieftaincy and Cultural Affairs should play an important role to reduce the spread of HIV and the stigma and discrimination surrounding the disease. Adequately resourced national and regional Houses of Chiefs should effectively support HIV and AIDS, STI interventions within their traditional jurisdictions. National House of Chiefs, Queen Mother's Associations and traditional authorities, as custodians of national cultural heritage, should:

- Provide the necessary leadership to eliminate negative cultural practices which militate against the empowerment of women and increase their vulnerability to HIV and AIDS, STIs;
- Uphold the nation's cherished traditional family values and ensure that these are taught to young people;
- Use their position of influence to oppose discrimination against HIV-infected persons; and
- Support appropriate intervention measures against HIV and AIDS, STIs.

#### **8. Ministry of Youth and Sports (MoYS)**

The MoYS should provide an enabling environment that ensures that the youth have access to youth-friendly HIV prevention information and services to prevent the transmission of HIV and other STIs. The MoYS, as the co-ordinating body for youth activities, is mandated to lead the national HIV response among youth and youth organisations. It should target them with

information, education and HIV testing and counselling. Campaigns that promote abstinence, mutual fidelity and correct and consistent condom use among sexually active youth should be their focus. This should target key and vulnerable youth, especially street youth, the poor and destitute and the physically and mentally challenged. The youth should be treated as the priority target group in the country's quest to create a generation free of HIV.

#### **9. Ministry of Interior**

The Ministry of Interior holds responsibility for the Ghana Police Service, the Immigration Service and the Ghana Prison Service and should develop and implement strategies, policies and programmes that respect, protect and fulfil the human rights of prisoners and service personnel. Prisoners are a vulnerable group and a key population in the spread of the infection to the general population on discharge and in the absence of HIV prevention, treatment and care services within the prisons. Thus, these key populations should be given the necessary care and support.

#### **10. Ministry of Defence**

The prevalence of HIV among the military and other service personnel is usually not made public. The military should however put in place very strong and comprehensive HIV and AIDS, STI programmes that should ensure non-discrimination.

#### **11. Ministry of Tourism, Culture and Creative Arts**

The tourism sector's potential as a source of HIV transmission is widely acknowledged. This Ministry and its agencies should be given direct oversight responsibility for the hospitality and tourism industry in matters related to HIV and AIDS, STI transmission, treatment, care and support within its sector. The Ministry of Tourism should develop and implement strategies, policies and programmes that respect and tackle HIV and AIDS, STIs in its sector.

#### **12. Ministry of Finance (MoF)**

MoF should ensure that HIV and AIDS, STI programmes are mainstreamed in the sector budget and ensure adequate and timely releases of government commitment towards implementation of the strategic plan.

In collaboration with recipient line ministries, MoF should solicit and co-ordinate donor support and other financial contributions for HIV and AIDS, STI prevention, care and support.

As a financial resource allocator and planner, the MoFEP should steer the course of poverty reduction to the benefit of vulnerable populations, including PLHIV and key and vulnerable populations.

#### **13. Ministry of Information and Media Relations (MoIMR)**

The MoIMR, as the key agency responsible for the dissemination and transmission of critical information on government priorities to the general public, should engage in the dissemination of HIV prevention education and BCC. It should also link people in need to critical HIV and AIDS services. The MoI and the Information Services Department should:

- Play an active role in information and education on HIV and AIDS, STIs through the development and broadcasting of programmes and advertisements on various aspects of HIV and AIDS, STIs; and

- Collaborate with the Ghana AIDS Commission, other sector Ministries, NGOs and civil society at large and the private sector to strengthen capacity for effective public media involvement in HIV and AIDS, STI prevention.

#### **14. The Ministry of Justice and Attorney General**

The Ministry of Justice and Attorney General and its agencies should:

- Provide assistance for the review and reform of legislation related to HIV and AIDS, STIs; and
- Prepare legislation on reproductive health, HIV and AIDS, STIs and related matters as approved by the Cabinet.

##### **9.2.6. Decentralisation**

In line with the Government's policy on decentralisation, the GAC Secretariat should collaborate with the political and administrative units of the country, especially the Regional Co-ordinating Councils and District Assemblies, to implement HIV and AIDS, STI programmes. Additionally, District Assemblies will be charged with the responsibility to lead community mobilisation against HIV and AIDS, STIs to expand the national response. District Assemblies will supervise and monitor HIV and AIDS implementers working in the districts.

The GAC Secretariat will collaborate with other sector Ministries to take advantage of the decentralisation and the unique position of District Assemblies to mobilise additional resources from the local level.

## 10. PRIVATE SECTOR POLICIES, ROLES and RESPONSIBILITIES

### 10.1. Introduction

Private sector organisations and enterprises should develop and implement workplace the policies and programmes for the management of HIV and AIDS, STIs in line with National Workplace HIV and AIDS Policy. These will include implementation of HIV and AIDS, STI prevention activities, such as education for workers, HTC, condom distribution and protection of the rights of PLHIV, key and vulnerable populations in the workplace.

Private sector organisations and enterprises are mandated to:

- Mobilise private sector financial and other resources for HIV and AIDS, STI services for the workforce and surrounding communities;
- Integrate HIV and AIDS, STIs into training courses for workers and managers where appropriate; and
- Address stigmatisation and discrimination in the workplace.

### 10.2. The Media

The government should encourage the development of policies and codes of conduct for the media and the advertising industry in order to increase sensitivity to HIV and human rights issues and avoid reinforcing negative stereotypes or sensationalism over HIV-related issues in reporting and advertising. Training and education of media men and women should be an integral part of media practice.

### 10.3. Civil Society

The role of civil society in implementing the HIV and AIDS, STI programmes is crucial. Efforts should be made to involve traditional rulers, opinion leaders, youth groups, religious groups, professional bodies and traders associations at each level. Civil society organisations, including NGOs, CBOs and those representing PLHIV, should be encouraged to formulate and implement appropriate programmes on HIV and AIDS, STIs. They should:

- Develop and implement innovative HIV and AIDS, STI prevention and care projects and activities in line with the priorities articulated in the National HIV & AIDS Strategic Plan, 2011–2015;
- Mobilise communities for HIV and AIDS, STI prevention and care activities that are affordable and sustainable;
- Advocate for the involvement of various sectors of government, at national, district and community levels in HIV and AIDS, STI prevention and care;
- Mainstream HIV and AIDS, STI issues in school curricula; and
- Collaborate and participate in national co-ordination activities to minimise duplication and enhance the establishment of complementary programmes, projects and activities.



## 10.4. Faith-based Organisations

The FBOs shall:

- Integrate messages and information about prevention, care and support into their ongoing activities;
- Identify and serve as advocates for vulnerable groups in society, such as young women, the orphaned and street children who are subjected to sexual exploitation or abuse;
- Develop BCC/IEC messages and programmes that stress the importance of family and moral values in stopping the spread of HIV and AIDS, STIs;
- Participate in care and support programmes for PLHIV;
- Not require HIV testing as a prerequisite for marriage, however, couples should be encouraged to undertake confidential testing before marriage; and
- Not perpetuate stigmatising messages against PLHIV, key and vulnerable populations.

## 10.5. Traditional Leaders

Traditional leaders should:

- Spearhead revoking practices that drive or spread the epidemic; and
- Reintroduce traditional practices that prevent HIV and AIDS, STIs.

## 11. NATIONAL HIV AND AIDS, STI WORKPLACE POLICY

### 11.1. Introduction

A nation's human resources constitute the source of its human capital and there is a positive correlation between the rate of a country's socio-economic development and the rate of its human capital formation. The HIV and AIDS, STI epidemics pose a serious challenge to Ghana's development because they are capable of reversing the modest human capital gains made since independence. There should be a national workplace policy based on the following legal frameworks:

- *International Labour Organisation Recommendation 200* (2010)
- *International Labour Organisation Convention No. 111*
- *Constitution of the Republic of Ghana* (1992)
- *Labour Act, 2003* (Act 651)
- *Workmen's Compensation Law, 1987*
- *Factories, Offices and Shop Act, 1990* (Act 328)
- *Ghana AIDS Commission Act, 2002* (Act 613)

### 11.2. Workplace Policy Goals and Objectives

The policy goal is to provide broad national guidelines to direct the formulation of workplace policies and programmes.

The specific objectives of the policy are to:

- Provide PLHIV with protection from discrimination in the workplace;
- Prevent HIV and AIDS, STI spread among workers; and
- Provide care, support and counselling for those infected and affected.

### 11.3. Workplace Policy Requirements

- Recognizing HIV and AIDS, STIs as a workplace issue to be treated like any other serious illness or condition in the workplace, there should therefore be no discrimination against workers on the basis of real or perceived HIV status;
- Gender inequality and the gender dimensions of HIV and AIDS, STIs shall be recognised;
- The work environment should be healthy and safe in order to prevent transmission of HIV;
- Promoting social dialogue: The successful implementation of HIV and AIDS, STI policy and programmes requires cooperation and trust between employers, workers, their representatives and government;
- Prohibiting screening for purposes of exclusion from employment: HIV and AIDS, STI screening should not be required of job applicants or persons in employment. HIV testing of

a job seeker or an employee for the purpose of recruitment, promotion, or any other reason is prohibited;

- The assurance of confidential access to personal data related to a worker's HIV status should be bound by the rules of confidentiality. A person's HIV status, the status of his or her partners, or that of his or her close relatives should not constitute a reason for refusal of employment or termination of employment. Fitness to work should be the relevant standard in these matters related to employment. This should not, however, apply in any case where an employer can prove that the requirements of the employment in question are that a person be in a particular state of health or medical or clinical condition;
- A person's HIV status should not be used to exclude him or her from any workplace programme. Persons with HIV-related illnesses should be allowed to work for as long as medically fit to ensure the continuation of the employment relationship;
- The prevention of new HIV infections can be achieved through changes in attitude and behaviour. It can be furthered through provision of information and education and through addressing socio-economic factors;
- Where employee health and wellness programmes exist, the interest of staff living with HIV should be incorporated;
- When employees with HIV-related illnesses are no longer able to discharge their duties on account of poor health, they should benefit from rights that pertain to employees affected by a long-term illness. For example, employers, in consultation with the employee or his/her representative, should take measures to provide reasonable accommodation for employees with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks and time off for medical appointments;
- Workers, including those with HIV, are entitled to affordable healthcare services;
- The Government of Ghana should ensure the provision of basic information and instruction on HIV and AIDS prevention and control at the workplace for employees of ministries, departments and agencies and employees of private and informal sectors;
- All MDAs should develop and implement viable policies and guidelines for HIV workplace programmes. The information provided under this section shall cover issues such as voluntary testing, confidentiality, privacy in the workplace and attitudes towards infected employees and workers;
- Within the public sector, the Government and its leading agencies in the response to HIV and AIDS, STIs should provide support to each MDA to establish viable and operational HIV workplace programmes;
- MDAs should appoint and train focal persons to coordinate the programmes. Capacity building of focal persons should include training and skills development on confidentiality and HIV-related stigma and discrimination;
- Human resources management policies of MDAs should include clauses that prevent stigma and discrimination against staff living with HIV;
- Workers' organisations should participate actively in developing workplace policies and programmes that ensure maximum protection and care for those affected by the disease.

Workers need to be strengthened and empowered to mobilise their workforce on HIV and AIDS, STI issues through information, education, communication, training and support;

- Employers should be encouraged to develop policies to prevent discrimination against workers who are infected with HIV and to implement workplace HIV educational programmes for employees and their families. Employers should also be educated to use the skills of PLHIV to the maximum for as long as possible. This will include retraining of employees where necessary and the appropriate use of their services; and
- Security Service authorities should ensure access for personnel and inmates to information and education about the causes, modes of transmission, means of prevention and management of HIV and AIDS. Messages on HIV and AIDS, as well as the actual provision of means of HIV prevention, should be provided.

## 12. RESEARCH, MONITORING and EVALUATION (M&E)<sup>56</sup>

### 12.1. Introduction

The purpose of the M&E system is to provide the data needed to:

- Guide the planning, co-ordination and implementation of the HIV response;
- Assess the effectiveness of the HIV response; and
- Identify areas for programme improvement.

In addition, M&E data are needed to ensure accountability to those infected or affected by HIV, as well as to those providing financial resources for the HIV response. Ghana adopted and is using the 12 components of the *UNAIDS Organising Framework for a Functional HIV M&E System* as the major framework for organising its National HIV and AIDS M&E Plan.

### 12.2. Research and Knowledge Management

The evolution of the HIV and AIDS, STI epidemic has been intriguing and complex in both its biological and social dimensions. Gaps still exist not only in the knowledge of HIV but also in terms of interventions and research. Existing challenges related to HIV and AIDS, STI research include:

- Gaps in defining national research priorities;
- Funding priority research;
- Coordinating research efforts; and
- Ensuring compliance with ethical standards

Results generated from the largely individually driven research endeavours, even when results are of national relevance are often poorly disseminated and hardly used to inform policies, programmes and practices. Overall, to make the national response more effective, it is important that research be conducted locally and that results are used to inform policies, practices and interventions.

#### 12.2.1. Research and Knowledge Management Goals and Objectives

The goal of a policy on research and knowledge management is to promote continuous generation and use of nationally driven, high-quality, scientifically credible and ethically sound evidence to improve the understanding of the HIV and AIDS, STI epidemic and to guide HIV and AIDS-related policy, practice and interventions.

The objectives are to:

- Promote the establishment of a sustainable framework for defining, funding and implementing national research priorities in HIV and AIDS, STIs in the context of multisectoral programming;
- Promote the conduct of operations research, basic biomedical research and social sciences and economic impact research as relevant to the country's HIV and AIDS, STI response;

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<sup>56</sup> Adapted from: Federal Government of Nigeria. *National Policy on HIV & AIDS, STI*. Oct 2009, pp. 43–47.

- Promote the conduct of population-based surveys and special surveys to track the HIV epidemic and behaviour trends;
- Strengthen the framework for collating, analysing and disseminating relevant research findings; and
- Promote the use of research findings to strengthen HIV and AIDS-related policy and programme interventions.

### 12.2.2. Research and Knowledge Management Requirements

In lieu of these objectives:

- The Government of Ghana, through GAC and other relevant research institutions should encourage and promote biomedical, basic, social and operational research in current and emerging areas of HIV and AIDS, STIs and related interventions.
- The Government should provide adequate resources for funding the co-ordination and implementation of HIV and AIDS, STI research activities, as well as the documentation and archiving of past and ongoing HIV and AIDS, STI-related research and the dissemination of findings.
- The GAC should annually identify and publish, based on the best available evidence, a list of national HIV and AIDS, STI research priorities and widely disseminate it to stakeholders.
- Government agencies, academic and research institutions and health facilities should promote the teaching of research ethics in HIV and AIDS, STI training curricula. They should ensure that HIV and AIDS, STI-related research that involves human participants complies with ethical standards and human rights requirements as embodied in national and international guidelines. They should also respect national norms and cultural sensitivities.
- The Government should promote the accessibility of national survey data in an ethical manner to researchers so that further analyses can be undertaken, at the same time, it should ensure the confidentiality of the individual research participant.
- GAC should identify the research agenda for HIV and AIDS, STIs research using a consultative and participatory approach.

#### **Non-discrimination in Research**

Respect for equal rights requires that policymakers and others involved in research observe the principle of non-discrimination in the determination of those who might benefit or suffer as a result of decisions pertaining to research. The selection of research sites should be based solely on scientific criteria. There will be the need to pay particular attention to ethical issues, specifically confidentiality, informed consent and the protection of human rights and this policy endorses this.

#### **Equitable Distribution of the Benefits of Research**

Respect for the right of everyone to the highest attainable standard of health and the principle of autonomy requires that any person should have access to the findings of research which have a bearing on their own circumstances. This will ensure that people make informed decisions as regards their own health and well-being. This is enshrined in Article 15 of the *International Convention on Economic, Social and Cultural Rights* and is supported by this policy.

Respect for these rights and principles further obliges states to ensure that when research leads to the discovery of an effective HIV vaccine or AIDS treatment or cure, this knowledge is accessible to all

and any products developed are distributed equitably. In this regard, the Government will assist Ghanaian researchers to patent their findings as needed.

All HIV and AIDS, STI research should go through Ghanaian-recognised and Ghanaian Ethical Review Boards for clearance.

### 12.3. Monitoring and Evaluation

Monitoring and evaluation (M&E) constitutes a cornerstone of evidence-based planning and decision making for each component of HIV and AIDS, STI programmes. They are essential to guide future strategies and interventions, as well as to inform new policies, strategies and plans. Data generated through M&E activities are critical to track the progression of the epidemic, assess the status of response efforts, and document gaps, needs and results of interventions.

The goal of M&E should strengthen and embed a sustainable systems-based approach to deliver a cost-effective, multidimensional monitoring and evaluation system that supports the continuous improvement of the national response.

The objectives are to:

- Harmonise and strengthen the use of the national monitoring and evaluation framework for the national response;
- Strengthen institutional and human capacity for monitoring and evaluation;
- Promote timely dissemination of monitoring and evaluation results and their use in programme management; and
- Promote and support evidence-based approaches in HIV and AIDS, STI interventions.

In line with commitments to the “Three Ones” principle, the Government of Ghana will continuously promote the use of one national monitoring and evaluation plan in the national response.

The Government is committed to the implementation of a comprehensive and responsive national HIV monitoring and evaluation framework to assess the success of the HIV response and will commit and mobilise adequate resources for M&E. Particular attention will be paid to document programme outcomes and utilise M&E data for key and vulnerable populations.

The Government of Ghana supports public health surveillance, surveys and HIV expenditure tracking on a regular basis. GAC, NACP and other stakeholders are to collaborate in implementing these research activities.

Human and material resources to effectively manage and coordinate the national M&E system and its activities should continuously be strengthened.

The Government is committed to establishing and maintaining a network of organisations, partners and stakeholders involved in the HIV and AIDS response at national, sub-national and service-delivery levels.

All HIV and AIDS, STI research should go through Ghanaian-recognised and Ghanaian Ethical Review Boards for clearance.

Data generated from national M&E activities and related national studies should be widely disseminated to the tiers of government, sectors, development partners and general public to promote their use for policymaking and programming.

Mechanisms for quality assurance and continuous data quality improvement should be established by the government.

The Government of Ghana, through GAC, should actively advocate that a percentage of HIV and AIDS, STI programme budgets of each institution engaged in HIV implementation be committed to monitoring and evaluation activities.

The Government of Ghana, through GAC, is committed to the regular update and dissemination of strategic information, the implementation of the national HIV and AIDS M&E plan, the support of regions to develop and monitor the implementation of region-specific HIV M&E plans and the strengthening of HIV databases at national and regional levels.

The GAC and relevant agencies will develop a core set of indicators/data that each stakeholder in the national response must submit to GAC on a regular basis, irrespective of whatever agencies and institutions to which they are also required to submit data.

Advocacy and communication will be used to develop a culture of monitoring and evaluation and data use by each stakeholder at each level to ensure transparency and accountability.



## **13. FUNDING MECHANISMS**

### **13.1. Introduction**

Much of the funding for HIV and AIDS, STIs has been from external sources that are now dwindling.

Funding has been deployed from Government of Ghana sources mainly for operational costs rather than programme interventions. Funding from the private sector is minimal and remains largely untapped.

Adequate and sustainable funding for HIV programmes is the core of the national response. The policy on funding mechanisms seeks to mobilise funding that will be adequate and dynamic to meet the changing circumstances and expansion of HIV prevention, treatment, care and support programmes.

Funding mechanisms should lead to predictable financial resources and accountability of the resources mobilised on a long-term basis.

### **13.2. Resource Mobilisation and Sustainability**

The focus for resource mobilisation should be on local resources from within the country before external sources are considered. The private sector should be encouraged to mobilise funds with tax and other incentives.

The development partner base for the mobilisation of funds for the national response should be expanded. GAC should continue to seek assistance from multilateral and bilateral partners and international organisations.

The Resource Mobilisation Strategy for the national HIV and AIDS response of GAC should provide the policy template for key resource mobilisation vehicles based on the inclusiveness of the public, private sectors and other stakeholders.

The GoG should be encouraged to fulfil its international obligations on the funding for national response.

### **13.3. Ghana HIV Fund**

As the Republic of Ghana has attained lower middle-income country status, development partners will be less inclined to provide significant funding for the national HIV and AIDS response. This policy favours the creation of an HIV Fund for HIV programmes. The sources of the Fund may include GoG and other local sources of funding, including the private sector and individual philanthropists.

Proper measures must be taken in the establishment and management of the fund. The fund should be backed by legislation.