

GHANA AIDS COMMISSION



Under the Office of the President

National HIV and AIDS Policy

**Universal Access to HIV Prevention,
Treatment and Care Services towards
Ending AIDS as a Public Health Threat**

September 2019

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LIST OF ABBREVIATION

AIDS	-	Acquired Immune Deficiency Syndrome
AIS	-	AIDS Indicator Survey
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral
BCC	-	Behavior Change Communication
CBO	-	Community-Based Organization
CHRAJ	-	Commission on Human Rights and Administrative Justice
CSO	-	Civil Society Organization
CSW	-	Commercial Sex Workers
DHS	-	Demographic and Health Survey
eMTCT	-	Elimination of Mother-To-Child Transmission
FBO	-	Faith-Based Organization
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
HIV SS	-	HIV Sentinel Survey
HSS	-	Health Systems Strengthening
HTS	-	HIV Testing Services
ICT	-	Information and Communication Technology
IEC	-	Information, Education and Communication
JUTA	-	Joint UN Team on AIDS
LEAP	-	Livelihood Empowerment Against Poverty
LESDEP	-	Local Enterprises and Skills Development Programme
LM	-	Lead Ministry
MARPs	-	Most-At-Risk Populations
M&E	-	Monitoring and Evaluation
MDAs	-	Ministries, Departments and Agencies

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
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 Framework
NSP	-	National HIV & AIDS Strategic Plan
NSPS	-	National Social Protection Strategy
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
SDGs	-	Sustainable Development Goals
STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
TC	-	Testing and Counselling
UNAIDS	-	Joint United Nations Programme on HIV and AIDS
WHO	-	World Health Organisation

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We also acknowledge the contributions of others who supported the process of revising this policy in diverse ways, including development partners, the MDAs, the civil society organizations (CSOs), faith-based organizations (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.

PREFACE

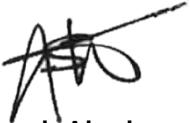
The Ghana AIDS Commission and partners desired to revise the National HIV & AIDS, STI Policy (February 2013). The revision was to develop a new policy that underpinned the national response by identifying the gaps and updating the current policy with relevant information that will support Ghana towards ending AIDS by 2030. The new policy is to address key and emerging trends in HIV prevention, treatment, care and support and align them with the sustainable development goals and the national development goals that underpin the multi-sectoral response to HIV in Ghana. The policy revision was also intended to provide the basis for the comprehensive engagement of all stakeholders towards ending AIDS in Ghana by 2030.

The review set out to find out if the current policy purpose goal and objectives were still appropriate, relevant, needed to be modified and more importantly what new policy strategies are required to achieve the overall policy goal and objectives.

National and regional stakeholders (individuals, institutions and organizations) from all sectors both public and private are actively engaged in the execution of the different aspects of national response. The different experiences and insights of these stakeholders were considered to ensure that the revised policy captured all perspectives and concerns about the national response's ability to support Ghana in creating a favourable environment in which AIDS can be eliminated by 2030.

Overall, the policy purpose, goal and objectives of the National HIV & AIDS, STI Policy (February 2013) were found to be appropriate and relevant. Recognizing that changes have occurred in the global and national HIV epidemiology, policy

and technology, modifications have been made to the policy to reflect these changes.



Kyeremeh Atuahene
Ag. Director General
Ghana AIDS Commission

EXECUTIVE SUMMARY

Ghana has a generalised low prevalence epidemic. Ghana has slowly, but steadily made good progress in its response to HIV and AIDS. The National Prevalence is 1.69% with Regional HIV prevalence ranging from 2.66% in Ahafo, as the region with the highest prevalence to 0.39% in North East region, the lowest. At the District level, HIV prevalence ranged from 5.56% in the Lower Manya Krobo as district with the highest to 0.07% in Karaga and Tolon as districts with lowest prevalence.

The median HIV prevalence in 2018 among pregnant women is 2.4% (Confidence interval: 2.18% - 2.62%). Regional HIV prevalence ranged from 3.1% in the Greater Accra and Western Regions as the regions with the highest prevalence to 0.6% in Northern region, the lowest. Median HIV prevalence was higher in urban than rural locations (2.6% compared to 2.2%). Mean HIV prevalence was also higher in urban than rural locations (2.6% compared to 2.0%). HIV prevalence among the young population (15-24 years), a proxy for new infections, remained stable at 1.5% for 2017 and 2018. Overall, a linear trend analysis of ANC HIV prevalence shows a decline from 2.9% in 2009 to 1.6% in 2014. However, between 2015 and 2018 there was an observed increase in the ANC prevalence from 1.8% to 2.4% respectively.

Since the first case of HIV was recorded, in 1986, the country has proactively responded to address it. Responses have included the establishment of the National AIDS/STI Control Programme (NACP) in 1987, the Ghana AIDS Commission (GAC) in 2000 and the preparation and execution of four National HIV and AIDS Strategic Frameworks/Plans (the National HIV and AIDS Strategic Framework (NSF I) 2001-2005, NSF II 2016 – 2020, National HIV and

AIDS Strategic Plan 2011-2015 and the National HIV and AIDS Strategic Plan 2016-2020).

There are prevailing institutional and programmatic challenges to achieving the desired levels of policy execution. These have been inadequate financial resources for prevention activities, procurement of treatment, care and support logistics; commitment and capacity of health and non-health sector stakeholders towards implementation. In addition is the sub-optimal multi-sector and multi-stakeholder cooperation, collaboration and coordination of activities. This policy provides the overarching perspective, position and direction of Ghana, as it continues on its journey to reach the 90-90-90 fast track targets by 2020 and ultimately the SDG 3 specific target 3.3 which calls for an end to the epidemic of AIDS by 2030.

This policy is guided by 4 pillars: Greater Involvement of People Living with HIV and AIDS, Alignment with global concepts and frameworks; Decentralized multisector and multidisciplinary planning, its execution and; Partnership and collaboration with public, private, local and international institutions. The policy sets out to achieve 4 objectives namely to:

1. Empower the population to prevent new HIV infections.
2. Ensure the availability of and accessibility to prevention, treatment, care and support services.
3. Mitigate the social and economic effect of HIV on persons infected and or affected by HIV.
4. Ensure the availability of adequate funding to execute the policy strategies.

Policy management and implementation arrangements have been defined in this policy document. These arrangements are primarily designed to reduce duplication and role ambiguity of stakeholder efforts. In addition, it is expected to ensure the

effective and efficient coordination, harmonization and implementation of the policy by the various stakeholders. The arrangements are expected to take advantage of existing and develop new synergies between MDAs and other partners.

1. INTRODUCTION

1.1. National Response

Since the first case of HIV was detected in Ghana in 1986 the following have comprised the national response:

- In 1987, the National AIDS/STI Control Programme (NACP) was established to lead the national response.
- In September 2000 the Ghana AIDS Commission was established. The GAC was mandated by Act 613 (2002) which was revised and replaced by the current Act 938 (2016). The previous and current Act provides policy direction as well as defined functions of the GAC to ensure that multisector responses are coordinated. The GAC has since led the development of four National HIV and AIDS Strategic documents to guide the implementation of the national HIV response i.e. National HIV and AIDS Strategic Framework (NSF I) 2001-2005, subsequently NSF II 2016 – 2020, National HIV and AIDS Strategic Plan 2011-2015 and the National HIV and AIDS Strategic Plan 2016-2020.
- Significant progress has been made as a result of implementing the various preceding national HIV policies, strategic plans and frameworks.

1.2. The Current Situation

Ghana has slowly but steadily made good progress in its response to HIV and AIDS. The 2018 HIV Estimates Report describes the current situation as follows: the National Prevalence is 1.69% with Regional HIV prevalence ranging from 2.66% in Ahafo as the region

with the highest prevalence to 0.39% in North East region, the lowest¹. At the District level, HIV prevalence ranged from 5.56% in the Lower Manya Krobo as district with the highest to 0.07% in Karaga and Tolon as districts with lowest prevalence².

The median HIV prevalence in 2018 among pregnant women is 2.4% (Confidence interval: 2.18% - 2.62%). Regional HIV prevalence ranged from 3.1% in the Greater Accra and Western Regions as the regions with the highest prevalence to 0.6% in Northern region, the lowest. Median HIV prevalence was higher in urban than rural locations (2.6% compared to 2.2%). Mean HIV prevalence was also higher in urban than rural locations (2.6% compared to 2.0%). HIV prevalence among the young population (15-24 years), a proxy for new infections, remained stable at 1.5% for 2017 and 2018.

The proportion of HIV subtype 1 is 98.8% compared to 0.7% for dual HIV type 1 and 2 and 0.5% for HIV type 2 infections in the 2018 survey³.

Overall, a linear trend analysis of ANC HIV prevalence shows a decline from 2.9% in 2009 to 1.6% in 2014. However, between 2015 and 2018 there was an observed increase in the ANC prevalence from 1.8% to 2.4% respectively.

¹ Ghana' HIV Fact Sheet 2018

² Estimated District Adults HIV Prevalence 2018

³ 2018 HIV Sentinel Survey Report

Table 1: Summary of 2018 HIV National Estimates Results⁴

Indicator (for general population)	Estimates
HIV Prevalence	1.69%
HIV Population	334,713
New Infections	19,931
Annual deaths	14,181
ART Coverage for children (0-14 years)	19.9%
ART Coverage for adults (15+ years)	35.16%
PMTCT Coverage	78.86%

Ghana had more than the projected HIV population for 2018 (334,713) which exceeds that projected population for 2020 as well.

Table 2: Projected HIV Populations for Ghana from 2019 to 2025

Year		2019	2020	2021	2022	2023	2024	2025
Projected Population	H I V	339,727	345,534	350,601	354,162	356,431	358,383	360,052

The number of persons initiated on ART from 2016 to 2018 has continued to increase year on year as shown in table 3 below.

⁴ Ghana's HIV Fact Sheet 2018

Table 3: Number Initiated on ART 2016 to 2018

Indicator	Jan-Dec. 2016	Jan-Dec. 2017	Jan-Dec. 2018
Total Number Initiated	20,297	26,969	28,782
Males Initiated on ART	5,368	25,325	8,347
Females Initiated on ART	14,929	19,467	20,435
15+	19,107	25,325	24,333
>15	1,390	1,644	4,449

Despite the evident progress Ghana has made to date in its efforts to curb the impact of HIV and AIDS on the population, there are prevailing institutional and programmatic challenges to the country's ability to further reduce the incidence, prevalence and risk of HIV and AIDS in the Ghanaian population. These have been acknowledged to include: limited availability and accessibility to evidence-based, culturally appropriate information to support the population adopt lifestyles that reduce their risk of getting infected with HIV; limited availability of and accessibility to comprehensive preventive, treatment, care and support services; inadequate financial resources (for prevention activities and the procurement of treatment, care and support logistics); and the need to improve multi -sector and multi-stakeholder cooperation, collaboration and coordination in the execution of the national response.

HIV is still a big threat. This is evidenced by:

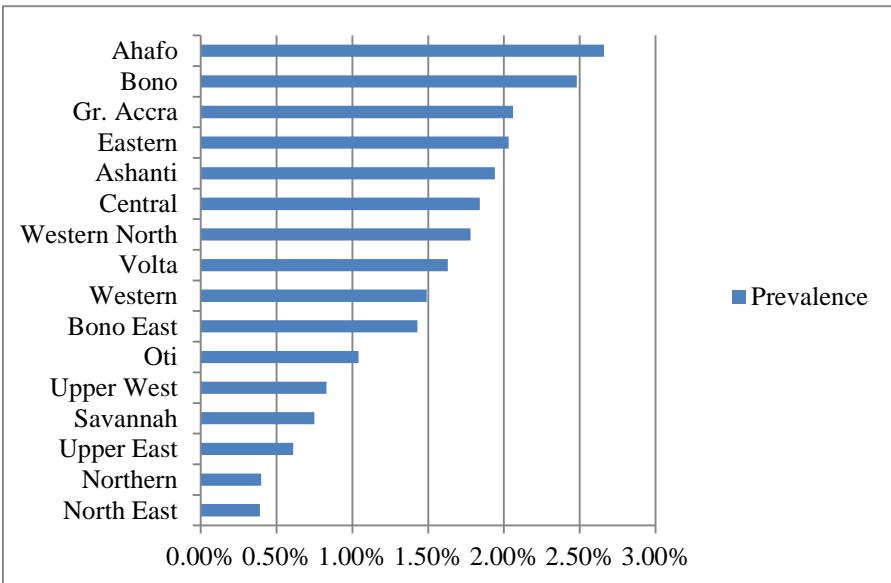
1. New infections having plateaued with a slight increase amongst young adults. This is supported by slight decline in

the 2018 Estimate for the age group 15-24years from 5,532 in 2018 to 5,406 in 2019.

2. The estimated number of new annual Infections, in 2018, was 19,931. For epidemic control we must reduce overall new infections from the current level to zero.
3. AIDS related death in 2018 is estimated at 14,181.
4. A five-year linear trend analysis of the 2018 National Estimates shows a steady but declining adult HIV prevalence between 2015 and 2019 from 1.77% to 1.67
5. MSM prevalence increased from 17.5% to 18.1% in 2017.

FSW prevalence of approximately 7% is a significant decrease from the 2011 level of 11.1%. The MSM and the FSW prevalence are significantly higher than the national adult prevalence of 1.69% as estimated in 2018. The HIV prevalence by regions (figure 1) shows that Ghana has a generalised low prevalence epidemic.

Figure 1: National Estimates 2018 HIV Prevalence by Region



2. POLICY FRAMEWORK

2.1. Policy Rational

Ghana has been consistent, since 1987, in designing and implementing national responses. These responses have been towards reducing the incidence and prevalence of HIV, as well as, mitigating its impact on the population. This policy provides the overarching direction of Ghana, as it continues on its journey to achieve the 90-90-90 treatment targets by 2020 and ultimately the SDG 3, specifically target 3.3, which calls for an end to the epidemic of AIDS by 2030.

In addition to ending the AIDS epidemic, Ghana, through this policy, intends to ensure that the impact of HIV and AIDS on the socio-economic life of people affected and living with HIV, in Ghana, ceases to be of public health and socio-economic concern.

The policy sets out the direction in which implementing stakeholders (individuals, organizations and sectors) are to focus their interventions. The policy recognizes that stakeholders have unique strengths and capabilities. The policy provides sufficient flexibility to enable stakeholders bring to bear their strengths and capabilities in support of the national response. The national policy is also designed to enable the development and execution of a national response that reflects global paradigms, yet addresses the local context in which it will be implemented.

2.2. Guiding Principles

HIV and AIDS is recognized as a developmental issue. It [HIV] has been appropriately and specifically included in the global

developmental agenda, the SDGs. Interventions to address the impact of HIV require a multi-disciplinary and multi-sectoral approach. In addition, as Governments alone cannot address the issues, public-private-partnerships that leverage the strengths of both sectors, is key. On account of these observations, the following guiding principles inform this policy;

2.2.1. Greater Involvement of People Living with HIV (GIPA)

This policy fully subscribes to the principle of greater involvement of people living with HIV (GIPA) as presented in the UNAIDS Policy Brief on same. The aim of the principle, "to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives" is fully endorsed by this policy. This policy commits to involve PLHIV in: policy making processes, programme development and implementation; leadership and support, group networking and sharing; advocacy; campaigns and public speaking; their personal care; treatment roll out and preparedness amongst others.

2.2.2. Alignment with global concepts and frameworks

Global frameworks have been developed to align, harmonize and leverage global support towards addressing HIV and AIDS. These frameworks are also intended to guide and coordinate national responses to HIV and AIDS. The policy recognizes and supports the following global health and development frameworks:

- i. Transforming our World: The 2030 Agenda for Sustainable Development
- ii. African Union Agenda 2063

- iii. United Nations Programme on HIV and AIDS (UNAIDS) Strategy 2016-2021: On the Fast Track to End AIDS. (UNAIDS)
- iv. End HIV and AIDS in Africa by 2030: HIV and AIDS Framework for Action in the WHO African Region, 2016-2020 (WHO AFRO 2017)
- v. Health in all Policies, Framework for Country Action (WHO 2013)
- vi. UNAIDS- Saving Lives, Leaving no one behind
- vii. All-In to end adolescent AIDS epidemic

2.2.3. Decentralized, multi-sector and multi-disciplinary planning and execution

This policy acknowledges that HIV has a health, socio-economic and developmental impact on the Ghanaian population. Ensuring local ownership and commitment, through a decentralized approach is considered key to the sustainability of the national response. For maximum effectiveness and efficiency, multi-sector and multi-disciplinary interventions are fundamental to program design and execution. The following national policies and plans will inform this pillar:

- i. The 1992 Fourth Republic Constitution of Ghana
- ii. National Development Plan
- iii. National HIV and AIDS Strategic Plan
- iv. Ghana AIDS Commission Act 2016, (Act 938)
- v. Health Sector Medium Term Development Plan
- vi. National Population Policy

2.2.4. Partnership and collaboration with public, private, local and international institutions

Government accepts the fact that it cannot address the issues and impact of HIV and AIDS in Ghana unilaterally. There are roles that the public, private sector and communities including young people and PLHIV can play in the design, implementation, resourcing and monitoring of the implementation of this policy. Government, through its respective Ministries, Departments and Agencies (MDAs), will proactively seek and establish partnerships with other institutions and organizations to achieve the goal and objectives of this policy.

3. POLICY VISION, GOAL, OBJECTIVES AND STRATEGIES

3.1. Vision

Ghana becomes a country where HIV and AIDS are eliminated.

3.2. Policy Goal

To create an enabling environment for the development and execution of effective and efficient HIV and AIDS interventions and for the achievement of epidemic control.

3.3. Policy objectives and strategies

The policy objectives are designed to address the institutional and programmatic challenges, recognized by this policy. In addition, the policy objectives will follow a public health approach with interventions to improve upon the prevention, treatment and other care and support aspects of the management of HIV and AIDS. The policy objectives will also support the reduction in the negative socio-economic impact of HIV and AIDS on the population. The following are the four objectives (with respective strategies) this policy will strive to achieve:

1. Empower the population to prevent new HIV infections.
2. Ensure the availability of and accessibility to prevention, treatment, care and support services.
3. Mitigate the social and economic effect of HIV on persons affected and living with HIV.
4. Ensure the availability of adequate funding to execute the policy strategies.

3.3.1. Objective 1: Empower the population to prevent new HIV infections

This policy objective commits to the provision of evidence-based information about HIV and AIDS to the population. This information will be designed to enhance the knowledge, attitudes and commitment of the population towards adopting lifestyles and behaviours that protect them from acquiring HIV.

Feedback from stakeholders (received during the national consultative fora that informed this revised policy), indicated that HIV education especially to the general public has reduced. They also noted that there is more focus on key population as against the general population. In addition, there is a felt need for strengthening and scaling up comprehensive sexuality education for in and out of school youth and adolescents.

Desired Outcome: The desired outcome of this objective is a population (general and key) that adopts lifestyles and behaviours to reduce or eliminate their risk of acquiring new HIV infections or getting re-infected. The following strategies have been identified and agreed upon:

3.3.1.1. Provide education to the general public, including key populations, in both rural and urban areas

This strategy will see to the provision of continuous information on HIV and AIDS to the general public as well as sustaining current interventions towards key populations. Tailored BCC materials for different risk populations will continue to be developed. Digital, social and other mass media and other channels will be used to facilitate the dissemination of the information to respective target

groups. The information will be designed to respect appropriate cultural norms and beliefs as well as dispel those that promote the spread of HIV and AIDS.

3.3.1.2. Provide HIV education and comprehensive sexuality education to in-and-out of school adolescents and young people.

The sustained presence of HIV in Ghana is directly correlated to the prevalence of the infection in the youth especially adolescent girls. In addition to HIV education, the youth need to be empowered with comprehensive and context specific information around sex and sexuality to enable them make decisions that prevents them from acquiring HIV and other STIs. Their empowerment should lead them to seek and use test and treatment services and develop respectful social and sexual relationships. This policy recognizes both in-and-out of school youth and will target them both with the appropriate information in the most acceptable manner.

3.3.1.3. Strengthen community systems to promote appropriate cultural norms/practices

The community is recognized as the locus in which attitudes and behaviours are formed and reinforced. The community is the primary place of habitation and socio-economic activity for all people including persons affected and living with HIV. Cultural norms and practices that act as barriers to accessing HIV prevention and adopting safe sexual behaviours need to be addressed. This strategy requires that all interventions at the community level are carried out in partnership and collaboration

with the chiefs and other traditional rulers, community elders, family/clan heads, religious and opinion leaders amongst others. The intention is to ensure that interventions are culturally sensitive and community owned for improved access, effectiveness and sustainability of the interventions being implemented.

3.3.2. Objective 2: Ensure availability of and accessibility to prevention, treatment, care and support services

The availability of and accessibility to prevention, treatment, care and support services for HIV is of fundamental importance to the achievement of the goal of this policy. The provision of HIV prevention, treatment, care and support services will be based on equity, the principles of the WHO Treat all Policy⁵ and the Fast track commitments to end AIDS by 2030⁶. Increased youth and especially male involvement in sexual and reproductive health education and programs and sustained access of key populations to integrated services will be ensured.

Desired outcome: The desired outcome of this objective is for the general population especially persons affected and/or living with HIV and AIDS to equitably receive gender responsive and differentiated services, in a continuous, sustainable manner, where they are and when they need them. The following strategies have been identified and agreed to:

⁵ Ghana announces adoption of WHO's Treat All HIV Policy on September 15 2016, with launch of New HIV Strategic Plan 2020.

<http://dailyguideafrica.com/ghana-adopts-treat-all-hiv-policy/>

⁶ UNAIDS 2017

3.3.2.1. Strengthen the health delivery system

The health delivery system is known to have limitations in its ability to provide the required services needed for the response to HIV. This strategy is intended to strengthen the health delivery system and to enhance the network of service delivery points at primary, secondary and tertiary levels. This will improve the provision of HIV prevention, treatment, care and support services to all population groups, especially high risk and vulnerable groups. Health systems strengthening interventions to improve upon the governance, human resources, health information, health infrastructure/technology, community participation, and research at all these service levels will be pursued.

3.3.2.2. Provide comprehensive differentiated and integrated HIV service delivery

This strategy includes ensuring the provision of a package of health services that addresses HIV prevention, treatment, care and support. The prevention services will include EMTCT, HIV testing and counselling, safe blood and blood products as well as tissue transfusion safety, pre and post -exposure prophylaxis (PrEP/PEP) and the provision of HIV prevention commodities. In addition are treatment services for HIV and co-infections such as: STIs, TB and relevant forms of viral Hepatitis amongst others. Other services such as the provision of psycho-social and nutritional support to persons affected by and or living with HIV will also be assured. This strategy will ensure that all prevention, treatment, care and support services will be provided in line with evidence based national and international protocols and guidelines. Acknowledging that the human resource limitations of the health system are significant, task sharing will be applied to support the provision of comprehensive care.

3.3.2.3. Promote the establishment of workplace HIV programs in public and private institutions

There is a slow uptake of workplace HIV programmes by formal and informal establishments with most not having working policies or programmes. The workplace is a recognized environment to easily reach a significant number of the population. Workplace HIV programmes not only directly benefit the worker but indirectly their families, friends and the community as well. This is a significant contribution towards improving access to and availability of HIV prevention, treatment, care and support services. This strategy will advocate for and create a supportive environment for the establishment of workplace HIV programmes in public, private, formal and informal workplaces.

3.3.3. Objective 3: Mitigate the social and economic effect of HIV on persons affected and living with HIV

HIV has and continues to exert significant socio-economic burdens on individuals, households, communities and the nation as a whole. These include HIV-related stigma, discrimination and issues of sexuality and gender.

Desired outcome: The desired outcome of this objective is that persons at risk of, affected by and living with HIV are able to live a life free of stigma, discrimination and economic hardship on account of HIV. The following strategies have been identified and agreed to:

3.3.3.1. Promote the human rights of all persons affected and/or living with HIV

All persons affected and/or living with HIV are equal, in terms of their human rights, to any other person and are entitled to exercise and benefit from these rights. HIV related stigma and discrimination especially towards PLHIV and key populations is still an issue in communities, churches, schools, workplaces and among family members. There still continues to exist discriminatory access to health, education, housing, work and other services to persons at risk of, affected by and living with HIV. This strategy is intended to actively educate, promote and protect the human rights of persons affected by and living with HIV in Ghana.

3.3.3.2. Create a supportive and protective legal and legislative environment

The existing laws prohibit discriminatory treatment of people affected by and living with HIV. Institutions such as Legal Aid and CHRAJ are available for the protection of the rights of the population in general, are also equally available to persons at higher risk of, affected and living with HIV. This policy recognizes the unique nature of HIV related stigma and discrimination and how this is affecting their rights to healthcare, education and work especially. This strategy will identify issues, unique to persons affected and living with HIV, that are not adequately addressed by existing laws and legislative instruments for the purpose of reviewing or crafting new ones to address the issue in the interest of persons affected by and living with HIV as well as the general public.

3.3.3.3. Provide social protection to persons affected and or living with HIV

The socio-economic impact of HIV on persons affected by and living with HIV is known and significant. Some persons, on account of HIV, become vulnerable. This strategy will ensure the appropriate inclusion of such persons affected by and or living with HIV [including orphaned children], into existing and future social protection schemes designed for vulnerable populations in the country.

3.3.4. Objective 4: Ensure the availability of adequate funding to execute the policy strategies.

Funding to support the execution of this policy is key. Ghana, as a lower middle-income country, is expected to increase its domestic financing capacity for its developmental and social needs. With the transition to the status of a lower middle-income country, Ghana has experienced a reduction in external funding.

Desired outcome: The desired outcome of this objective is that there will be a proportional increase in domestic funding towards the execution of policy. The following strategies have been identified and agreed:

3.3.4.1. Increase domestic financing for HIV activities

The GAC 2016, (Act 938) makes provision for a National HIV and AIDS Fund. There must be a conscious effort to sustain domestic funding already earmarked for HIV Activities. The intent of this strategy is to ensure that the HIV and AIDS Fund is resourced and

utilized appropriately. In addition, new options for local mobilization of funds, including private sector involvement, for HIV and AIDS work must be identified and pursued.

3.3.4.2. *Increase external funding for HIV activities*

External funding for HIV and AIDS has been dwindling over the years. There is still the need for increased funding, which is a critical factor to Ghana's ability to sustaining gains made to date and achieve the goal of this policy. External funding will be pursued to support programmatic activities. In addition, new and innovative external sources of funds shall be explored to support Ghana achieve its policy goal and objectives.

4. POLICY MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

These policy management and implementation arrangements are designed to ensure the effective coordination and harmonization of the various stakeholders and their activities. The arrangements are expected to take advantage of existing relationships as well as develop new synergies between MDAs and other partners. In addition, the arrangements will reduce duplication, role ambiguity and improve the overall efficiency of the implementation of the policy.

4.1. Stakeholders' roles and responsibilities

4.1.1. The Ghana AIDS Commission

The Ghana AIDS Commission (GAC) is responsible for the execution of this policy. This is supported by section 2 of the Ghana AIDS Commission GAC 2016, (Act 938) which states the object of the GAC being: "to formulate policy on the HIV and AIDS epidemic and to direct and coordinate activities in response to HIV and AIDS". The GAC shall carry out its functions, as described in section 3 of Act 938 2016, in support of the execution of the policy objectives and strategies.

4.1.2. Ministries, Departments and Agencies:

It has been noted that most Ministries do not see HIV to be part of their core business nor consider themselves programmatically accountable to the GAC. Partnership amongst Ministries is also weak. This situation has led to challenges with the effective and

efficient implementation of national responses, especially when interventions require the inputs and collaboration of different sectors to be effective.

The policy places responsibility on the sector Ministries to own and drive the execution of this policy. Ministries, in the context of this policy include their respective departments and agencies. All ministries are to participate in the national response. All MDAs will be responsible to implement interventions in their own institutions, in the form of workplace HIV-programs. Some MDAs, on account of their mandate and jurisdiction will in addition, be responsible for nationwide intervention design and implementation.

To enhance collaborative partnerships amongst the different Ministries (including their respective departments and agencies), this policy categorizes them into Lead or Complementary with respect to a policy objective and strategy. Lead Ministries (LM) are those whose primary mandate, functions and jurisdiction is reflected by the policy objective/strategy. The LM also has a comparatively stronger technical competency (through its departments and agencies) over other Ministries in design and implementation activities that will support the execution of the strategy and achievement of the objective.

As a Lead Ministry, it will be responsible to provide evidence based technical inputs for the development of effective and efficient interventional activities for all implementers including themselves. Lead Ministries shall be the source of technical advice and support to all other implementers for the achievement of the respective policy objective and strategy. Lead Ministries will have supervisory responsibilities on the technical inputs and activities of the Complementary Ministries.

Complementary Ministries (CM) are those, who, by virtue of their mandate, function and jurisdiction, are required to provide administrative, logistic and collaborative support for the effective and efficient achievement of the policy objective/strategy. They are responsible for developing interventions, unique to their sector, mandate, functions and jurisdictions that are necessary for the appropriate execution of the respective strategies. Complementary Ministries are expected to seek technical inputs from the Lead Ministry in the design and development of their strategic activities.

Table 4: Lead and Complimentary Ministries/Stakeholders to Policy Objectives 1

Policy Objective 1 and Strategies		Lead	Complementary
1	Empower the population to prevent new HIV infections	Ministry of Information and Media Relations	Ministry of Education Ministry of Youth and Sports Ministry of Health NGO/CSO/FBO Development Partners
1.1	Provide education to the general public, including key populations, in both rural and urban areas	Ministry of Information and Media Relations	Ministry of Local Government and Rural Development Ministry of Food and Agriculture NGO/CSO/FBO Development Partners
1.2	Provide HIV education and comprehensive sexuality education to in-and-out of school adolescents and young people.	Ministry of Education	Ministry of Local Government and Rural Development Ministry of Information and Media Relations Ministry of Health NGO/CSO/FBO Development Partners
1.3	Strengthen community systems to promote appropriate cultural norms/practices	Ministry of Gender, Children and Social Protection	Ministry of Justice and Attorney General's Department Ministry of Interior Ministry of Education NGO/CSO/FBO Development Partners

Table 5: Lead and Complimentary Ministries/Stakeholders to Policy Objectives 2

Policy Objective 2 and strategies		Lead	Complementary
2	Ensure availability of and accessibility to prevention, treatment, care and support services	Ministry of Health	Ministry of Local Government and Rural Development NGO/CSO/FBO Development Partners
2.1	Strengthen the health delivery system	Ministry of Local Government and Rural Development	Ministry of Chieftaincy and Traditional Affairs NGO/CSO/FBO Development Partners
2.2	Provide comprehensive differentiated and integrated HIV service delivery	Ministry of Health	Ministry of Local Government and Rural Development NGO/CSO/FBO Development Partners
2.3	Promote the establishment of workplace HIV programs in public and private institutions	Ministry of Employment and Labour Relation	All MDAs NGO/CSO/FBO Development Partners
2.4	Strengthen delivery of community system	GHANET	NAP+ NGO/CSO/FBO Development Partners

Table 6: Lead and Complimentary Ministries/Stakeholders to Policy Objectives 3

Policy Objective 3 and strategies	Lead	Complementary
3 Mitigate the social and economic effect of HIV on persons affected and living with HIV	Ministry of Gender, Children and Social Protection	Ministry of Interior Ministry of Local Government and Rural Development Ministry of Justice and Attorney General's Department CHRAJ NGO/CSO/FBO Development Partners
3.1 Promote the human rights of persons affected and or living with HIV	Ministry of Justice and Attorney General	Ministry of Health Ministry of Education Ministry of Employment and Labour Relation Ministry of Local Government and Rural Development CHRAJ Ministry of Information NGO/CSO/FBO Development Partners
3.2 Create a supportive and protective legal and legislative environment	Ministry of Justice and Attorney General	Ministry of Health Ministry of Education Ministry of Labour Ministry of Social Welfare Ministry of Gender, Children and Social Protection Ministry of Interior CHRAJ NGO/CSO/FBO Development Partners

3.3	Provide social protection to persons affected and or living with HIV	Ministry of Gender, Children and Social Protection	Ministry of Local Government and Rural Development NGO/CSO/FBO Development Partners
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Table 7: Lead and Complimentary Ministries/Stakeholders to Policy Objectives 4

Policy Objective 4 and strategies		Lead	Complementary
4	Ensure the availability of adequate funding to execute the policy strategies	Ministry of Finance	Parliament Office of the President Ghana AIDS Commission NGO/CSO/FBO Development Partners
4.1	Increase domestic financing for HIV Activities	Ministry of Finance	Parliament Office of the President Ghana AIDS Commission NGO/CSO/FBO Development Partners
4.2	Increase external funding for HIV Activities	Ministry of Finance	Ministry of Finance Parliament Ghana AIDS Commission NGO/CSO/FBO Development Partners

4.1.3. Local Non-Governmental, Civil Society and Faith-Based Organizations

Government welcomes and will partner with all local non-governmental, civil society and faith-based organizations (NGOs/CSOs/FBOs) interested in and committed to supporting the achievement of the policy goal and objectives. NGO/CSO/FBO programs and interventions should be informed by and directly supportive of the policy objectives/strategies. NGOs/CSOs/FBOs should identify a LM responsible for their areas of interest and partner with them. These partnerships should be facilitated by the GAC to ensure a fair and equitable spread of partnerships with government.

4.1.4. Development Partners

Government welcomes and will partner with all development partners, interested in and committed to supporting the achievement of the policy goal and objectives. Programs and interventions of development partners should be informed by and directly supportive of the policy objectives/strategies. The development partners should identify a LM responsible for their areas of interest and partner with them. These partnerships should be facilitated by the GAC to ensure a fair and equitable spread of partnerships with government.

4.2. Policy implementation arrangements

4.2.1. Coordination of Policy Implementation

The Ghana AIDS Commission Act, 2016, (Act 938) makes provision for a governing board (section and committees of the board

(section 8). The Board committees are to support the GAC in the execution of its functions and implicitly with respect to this policy. The policy recommends that the board committees be assigned specific policy objectives to oversee and coordinate.

In line with subsection 5 of section 8 of Act 938 this policy recommends the following objectives to be the responsibility of the respective committees as follows:

- a. Programmes committee: this committee shall be responsible to oversee the implementation of policy objectives 1 and 2
- b. Research monitoring and evaluation committee: this committee shall be responsible to ensure that the research, monitoring and evaluation functions in this policy are carried out
- c. Legal and ethics committee: this committee shall be responsible to oversee the implementation of policy objective 3
- d. Resource Mobilization committee: this committee shall be responsible to oversee the implementation of policy objective 4.
- e. HIV and AIDS Fund Management Committee: this committee shall be responsible to oversee the implementation of policy objective 4.

Table 8: GAC Committees with respect to Policy Objectives

No	Policy Objective and respective strategies	Committee of the Board
1	Empower the population to protect and prevent themselves from HIV and AIDS	Programmes committee
2	Ensure the availability of and accessibility to treatment, care and support services	Programmes committee
3	Mitigate the social and economic effect of HIV on persons affected and living with HIV	Legal and Ethics Committee
4	Ensure the availability of adequate funding to execute the policy strategies	Resource Mobilization committee Ghana HIV and AIDS Fund Management Committee

4.2.2. Preparation of Operational Strategic Plans

All implementing stakeholders are expected to prepare operational strategic plans. These plans must be informed by the policy guidelines, goal, objectives and strategies. The activities of the respective operational strategic plans should reflect the mandates, functions and jurisdiction of the implementing stakeholders as applicable to supporting the execution of respective policy strategies.

Stakeholders are required to submit their operational strategic plans, to the GAC, for review and inputs. The review is intended to ensure that stakeholder plans are reflective of the policy guiding principles and in alignment with the policy objectives and strategies. The review is also to reduce the potential for duplication of interventions (in terms of actual activities planned, target groups and geographical location) amongst stakeholders.

5. RESEARCH, MONITORING AND EVALUATION

Research, monitoring and evaluation shall be aimed at ensuring social accountability of all stakeholders to each other. The Ghana AIDS Commission shall ensure that the following activities are carried out, in collaboration with stakeholders:

- i. Prepare and oversee the implementation of a research agenda that supports the achievement of the policy goal and objectives;
- ii. Set annual policy targets;
- iii. Collect, review and collate stakeholder operational strategic plans and provide feedback on the plans to the implementing partners;
- iv. Review stakeholder performance in the execution of respective operational strategic plans;
- v. Convene an annual HIV policy implementation review meeting; and
- vi. Prepare and disseminate a policy implementation report annually.

All stakeholders are encouraged to conduct research in their areas of activity and interest. Conducted research should be scientifically sound and contribute to the attainment of the policy goal and objectives.

6. POLICY INDICATORS

The progress and achievement of the policy goal and objectives will be informed by the desired results (outcomes) achieved not the interventions and activities carried out (outputs). The policy indicators are therefore limited to indicators of the outcomes of the policy goal and respective policy objectives. The table below shows the respective indicators for the policy goal and objectives.

Table 9: Table 9 Summary of policy indicators

Policy Goal		Indicator
Achieve Epidemic Control		Annual new infections HIV and AIDS related deaths HIV prevalence and incidence
Policy Objective	Indicator	
1	Empower the population to protect and prevent themselves from HIV and AIDS	<ul style="list-style-type: none"> DHS composite indicator % of males and females with comprehensive knowledge of HIV (details disaggregated across levels and by respective age cohorts) Percentage of young people aged 15-19 years old who had sex before the age of 15. DHS indicator on risky sexual behaviors, condom use etc.
2	Ensure the availability of and accessibility to treatment, care and support services	<ul style="list-style-type: none"> % of health facilities providing testing and ART and Populations receiving services (disaggregate by public, private, Geography and demography)
3	Mitigate the social and economic effect of HIV on persons affected and living with HIV	<ul style="list-style-type: none"> Stigma index
4	Ensure the availability of adequate funding to execute the policy Strategies	<ul style="list-style-type: none"> % GOG funds released % private sector funding Total available funding

Implementing institutions and stakeholders will be assessed by their respective interventions and activities carried out (outputs) and by how these contribute to the achievement of the policy indicators.

7. APPENDICES

There are in existence and in use operational guidelines and standards for the provision of services related to HIV and AIDS. These available documents are to inform the development of specific activities for the policy strategies. For each policy objective, selected available laws, policies and guidelines have been identified for reference:

7.1. Supporting reference documents for Objective 1

1. International technical guidance on sexuality education (Revised Edition). UNESCO 2018
2. Measuring the education sector response to HIV and AIDS, guidelines for the construction and use of core indicators. UNESCO 2013
3. Act 778 (All-inclusive education specifically on HIV)

7.2. Supporting reference documents for Objective 2

1. Ghana Health Service Operational Policy and Implementation Guidelines on Task Sharing, July 2017
2. Guidelines for Anti-retroviral Therapy in Ghana, Sixth Edition. NACP 2017
3. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO 2016 (Treat All)
4. Consolidated guidelines on HIV testing services. WHO 2016
5. Guidelines on HIV Self-testing and Partner Notification: Supplement to Consolidated Guidelines on HIV Testing Services. WHO 2016

6. 90-90-90 An ambitious treatment target to help end the AIDS pandemic. UNAIDS 2014
7. National Guidelines for the implementation of HIV Counselling and testing in Ghana. Republic of Ghana 2008
8. National Guidelines for prevention of mother to child transmission of HIV. Ministry of Health Ghana, 2014.
9. Clinical blood transfusion policy, First Edition. National Blood Service Ghana, 2013
10. Ghana HIV 2020 Prevention Roadmap
11. Differentiated HIV and AIDS service delivery in Ghana operations Manual. 2018
12. HIV and AIDS task sharing guidelines. 2018
13. Registration of births and deaths Act, 1965 (Act 301)
14. Adolescent Health Sector Policy
15. Private Health Sector Policy (MOH)
16. Mental Health Act 2012, Act 846
17. National Health Quality Strategy (MOH 2017)
18. Health Sector Strategic Framework
19. Public Services Commission Human Resource guideline (HIV workplace policy)
20. National Workplace HIV and AIDS Policy, National Tripartite Committee/ Ghana AIDS Commission 2012.

7.3. Supporting reference documents for Objective 3

1. Constitution of the Republic of Ghana (Chp 5)
2. The Labour Act 2003, Act 651
3. Security and Intelligence Agencies Act 1996, Act 526
4. Policy on Privacy and Confidentiality. CHRAJ 2014
5. The Data protection Act 2012, Act 843
6. Criminal Offenses Act 1960, (Act 29)
7. Domestic Violence Act, 2007 (Act 732)

8. Persons with Disability Act 715
9. All-Inclusive-Education Act 778
10. Public Health Act 2012, Act 851
11. Public Services Commission guideline on Human Resources (workplace HIV)
12. NDPC Agenda for Jobs 2018 – 2021
13. National Key Populations Standard Operating Procedure (KP SOP)

7.4. Supporting reference documents for Objective 4

1. GAC Act, 2016, (Act 938)
2. National HIV and AIDS Resource Mobilization Strategy

7.5. Current position on key Issues

At the time of preparation of this revised policy, numerous issues of policy and operational import were in discussion or had been concluded upon. To avoid engaging in “new” debates on old issues, the current national position on some of these issues have been presented here.

1. Age of consent for testing: Children’s Act

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. The Children's Act and reproductive health policy applies here. There are however ongoing engagements to lower the age of consent for HIV testing.

2. Managing unsubstantiated pronouncements of HIV and AIDS treatment outcomes

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. Traditional medical practitioners should therefore not advertise drugs and claims of a cure for HIV until they have been certified by the appropriate agencies.

3. 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 required 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.

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.

4. Herbalist and traditional healers

Traditional medical practitioners are encouraged to refer PLHIV to health facilities for care in order to reduce the development of drug resistance. 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 sterilization and disinfection procedures.

5. Pre-exposure prophylaxis (PrEP) {ART based Prevention}

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.

Global adoption of PrEP as an ART based prevention method has shown promising results in decreasing HIV transmission rate in key

populations especially in the MSM community. While pilot programs have been conducted in many African countries a few have scaled up the uptake of PrEP. Likewise, Ghana will build on the initial pilot data gathered, adopt national guidelines based on WHO recommendations and ensure access for priority populations.

6. HIV Self-testing

Self-testing and peer-led testing in Ghana will provide additional avenues for providing HTS that will reach many sub-populations especially MSM. These testing methods are to be initiated in Ghana starting in 2019/2020 after piloting this approach. The policy guidelines for self-testing would be covered in details in the HIV testing Guidelines in a combined document recommended by WHO. For approval there will be the need to pilot test these approaches and if found appropriate, a policy directive prepared to guide its introduction and use.

7. Community Based Supply of ARVs or decentralization of HIV treatment services

This will be achieved with strengthening and intensifying the implementation of the National Task Sharing Policy.

8. Test and Treat or Treat All

Ghana has adopted the "Test and Treat Policy" for all people who test positive for HIV for full implementation beginning 2017. The "treat all policy" is a key strategy for achieving the 90-90-90 by 2020 and ultimately ending AIDS by 2030. This calls for the provision of treatment immediately following a positive test result irrespective of individual health parameters.

9. Pre-employment HIV Testing

The Ghana AIDS Commission Act, 2016 (Act 938) states that an applicant for employment shall not be tested to ascertain the HIV status of the applicant for the purpose of recruitment, promotion or any other reason.

10. HTS at ANC

It is critical to test clients seeking ANC services. Mandatory offer of HTS by service providers is what is required. Mandatory offer of HTS should be extended to all pregnant women during maternity and post-natal care services. The offer should also be extended to include the spouse and immediate family of the pregnant woman.

