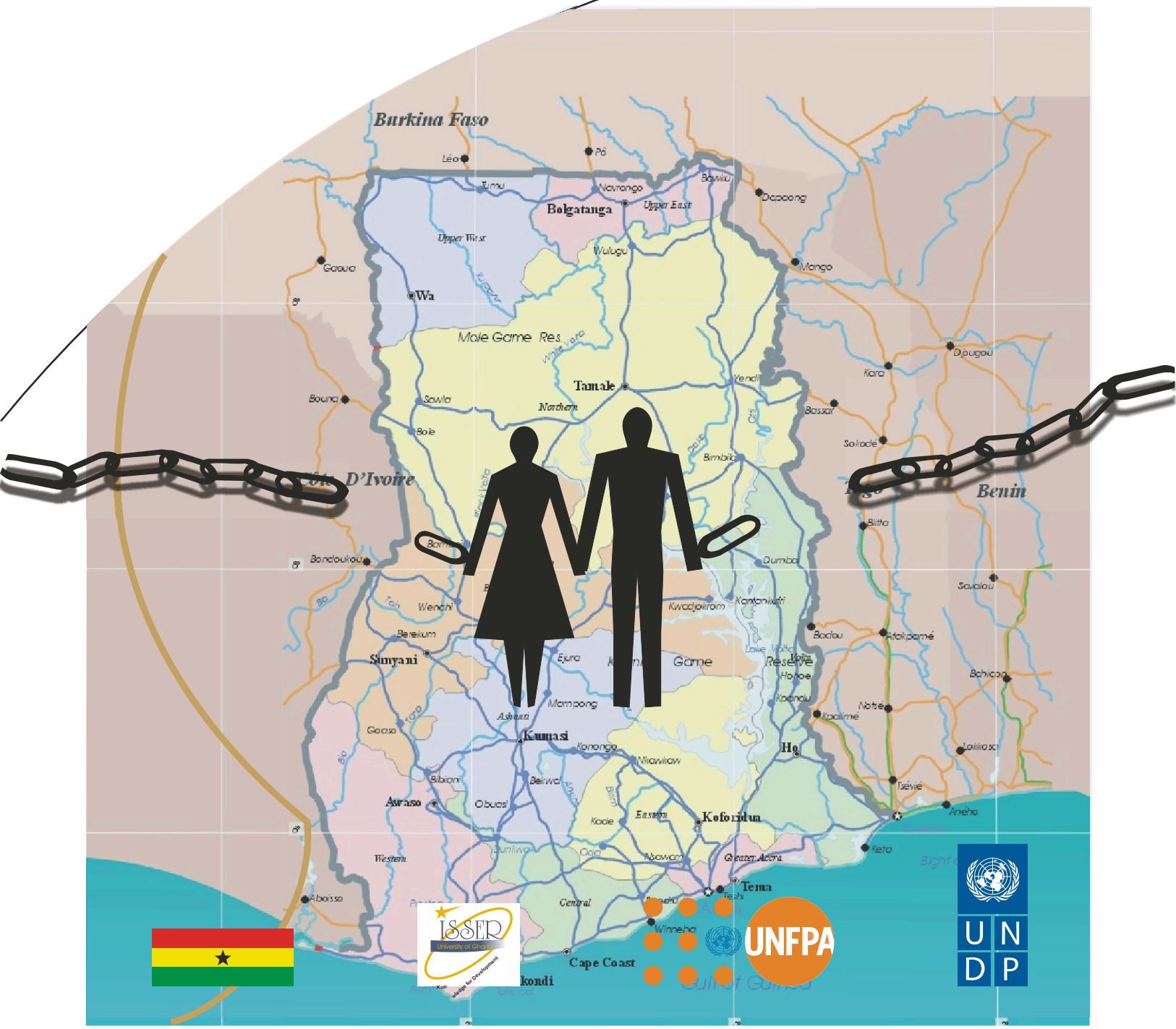
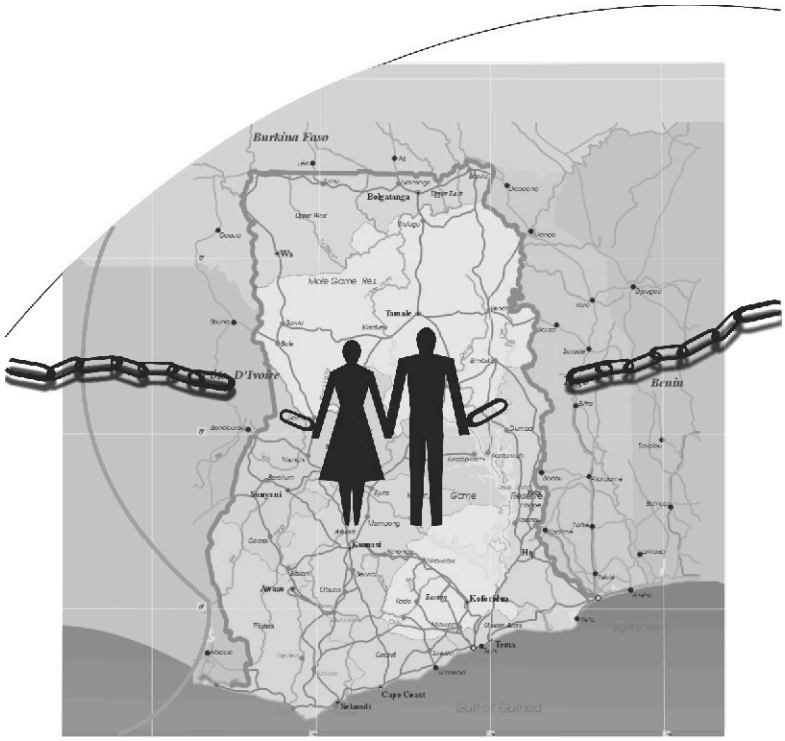
GHANA HUMAN DEVELOPMENT REPORT 2004

BREAKING THE HIV/AIDS CHAIN:
A HUMAN DEVELOPMENT CHALLENGE





Being in chains is a sign of enslavement or imprisonment as epitomised by the traditional Ghanaian *Adinkra* symbol, '*Epa*' or the handcuff, which is translated in Twi as
"*Onni a ne pa da wo nsa, na n'akoa ne wo*",
literally meaning
"you are a slave to him whose handcuffs you wear".

The symbol of a broken chain therefore is an indication of freedom. In this light, the Ghanaian society and indeed the whole world which is threatened by the HIV/AIDS is expected to break the HIV/AIDS chain through the development of its human resource.
Of uppermost importance is the need for behaviour change to break this chain.

The male and female human figures also depict the present and the future of the human race breaking free of the enslaving chain of HIV/AIDS.

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FOREWORD

The Republic of Ghana has not been spared the global HIV/AIDS pandemic. The country has had its fair share of the impact of the disease, which is increasingly becoming a threat to the nation's development. At the end of 2003, it was estimated that 3.6% of the adult population aged 15 to 49 years were living with HIV/AIDS.

Progressively, global attention on HIV/AIDS has expanded considerably from a narrow focus on medical characteristics and the search for a vaccine to a more vigorous campaign for behavioural change to halt its spread. Available evidence indicates that while the need for comprehensive care and support continues to grow, traditional structures for providing these functions are shrinking with the effect of the disease. Happily, State, Community-Based Organisations (CBOs), NGOs and donors have all yielded to pressure to expand the focus of the HIV/AIDS campaign to embrace treatment, including psycho-social care and support. This is in recognition of society's moral responsibility towards people infected with, or affected by the disease. In recent times, the government has enhanced its contribution to the fight against the pandemic by providing antiretroviral drugs to some AIDS patients.

Many seminars have been held to train peer advocates and leaders both at national and local levels to help disseminate information to sensitise the public on the causes and prevention of the disease. This has created the much needed awareness within communities all over the ten regions of the country. However, it is yet to be proved that the sustained education has yielded the required dividend of behavioural change.

The theme for Ghana's Human Development Report 2004: "Breaking the HIV/AIDS Chain: A Human Development Challenge" hits the nail right on the head. The theme provides the right focus as Ghanaians continue to contend with the pandemic in order to achieve the sixth of the Millennium Development Goals (MDGs) of combating HIV/AIDS by 2015.

The Report opens the debate once again on the direction in which Ghana is heading in the fight against HIV/AIDS vis-à-vis human development issues. It gives a general assessment of HIV/AIDS in Ghana and the world at large, and also promotes a holistic approach to dealing with the disease. Above all, the Report provides a platform for the various initiatives that are being taken to combat the disease, highlighting the best practices and the least effective methods.

Ghana must continue to expand her response to HIV/AIDS despite the legion of problems facing her, especially the challenge of achieving economic growth and accelerated national development. This is because HIV/AIDS has proved to be an implacable enemy, and constitutes one of the greatest threats not only to Ghana's development but also to the whole continent's development in the 21st Century. It is for this reason that government is doing its best to eradicate the disease or curb its spread by 2015, the global date set to wipe HIV/AIDS, malaria and other diseases from the face of the earth.

The fight against HIV/AIDS must include both personal and collective commitment and strategies. The greatest challenge of all is for behavioural change within the society, especially in terms of sexual practices, and a commitment to increased education and awareness promotion. It must be stressed at all times that abstinence is best, if not, protection is sensible. But whichever approach is adopted to fight HIV/AIDS, half the battle would have been won if Ghanaians would recognize that the disease threatens our collective survival.

H. E. JOHN AGYEKUM KUFUOR
PRESIDENT OF THE REPUBLIC OF GHANA

PREFACE

The fact that HIV/AIDS is no longer solely a health problem but a crucial development problem in many countries is widely recognized and accepted. Ghana is no exception. It is the understanding in the country that the epidemic is quietly devastating the country; therefore response to the epidemic must be quick and appropriate. The national HIV prevalence rate of 3.6 percent in Ghana in 2003 is still low relative to that of neighbouring countries. This fact can be interpreted in two ways: If the country response is quick and appropriate enough, the impact of the epidemic can be successfully minimized; however if not, it will pose a severe challenge to the country. At present, the country's response is not sufficient, but it is still in the formative stage. This is why UNDP is assisting the country in mainstreaming HIV/AIDS into its development agenda, in the process of accelerating sustainable human development. In its effort, UNDP's primary partner is the Government of Ghana, particularly the Ghana AIDS Commission (GAC) as the government's counterpart. UNDP is also in close collaboration with the members of the Expanded UN Theme Group on HIV/AIDS, which responds to various needs and demands of the country in search of viable strategies for scaling up the national response to HIV/AIDS crisis in Ghana.

In the broad context of the above, specific Expanded UN Theme Group' interventions include the following:

- Enhancing Ministry of Food and Agriculture's (MOFA) Capacity to Control HIV/AIDS
- Support to Ghana AIDS Response Fund (GARFUND) Project
- A Study of the Status of HIV/AIDS Orphans towards the Formulation of National Policy in Ghana
- Development of Best Practice Materials in Ghana (District Response Initiative Best Practices)
- Promoting Partnerships for Scaling up of the DRI

The UNDP HIV/AIDS Leadership Development Programme has focused its current efforts at generating a core of committed Leaders to facilitate capacity building of institutional programmes; workplace programmes and has affected policy issues in the country's multi-sectoral response strategy. UNDP trained 100 institutional leaders and 80 community level workers. The people trained included parliamentarians, Chiefs, NGOs, CBOs, Sector Ministries and Women Organizations.

UNDP exercises oversight in the District Response Initiative (DRI) on HIV/AIDS by providing technical assistance to the Ministry of Local Government and Rural Development. The DRI is the major vehicle for implementing HIV/AIDS programmes at the community level.

It is to underscore UNDP's belief on the importance of developing a holistic approach to addressing the HIV/AIDS pandemic that this year's National Human Development Report (NHDR) focuses on HIV/AIDS.

The thrust of the report is to put together the various initiatives that are taken to combat the disease, highlighting especially the best practices, but also noting the less effective methods. The report is to positively galvanize the adoption of multi-sectoral and multi-disciplinary approaches to the management and study of HIV/AIDS and the dissemination of information about the disease in Ghana. In this process, stakeholders should find gaps that they can contribute their resources to fill.

The publication of the report is timely as it comes at a time when we are inclined to take for granted the devastating nature of the epidemic because of the comparatively low prevalence rate in Ghana.

UNDP has played the lead role in the production of the Human Development Report on HIV/AIDS in collaboration with

UNFPA and ISSER of the University of Ghana, Legon.

This report will serve as the instructional material to inform the crafting of the Strategic Direction of HIV/AIDS interventions in Ghana over the next five (5) years.

I highly recommend this Ghana Human Development Report for adoption as a tool for mainstreaming HIV/AIDS into policy formulation and national development agenda as well as for the reading public.

Alfred S. Fawundu

RESIDENT REPRESENTATIVE, UNDP and
RESIDENT COORDINATOR, UN

OVERVIEW

PREAMBLE

The world is under serious challenge to find resources to achieve the Millennium Development Goals (MDGs); at the same time it faces the ugly reality of the potential devastation that lies in wait if the HIV/AIDS pandemic remains unchecked, particularly in Africa. AIDS is now in the top five list of leading causes of death in the world (WHO, (2000). The Declaration of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and the Millennium Development Goals both acknowledge the strong links between HIV/AIDS and current efforts to achieve human security through poverty reduction and overall human development. By the end of 2003, over 40 million people worldwide were living with HIV. Women in Africa have emerged as the most vulnerable to the disease, a situation described by UNAIDS as the 'feminisation' of the disease. (UNAIDS, 2004) Several African countries risk having their life expectancy drastically reduced as a result of the pandemic. Analysts caution that available statistics on HIV/AIDS may represent only a tip of the iceberg, as many cases going unreported. Ghana is no exception to the list of African nations that might be dealt a blow by uncontrolled HIV/AIDS, as the Ministry of Health has stated on several occasions (MoH/Ghana Health Service, 2003).

The private and public costs of HIV/AIDS are known to be high and difficult to redeem, simply because it takes a long time to grow human beings and human capital: not only are affected families decimated if its spread is unchecked, but businesses are bound to collapse as a result of loss of labour and increased welfare costs. To make strides in human development against the looming threat of HIV/AIDS will depend on a well-coordinated and sustained control, care and support programme.

Treatment is now available though at great cost. For poor countries like Ghana perhaps the more viable options are direct behaviour change for people to reduce the risk of infection and of spreading it to others.

This report, with its theme: **Breaking the HIV/AIDS Chain: a Human Development Challenge,** explores:

- the links between HIV/AIDS and efforts to promote social well-being;
- the social, cultural, religious and economic aspects of the prevention and management of the pandemic;
- the reorganisation of the health care services to equip care-givers to deliver appropriate and adequate care to people living with HIV/AIDS and their families; and
- public and private sector responses to the challenge of HIV/AIDS and human development, and collaboration with civil society and development partners.

Several initiatives to fight the diseases have emerged in Ghana, but they are not very well known to the public, or at best are disseminated in a rather fragmented manner. This Report therefore, attempts to highlight best practices as well as less effective methods. It is hoped that this will facilitate the adoption of multi-sectoral and multi-disciplinary approaches to its study and management, and the dissemination of information about it in Ghana.

MAIN FEATURES OF THE GHANA HUMAN DEVELOPMENT REPORT(GHDR) 2004

The GHDR 2004 draws attention to the pattern and implications of HIV/AIDS in Ghana. The point which is repeatedly made in the report is that despite a relatively low infection rate at present (3.6%) Ghana is likely to follow the fate of other African

countries presently being rocked by the disease, unless unusual or innovative steps are taken to halt the HIV/AIDS disease. The report is made up of seven chapters under three parts, which are briefly outlined below. The rest of the Report is made up of annexes of relevant statistical tables on human development and HIV/AIDS in Ghana.

PART ONE: HIV/AIDS AND THE STATE OF HUMAN DEVELOPMENT IN GHANA

Chapter One - Introduction and Background provides a brief review of the global as well as local status of HIV/AIDS and notes some of its direct implications for human development. The themes that arise from this review become the core areas of analysis for the rest of the report. **Chapter Two -** The State Of Human Development in 2003 reflects on the basic human development indicators of education, health and livelihoods, as well as the situation of HIV/AIDS in the country since 2000 when the last Ghana Human Development Report was launched. Despite modest progress in some areas, the report shows that on most indicators Ghana has a long way to go to meet key Ghana Poverty Reduction Strategy (GPRS) objectives and the MDGs.

PART TWO: SOCIAL, ECONOMIC AND GOVERNANCE ASPECTS OF HIV/AIDS AND DEVELOPMENT

Chapter Three - Social and Ethical Challenges Of HIV/AIDS in Ghana focuses on the way People Living with HIV/AIDS (PLWHAs) and others affected by the condition, such as family members, are treated by society and the attempts that are being made by public and private agencies to counter discrimination. **Chapter Four** - Economic Challenges Posed By HIV/AIDS in Ghana examines the potential medium to long-term effects of the HIV/AIDS pandemic on social and economic life in Ghana, with emphasis on human capital, production, trade and service delivery. How all these affect macroeconomic stability and growth in the long run is also addressed. **Chapter Five -** Health Care Response to the HIV/AIDS Pandemic focuses on the capacity of the public health care system to manage the disease, through improving the safety of blood transfusions, prevention of mother-to-child transmission, voluntary counselling and testing (VCT), home-based care for PLWHAs and herbal treatment. The chapter also discusses treatment programmes introduced by the Ghana Health Service since 2001.

PART THREE: THE WAY FORWARD

Chapter Six - Confronting the HIV/AIDS Challenge in Ghana: Reclaiming the Future looks closely at the institutional framework, including policies and guiding principles that have been put in place in Ghana to provide a management structure to cope with HIV/AIDS. The chapter pays considerable attention to the role that non-government organisations, civil society groups and development partners are playing in this process. **Chapter Seven** - Conclusion and Policy Implications outlines the main messages emanating from the Report.

THE CHALLENGE FACING SUB-SAHARAN AFRICA

The message from the African Development Forum on HIV/AIDS in Addis 2000 was that, Africa had to build a leadership corps to lead the campaign against HIV/AIDS. In the past five years, African governments and their local and international partners have stepped up their efforts, and are actively working with the International Partnership Against HIV/AIDS in Africa (IPAA) sponsored by the UN in January 1999 to halt the

spread of the disease. Strategies being adopted by these agencies include:

- improved access to information and services - voluntary counselling and testing, condom promotion, alternative strategies for information dissemination and service provision, etc;
- multi-sectoral efforts and multi-partners;
- safe sex campaigns;
- peer pressure mechanisms; and
- community-based care and support systems.

A critical aspect of the campaign which has been slow to sell is the idea and practice of voluntary counselling and testing (VCT). Infected persons tend to remain silent about their condition to avoid the backlash from disclosure.

While the majority of Africans are HIV-free, close to two-thirds of the world's AIDS cases are in sub-Saharan Africa. (UNAIDS, 2004) In 2003 alone, an estimated 3 million people in the region became newly infected, while 2.2 million died of the disease.

GHANA AND THE HIV/AIDS PANDEMIC

Efforts at human development in Ghana have come under serious threat from HIV/AIDS-related impacts on human capacity, resource allocation and social cohesion. The GPRS thus incorporates the fight against HIV/AIDS into its core activities.

By the end of 2002, 335,000 Ghanaians were living with HIV infection, and this is projected to increase to about 365,000, by the end of 2004. Six sentinel sites out of 23 in 2003, recorded prevalence rates of 5%, with a national range of between 0.6% and 9.5. %. (GHS, 2003) Certain categories of people have much higher rates. Among commercial sex workers, for instance, the rate shot up from 2% in 1986, when it was first reported in Ghana, to nearly 40% in 1991. By 1997, the prevalence rate among sex workers tested in Accra had reached a staggering 73%. The anticipated worsening disease burden for families, communities, the state and private business cannot be overestimated. (UNICEF, 2000) Over 80% of HIV transmission in Ghana is through heterosexual sex, followed by mother-to-child transmission and through blood products. For example, an estimated 90% of hospital beds will be going to AIDS patients by 2010 unless there is a dramatic turnaround in the pace of infection. (Asamoah-Odei et al. 1995)

Major steps that have been taken to combat the disease include the establishment of the National AIDS Control Programme (NACP) in 1987, and the Ghana AIDS Commission (GAC) in 2000. Policy documents and guidelines have since been developed to guide intervention in this area including for example, the National Strategic Framework on HIV/AIDS (2001-2005) and the National HIV/AIDS/STI Policy (2004).

The campaign in Ghana has come a long way from the early focus on policy and medical concerns to a focus on development and public health. Thus, the Ghana Response Initiative is based on the following types of campaigns:

- promoting abstinence and faithfulness-reducing the overall number of sexual partners,
- delaying the onset of sexual activity among adolescents,
- promoting the consistent availability and use of condoms, including female condoms,
- strengthening programmes for the

control of sexually transmitted diseases (STD), and encouraging voluntary counselling and testing (VCT).

The prevalence of HIV/AIDS is going up rather than declining as policy makers had hoped. From 2.3% in 2000, the median prevalent rate in the country rose to 3.6% at the end of 2003. (GHS, 2003) The analogy of "breaking the HIV/AIDS chain which is used in the title of the report comes from the idea that HIV/AIDS threatens to 'imprison' the Ghanaian society. This is epitomised by the traditional Ghanaian Adinkra symbol, '*Epa*' or the handcuff, which is translated in Twi as *"Onni a ne pa da wo nsa, na n'akoa ne wo",* literally: "you are a slave to him whose handcuffs you wear." Slow behaviour change has been blamed for the limited progress in fighting the spread of HIV/AIDS, but poor coverage of VCT and affordable treatment coupled with discriminatory cultural practices that discourage people from coming out of the closet to declare or investigate their status contribute to the rising prevalence rate.

In Ghana too, condom use is seen to be a fast track approach to halting the pace of the disease. Innovative marketing strategies relying on private informal sector vendors have been used to popularise condoms in Ghana, leading to a dramatic rise in condom sales between 1999 and 2000. (NACP, 2001) But condom use is still very low - estimated to be about 6% among men and 2% for women. Besides, the cost of mounting a full-scale prevention and treatment campaign is prohibitive, especially for a developing country like Ghana. Of an estimated $120 million required to launch a sustained campaign in the country only $60 million had been raised by 2002. In spite of the financial constraints, an HIV and STI Sentinel Surveillance System was introduced in 1990, and surveys have been conducted annually since 1994. (GHS, 2003) The system currently includes four public health reference laboratories.

Trade Related Intellectual Property Rights (TRIPS) Agreement of the World Trade Organisation (WTO) makes it difficult for countries like Ghana to develop and produce or to import cheap generic drugs. More attention is being paid to the potential role of herbalists in the search for affordable treatment options by both international (WHO) and local institutions (MOH, Noguchi Memorial Institute for Medical Research (NMIMR), Centre for Scientific Research into Plant Medicine (CSRPM), Mampong).

Campaign leaders and the general public need broad-based as well as specialised information on the socio-cultural, economic, political and religious climate within which HIV/AIDS occurs. While information on the epidemiology of the disease is important for surveillance and management, that is already reasonably well documented (see NACP, 2000; GAC, 2001), and continues to engage the attention of many HIV/AIDS gatherings. To complement this, the Ghana Human Development Report 2004 focuses on the less widely addressed essentials, particularly, socio-economic effects, evolving care issues and the political dimensions of the disease.

The fight against HIV/AIDS must include both a personal-level strategy and a collective strategy. A central aspect of the campaign is collaboration between neighbours within borders and across borders. This is fully recognised by the Government of Ghana. In its address to the UN World Summit on Sustainable Development (August 2002), the Government of Ghana prescribed as the way forward the need to:

- Make fighting HIV/AIDS a major presidential initiative in all African countries; Recognise the combined impact of lifestyle and poverty;
- Affirm HIV/AIDS as a regional integration problem; Strengthen the position of HIV/AIDS in the GPRS, MDGs and the New Partnership for Africa's Development (NEPAD) programmes as a human Resource /capacity issue; and
- Make HIV/AIDS a personal, visible, national issue.

There is no consensus as yet on how to proceed to increase the effectiveness of the anti-HIV/AIDS campaign. A sharp difference has emerged between religious bodies and their secular partners in this campaign. While orthodox religious bodies have insisted on preaching the old doctrine of abstinence, the secular partners argue that the campaign should also be about protection through the use of condoms, as propagated by the national campaign message of abstinence [A], faithfulness [B-be faithful] and condoms [C].

Whatever the approach adopted to fight HIV/AIDS, the battle can only be won when a country and its people recognise that the dynamics of the disease undermine human rights and human security, and threaten a people's collective survival. However, to be successful at implementing any ameliorative programmes, people need information about the nature of HIV/AIDS and how it is affecting livelihoods, social relations and policy decisions on resource mobilisation and distribution. In short, people need a report that addresses the challenge posed to human development by HIV/AIDS.

CONCLUSION

Ghana has sustained her interest in creating an enabling environment to promote development, both by supporting growth-related initiatives and by promoting social justice. In this, she is in tune with major global initiatives to achieve equity-based development, while recognizing and supporting the private sector. The 1992 Constitution lays a firm foundation for a development agenda that is sensitive to the ideals of human development, expanding people's choices to live meaningful and rewarding lives as individuals and groups. Ghana's Human Development Index has improved from 0.556 in 2000 to 0.568 in 2004, even as her ranking has declined from HDI 129 in 2000 to 131in 2004. A further negative sign is the downward revision of the estimated life expectancy from 60.4 to 57.8 between 2003 and 2004.

The Ghana Human Development Report 2004 has analysed the implications of HIV/AIDS for progress and survival in Ghana. It is acknowledged that HIV/AIDS poses a unique threat to the country as it does to the whole of humanity. The Report characterises this challenge as one of bondage - a state of being held in chains. To overcome it therefore, involves breaking the chain.

Chapter One lays a brief sketch of the global as well as local crises of the HIV/AIDS pandemic. The peculiar situation facing Ghanaians is that while prevalence rates (3.6%) are relatively low by international standards, they are close enough to the breaking point (5%) in the spread of the disease to cause serious concern. Particularly worrying is the realisation that a growing number of places in Ghana already have prevalence rates

exceeding 5%. Relatively low average rates appear to breed complacency and hold back acceptance of the looming threat among a large segment of the population.

Areas of development activity that have been recognized as key to achieving expanded development, namely education, health and livelihoods have continued to be the focus of much attention since the 2000 Ghana Human Development Report was launched. In collaboration with development partners, including development-oriented non-government organizations and other civil society groups, several new initiatives have been pursued to improve people's capacities in these areas, particularly among the poor. Some of these programmes are discussed in Chapter Two in addition to a section on the profile of HIV/AIDS in Ghana.

Many pilot projects have been launched in the education sector for a variety of objectives, though the main focus is on quality improvement. The record shows that the outcomes of education, particularly in the public sector, have been well below expectation, except in the rehabilitation and provision of new infrastructure, areas in which Government has traditionally been strong. Such fundamental capacity development constraints cast doubts about the overall goal of transforming the national economy into a knowledge-based economy of middle-income status in the short to medium term. At this rate, Ghana is unlikely to meet the key MDGs. Another feature that stands out is the apparent lack of replication of pilot projects, even where it is demonstrated that they offer superior methods and systems, compared to existing ones.

With specific reference to HIV/AIDS, the formal education system offers opportunities for sensitising young people to adopt protective sexual behaviour habits. The School Health Education Programme (SHEP) and similar initiatives have already provided entry points for introducing pupils and older students to HIV/AIDS. Lack of material and other support for these types of programmes, however, is bound to limit their effectiveness as channels of sex education.

Health infrastructure has benefited from increased support over the past four years. Yet chronic problems of poor equipment and generally poor working conditions persist. From all indications, the health status of Ghanaians has largely stagnated or in certain respects declined somewhat since 2000. This is based on the simple fact that health conditions of children under five years has not improved appreciably, with nearly 30% of children suffering from stunting or being underweight. In addition, all the evidence suggests that the consumption of micronutrients is relatively inadequate, and anaemia is prevalent among women and children. Poor nutritional status holds grave implications for fighting HIV/AIDS, posing major problems for PLWHAs, as they lose their means of livelihoods and support. In addition, links between nutrition and learning outcomes are not being adequately addressed.

Without doubt the biggest challenge facing the campaign against HIV/AIDS is how to overcome it in a way that leaves intact the rights of those infected and those affected as well as the society at large. The compassion campaign has helped to draw attention to the rights of PLWHAs. More concretely, the challenge is about what strategies to adopt in response to changes in the tools for achieving needed behaviour change.

A level of tension can be observed in the direction that the AIDS Campaign has taken

in recent times. To a certain extent the need to achieve acceptance of PLWHAs now seems to overshadow the drive to make people adopt precautionary behaviour. The ideal situation would be one in which people are challenged by the information they receive from the media and other places, to be concerned about both self-preservation and the harm they may cause to others by their behaviour.

Though some categories of behaviour are characterized as high risk, experience shows that it would be highly dangerous to limit the risk factor to only selected social groups. This is because of the risk-prone lifestyles found generally in the population, e.g. early start to sex and multiple sexual networking. The social challenges actually go beyond lifestyles. It is also linked to poverty and gender which worsen the plight of PLWHAs and their families, and also aggravates the vulnerability of women and children as discussed in Chapter Three.

On the issue of workplace programmes for addressing the potential work-related aspects of HIV/AIDS, Chapter Four indicates that most firms are yet to start or have only just begun to look at the potential impact of the disease on their operations. Employers and workers both have a major hurdle to overcome in accepting PLWHAs as co-workers. It is also necessary to resolve ethical conflicts over whether to spend the firm's resources to extend the contributions of PLWHAs to the organisation, and in the process prolong their lives.

The decision of the Government of Ghana to introduce highly subsidized antiretroviral drugs is a major step forward. However, even with the best intentions, this and other programmes for PLWHAs, and others interested in voluntary counselling and testing (VCT) cannot be given wide coverage for a number of reasons, including: human capacity limitations within the health service and allied services (counsellors); serious funding and infrastructure shortfalls. Of particular importance is the need for innovative schemes to stem the brain drain of medical personnel. Chapter Five highlights the difficulty of popularising voluntary counselling and testing (VCT) among the general population. The obvious danger here is that, without knowing their status people will not be able to protect themselves and others. Every means must be found to increase the rate of VCT as a matter of urgency. Disclosure of HIV status is seen as the responsibility of those infected rather than an obligation on everyone.

It is gratifying to note the relatively high level of cooperation in addressing HIV/AIDS in Ghana as highlighted in Chapter Six. Unlike the situation about ten years ago, it is clear that all the major stakeholders are now involved in the awareness and compassion campaign, which explains the near 100% awareness in the country. The international community has made important contributions in this process; besides funding there has also been technical assistance to augment local expertise in dealing with the situation. There are, however, areas in which more private efforts could make a big difference. Instances include the provision of support for PLWHAs, orphans and civil society groups, as well as intervention in VCT and treatment programmes.

POLICY IMPLICATIONS

The major issue emerging from the analysis of socio-economic impacts of HIV/AIDS on human development in Ghana remains how to meet the threat - how to break the chain. Research and experience suggest a number of ways in which the campaign should generally be modified in order to

extend its benefits. While these observations are not necessarily new, their importance lies in the call for an intensification of ongoing strategies. They may be summarized as follows:

- Given that all institutions and activities in the country are bound to suffer from the human capacity loss associated with HIV/AIDS, the campaign should become more mainstreamed into all aspects of human development in Ghana
- The scope of the campaign should be multi-faceted to ensure that all aspects of dealing with the management of the disease are tackled simultaneously
- The agencies in charge of managing the campaign should seek more home-grown solutions to achieve behaviour change
- Decentralized agencies should be given greater technical and material support to be able to develop and sustain more regular campaigns and monitoring
- District assemblies should be required to devote more of the health budget from the District Assemblies Common Fund (DACF) to fighting the spread of the disease.
- Effort should be devoted to empowering foot soldiers for the campaign to make the community-based efforts more effective
- With the flight of health workers at a critical time such as now, donors should rethink their reluctance to fund recurrent costs (e.g. salary top ups)!
- More GAC funds should be allocated to NGOs committed to community-based care to increase family and community ownership of this initiative.

Following are specific issues linked to the various sub-themes addressed in this 2004 Report.

State of Human Development

- Support to girls, with such measures as scholarships and food rations should be expanded on a wider scale around the country, as this has been shown to improve enrolment and retention in school. Boys in selected troubled spots should be given similar assistance.
- Urgent attention should be given to best practices from pilot project in basic education such as QUIPS which have demonstrated that it is possible to improve quality significantly in the public school system by applying new and more rigorous management techniques to the school environment.
- Improving nutritional levels of children must be addressed as part of a strategy to improve not only their physical well-being, but also their learning ability and their future capabilities.

Dealing with the Social and Ethical Challenges

- The HIV/AIDS campaign has to devise more persuasive messages to encourage people to make far-sighted decisions about safe sex, especially as it moves to address younger children seen to be the window of hope.
- To counteract the deepening complacency, issues of prevention, care and compassion should be pursued simultaneously at all times.
- The general public should be made aware of the existence of high prevalence rates in particular parts of the country to help dispel the notion that Ghana is safe from the pandemic.
- It is important to emphasise to the public that awareness by itself is no protection against infection unless behaviour change occurs.

Economic Challenges

- For Ghanaian society to safeguard its labour force, it is imperative that the government maintains an active interest in the provision of care and treatment to PLWHAs, and that business organisations prepare support mechanisms to help PLWHAs get treatment so that they may continue to contribute to their organizations.
- New schemes will have to be designed to accommodate alternative employment arrangements such as time-share to enable skilled labour work reduced hours when incapacitated by HIV/AIDS, while at the same time, making it possible for such people to contribute to the families.

The Health Care Response

- Given the shortage of medical and paramedical personnel, more attention should be devoted to training non-health personnel to perform some of the psychosocial services that will have to be expanded as the demand for counselling and testing increases.
- Public health education about associated illnesses, including opportunistic infections such as TB, should be intensified.

Reclaiming The Future

By all indications, the success of the HIV/AIDS Campaign can only be won through cooperation and collaboration between stakeholders from all sides of the table. Certain basic features of such a state of affairs may be described as follows:

- All public agencies should share a common understanding and adoption of common goals for directing the HIV/AIDS Campaign to reduce tension, conflict and waste.
- Greater efforts should be made to arrive at shared goals with non-state agencies that may be bound by their own philosophies to move the campaign in directions that may conflict with the general GAC-sponsored framework.
- There should be support for innovativeness and experimentation to allow people to pursue alterative strategies for managing the disease. Religious organisations and activist groups should be encouraged not only to counsel the public about reaching out and compassion, but also to open up debates about lifestyle, self-preservation and obligation which obviously play a role in the spread of the disease.
- District Assemblies should work more closely with parliamentarians and assembly members to deepen local HIV/AIDS initiatives.
- Accelerating growth is essential to changing the pace of human development. This is directly linked to getting the human fundamentals right - direct intervention in basic education and basic health (nutrition and morbidity) resulting in wellness to boost productivity. Uncontrolled HIV/AIDS makes the aspirations all seem the more difficult to achieve.
- Finally, to fully articulate the way forward and reclaim the future, a strong case is made for volunteerism in Ghana. The UN Volunteers Programme (UNV) in Ghana has a good pedigree in grassroots and community interventions. At short notice, the Programme can draw from its enormous experienced but cost-effective human resource base to assist in the areas of advocacy, monitoring, evaluation and reporting on the pandemic.

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CHAPTER 6 - CONFRONTING THE HIV/AIDS CHALLENGE IN GHANA: RECLAIMING THE FUTURE
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CHAPTER 7 - CONCLUSION AND POLICY IMPLICATIONS
Ellen Bortei-Doku Aryeetey, ISSER • Akilagpa Sawyerr, AAU

ANNEXES
Annex A: Statistical Information on Human Development in Ghana
Dorcas Dennis, NDPC • Ransford Bekoe, AAU

Annex B: Familiarity with HIV/AIDS Sickness and Death
Ellen Bortei-Doku Aryeetey, ISSER • John Agyei, ISSER • Cynthia Addoquaye Tagoe, ISSER

Annex C: Annotated Bibliography on HIV/AIDS-Related Research in Ghana
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ACRONYMS

AGC	-	Ashanti Goldfields Corporation
AIDS	-	Acquired Immune Deficiency Syndrome
AIM	-	AIDS Impact Model
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral
ATM	-	Automated Teller Machine
BECE	-	Basic Education Certificate Examination
CAS	-	Country Assistance Strategy
CBC	-	Collective Bargaining Certificate
CBOs	-	Community-Based Organisations
CDS	-	Community Decisions System
CHPS	-	Community-based Health Planning Services
CRT	-	Criterion-Referenced Test
CSOs	-	Civil Society Organisations
CSRPM	-	Centre for Scientific Research into Plant Medicine
CSW	-	Commercial Sex Worker
CWIQ	-	Core Welfare Indicator Questionnaire
CWSA	-	Community Water and Sanitation Agency
DfID	-	Department for International Development
DHMTs	-	District Health Management Teams
DMB	-	Domestic Money Bank
DPT	-	Diphtheria, Poliomyelitis and Tetanus
DRI	-	District Response Initiative
DRMT	-	District Response Management Team
ECOWAS	-	Economic Community of West African States
ESP	-	Education Strategic Plan
EU	-	European Union
FBOs	-	Faith-based Organisations
fCUBE	-	free Compulsory Universal Basic Education
FGD	-	Focus Group Discussion
FHI	-	Family Health International
FIDA	-	Federation of Women Lawyers
GAC	-	Ghana AIDS Commission
GARFUND	-	Ghana AIDS Response Fund
GDHS	-	Ghana Demographic and Health Survey
GDP	-	Gross Domestic Product
GEA	-	Ghana Employers' Association
GER	-	Gross Enrolment Ratio
GES	-	Ghana Education Service
GETFund	-	Ghana Education Trust Fund
GFATM	-	Global Fund to fight Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis and Malaria
GHAMFIN	-	Ghana Micro-finance Institutions Network
GHDR	-	Ghana Human Development Report
GHS	-	Ghana Health Service
GIMPA	-	Ghana Institute of Management and Public Administration

GIPC	-	Ghana Investment Promotion Centre
GLSS	-	Ghana Living Standards Survey
GoG	-	Government of Ghana
GPER	-	Gross Primary Enrolment Ratio
GPRS	-	Ghana Poverty Reduction Strategy
GSE	-	Ghana Stock Exchange
GSMF	-	Ghana Social Marketing Foundation
GSS	-	Ghana Statistical Service
GUSS	-	Ghana Universal Salary Structure
GWCL	-	Ghana Water Company Limited
HAART	-	Highly Active Antiretroviral Therapy
HIPC	-	Highly Indebted Poor Country
HIV	-	Human Immunodeficiency Virus
IAE	-	Institute of Adult Education
ICT	-	Information, Communication Technology
IDA	-	International Development Agency
IDU	-	Intravenous Drug Use
IEC	-	Information, Education and Communication
ILO	-	International Labour Organisation
IOM	-	International Organisation for Migration
IPAA	-	International Partnership against AIDS in Africa
ISD	-	Information Services Division
ISSER	-	Institute of Statistical, Social and Economic Research, University of Ghana
ITN	-	Insecticide Treated Net
JHU	-	John Hopkins University
JSS	-	Junior Secondary School
KILM	-	Key Indicators of Labour Market
KNUST	-	Kwame Nkrumah University of Science and Technology
LPG	-	Liquefied Petroleum Gas
M & E	-	Monitoring and Evaluation
MCH	-	Maternal and Child Health
MDAs	-	Ministries, Departments and Agencies
MDGs	-	Millennium Development Goals
MESW	-	Ministry of Employment and Social Welfare
MLGRD	-	Ministry of Local Government and Rural Development
MMDE	-	Ministry of Manpower Development and Employment
MoEYS	-	Ministry of Education, Youth and Sports
MOFA	-	Ministry of Food and Agriculture
MOH	-	Ministry of Health
MoI	-	Ministry of Information
MOWAC	-	Ministry of Women and Children's Affairs
MTCT	-	Mother-to-Child Transmission
MSD	-	Meteorological Services Department
MSM	-	Sexual transmission among men who have sex with men
NACA	-	National Advisory Commission on AIDS

NACP	-	National AIDS Control Programme/National AIDS/STI Control Programme
NCCE	-	National Commission on Civic Education
NCTE	-	National Council for Tertiary Education
NDPC	-	National Development Planning Commission
NEPAD	-	New Partnership for Africa's Development
NGP	-	National Governance Programme
NHDR	-	National Human Development Report
NHIS	-	National Health Insurance Scheme
NMIMR	-	Noguchi Memorial Institute for Medical Research
NSF	-	National HIV/AIDS Strategic Framework
OAU	-	Organisation of African Unity
OHCS	-	Office of the Head of Civil Service
OVCs	-	Orphans and Vulnerable Children
PEF	-	Private Enterprise Foundation
PLWHAs	-	People/Persons Living With HIV/AIDS
PMTCT	-	Prevention of Mother-to-Child Transmission
PMT	-	Performance Monitoring Test
POPFLE	-	Population and Family Life Education
PPAG	-	Planned Parenthood Association of Ghana
PSI-DL	-	President's Special Initiative on Distance Learning
PTR	-	Pupil-Teacher Ratio
PURC	-	Public Utilities Regulatory Commission
QUIPS/ILP	-	Quality Improvement in Primary Schools/Improving Learning through Partnership
SHEP	-	School Health Education Programme
SIF	-	Social Investment Fund
SIPAA	-	Support to the International Partnership against AIDS in Africa
SSNIT	-	Social Security and National Insurance Trust
SSS	-	Senior Secondary School
SSSCE	-	Senior Secondary School Certificate Examination
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
TASO	-	The AIDS Support Organisation
TUC	-	Trades Union Congress
TRIPS	-	Trade Related Intellectual Property Rights
TB	-	Tuberculosis
UCC	-	University of Cape Coast
UCE	-	University College of Education
UG	-	University of Ghana
UN	-	United Nations
UNGASS	-	United Nations General Assembly Special Session on HIV/AIDS
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme

UNFPA	-	United Nations Population Fund
UNHCR	-	United Nations High Commission for Refugees
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
WAEC	-	West Africa Examination Council
WATSAN	-	Water and Sanitation
WB	-	World Bank
WHO	-	World Health Organisation
WTO	-	World Trade Organisation

GLOSSARY OF WORDS AND CONCEPTS

HIV/AIDS: Understanding the Syndrome

A group of signs and symptoms that occur together and characterize a particular abnormality is referred to as a syndrome. Acquired Immune Deficiency Syndrome (AIDS) represents the final stages of the body's response to, or struggle against an infection by the Human Immunodeficiency Virus (HIV). The ultimate effects of AIDS are devastating for both the patient who is infected, the people around the patient, the affected, as well as the non-infected because of the need to divert resources of the community in an attempt to stop the spiralling deterioration of the quality of life of all three groups of people. Understanding the syndrome is imperative if we are to halt the deteriorating conditions successfully.

HIV, unlike other viruses, attacks the immune system that the body uses to ward off infectious diseases, or to mount an attack for ridding itself of things that do not belong to it, including viruses. No other known virus that can attack the human body, attacks the immune system. The HIV does not only attack the cells of the immune system that fight diseases, it makes itself part of the core of these cells, so that it cannot be destroyed without destroying these beneficial cells. In addition, the virus uses the components of these cells to make more virus particles, which attack new immune cells, which are made and put into circulation in response to the destruction of the old ones. Treatment therefore, is merely reducing the number of viral particles produced, so that new immune cells produced will not be attacked and destroyed. The viral particles that have become part of the immune cells continue to stay since it is impossible to get rid of them once they have become part of the cell. They can always make more of themselves, hence the need to continue the therapy for life. With the immune system compromised by the HIV infection, the body is unable to fight other infections and becomes vulnerable to opportunistic infections. Now there is drug therapy to treat people. Good nutrition is particularly important in this situation as it is essential for the proper function of the immune system even in the absence of HIV.

Transactional Sex

The tradition of sex for material gain goes beyond overt commercial sex as is normally assumed. The idea of transactional sex captures all the forms of sexual liaisons that are driven largely by expectation of material rewards. The general trend is that poor disadvantaged girls are attracted to relationships with well-off men who can give them temporary relief from material hardship in exchange for sex. This has been cited as one of the major reasons behind many of the young women-older men marriages, referred to as inter-generational marriages, especially in poor countries. Transactional sex would seem to exclude coerced sexual relationships, except that in situations of conflict, demands for sex may be used as a bargaining tool by captors.

Commercial Sex Work

Commercial sex work simply refers to sex retailing for direct financial gain. Commonly referred to as prostitution, it is illegal in many countries and is widely associated with women. The number of male sex workers is however known to be growing around the world. Commercial sex work thrives on multiple sexual networking, exposing both service giver and client to a high risk of infection from STIs including

HIV. In addition, regular partners of sex workers (including spouses) are automatically exposed to the risk of infection.

Sexual Networking

Sexual networking describes the pattern of sexual relations that are maintained by individuals and in a global sense the general partnering habits of a population. There is concern that multiple sexual networking by both married and unmarried people increases the risk of infection. This is true whether multiple networking is practiced serially or simultaneously.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF BOXES

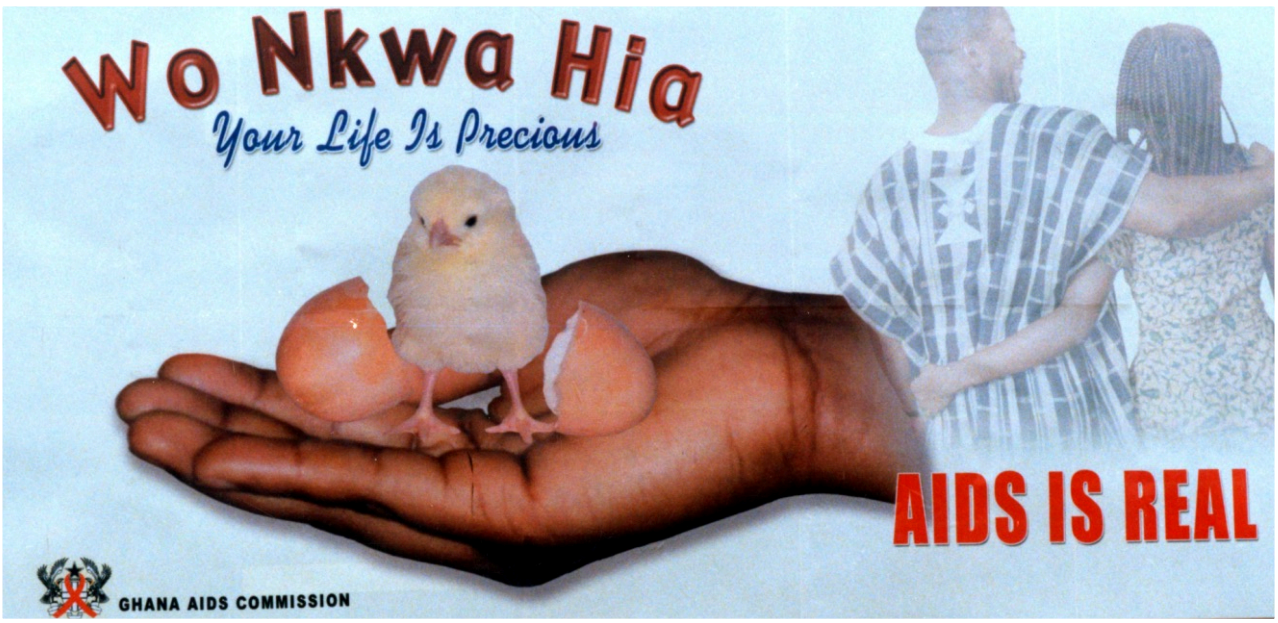
LIST OF FIGURES

PART ONE

HIV/AIDS AND THE STATE OF HUMAN DEVELOPMENT IN GHANA

CHAPTER ONE: INTRODUCTION AND BACKGROUND

CHAPTER TWO: THE STATE OF HUMAN DEVELOPMENT IN 2003



CHAPTER ONE

INTRODUCTION AND BACKGROUND

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.0 INTRODUCTION

Achievements in the human development agenda of a nation can be set back by a number of occurrences, some catastrophic such as earthquakes, floods and bush fires, all natural phenomena from the physical environment. Other factors could be health related, such as plagues or famine from a major crop failure. From such catastrophes, a nation can bounce back if its human resources and development agenda are and remain on course. However, when the catastrophe undermines human development by eroding previous gains and reducing the capacity to self-develop, it then threatens the very existence of a people.

Such is the HIV/AIDS[1] pandemic. Its causative agent, the HIV virus, "imprisons" the very immune system that the body would use to get rid of it and other disease-causing agents. It is as if with HIV/AIDS the only protective system the body has, is disabled by the very same disease. Similarly, at the societal level, by stunting economic growth, destabilising the family and other social support structures and disrupting education and the health services, the pandemic undermines the social capacity to deal with it effectively. The nature of the syndrome, its devastating effects and our seeming inability to stop these effects, particularly in Africa, present a picture of humanity in chains. We have to break these chains to stay alive.

The Declaration of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and the Millennium Development Goals (MDGs) both acknowledge the strong links between HIV/AIDS and current efforts to achieve human security through poverty reduction and overall human development. This observation has been fully taken on board by policy makers in Ghana as is evident in the following statement of the Government of Ghana:

The Republic of Ghana has not been spared the global HIV/AIDS pandemic. It was estimated that 3.6% of the adult population aged 15 to 49 years were living with HIV/AIDS as at the end of 2003. Increasing demand on health care services, increases in both adult and under five mortality, rising numbers in orphans and vulnerable children, a shrunken labour force with its resulting loss in productivity are some of the challenges that the country has to face as the epidemic increases. (Ghana Health Service, 2003: v)

In addition to the challenges identified in the statement, there is evidence that, as the need for comprehensive care and support has grown, traditional structures for such care and support have shrunk partly as a result of the effects of the disease. Social scientists have alerted the world that the disease, with its consequent sickness and death among able-bodied parents, is wiping out livelihood systems and coping strategies. In the areas of severest impact, children and other dependants are left in the care of young relations, elderly relatives, or even neighbours. Thus, traditional patterns of family relations, roles and responsibilities are, to some extent, being re-written all over the world, especially in hard-hit Africa. (Bollinger et al, 1999)

Fortunately, the spread of the disease can

[1] HIV/AIDS - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

be significantly held back by specific human behaviour, alteration of which can make a decisive difference. Hence the emphasis on behavioural change - in both the infected and the non-infected - as a means of control. The problem, however, is that behavioural change is a slow process and, therefore, additional measures are needed to help contain the pandemic.

This report, with its theme: **Breaking the HIV/AIDS Chain: a Human Development Challenge**, discusses:

- the links between HIV/AIDS and efforts to promote social well-being;
- the social, cultural, religious, and economic aspects of the prevention and management of the pandemic;
- The reorganisation of the health care services to equip care-givers to deliver appropriate and adequate care to people living with HIV/AIDS and their families; and
- public and private sector responses to the challenge of HIV/AIDS and human development, and collaboration with civil society and development partners.

While new insights are being gained about the mode of spread of HIV/AIDS and the strategies for arresting its spread, this is not as widely known as it should be.[2] This Report therefore attempts to bring together the key initiatives under way to combat the disease, highlighting best practices and noting the less effective methods. It is hoped that this will help promote information dissemination and a holistic approach to dealing with the disease. In particular, it should facilitate the adoption of multi-sectoral and multi-disciplinary approaches to its study and management, and the dissemination of information about it in Ghana. In the process, stakeholders should be able to identify niches for which they could mobilize their resources.

This Chapter looks briefly at global conditions, some Africa-related concerns and an overview of the Ghana situation. It concludes with a reflection on human development in general and an outline of the rest of the Report.

1.1 HIV/AIDS: A GLOBAL DEVELOPMENT CHALLENGE

Global concerns with HIV/AIDS have expanded significantly from a narrow focus on its medical characteristics and the search for a vaccine, to a more vigorous campaign for behavioural change to halt its spread. More recently, both state and societal agents have broadened the focus of the campaign further, to embrace social and moral responsibility towards people infected with, or affected by, the pandemic. There is, moreover, increasing recognition of the obligation to support People Living with HIV/AIDS (PLWHAs) to live meaningful lives for as long as possible. Several international donor and non-governmental organisations are working alongside public agencies to achieve these multiple objectives. The concern is also linked to survival of society in general. The World Health Organisation (WHO) reports that AIDS-related deaths are the second leading cause of death in the world today, second only to acute respiratory infections. (WHO, 2000) Equally grave are declines in life expectancy which have been observed in some of the worst-affected countries, such as South Africa, Botswana and Zimbabwe. (UN Population Division, 1998) HIV/AIDS, thus, threatens to reverse hard-won

[2] The Ghana Human Development Report 2004 relies mainly on existing data. In addition, selected interviews were conducted with key persons. It was managed through the collaborative efforts of the UNDP, UNFPA, ISSER at the University of Ghana, and a team of local consultants drawn from a wide disciplinary background.

The governance structure of the Report included a Technical Committee made up of UNDP, UNFPA, ISSER personnel and subject/ thematic specialists. The work of the consultants was periodically reviewed by an Advisory Panel of about 40 representatives from government, NGOs, the donor community, private sector and civil society organisations. Three reviewers were appointed locally to critique various drafts of the Report in addition to a HDR network review team. The whole process was facilitated by a coordinator and an editor.

developmental gains made by poor nations since the end of the Second World War.

In many respects the global rates of infection and death best tell the story of the disaster that is AIDS. By the end of 2003, over 40 million people worldwide were living with HIV. In 1997, women were 41% of people living with HIV; by 2003, the figure had risen to almost 50%, a trend most marked in the Caribbean and sub-Saharan Africa, places where heterosexual sex is the dominant mode of HIV transmission. (Table 1.1)

Table 1.1: Regional HIV/AIDS Statistics and Features, end of 2003

Region	Adult /children living with HIV/AIDS	Adults/children newly infected with HIV	Adult prevalence rate (*)	Adult and children deaths due to AIDS	Main modes of transmission (#) adults living with HIV/AIDS*
Sub-Saharan Africa	25.0m - 28.2m	3.0 - 3.4 m	7.5 - 8.5%	2.2 - 2.4m	Hetero
North Africa & Middle East	470,000 - 730,000	43,000 - 67,000	0.2 - 0.4%	35,000 - 50,000	Hetero, IDU
South & South–East Asia	4.6m -8.2m	610,000 -1.5m	0.4 - 0.8%	300,000 - 590,000	Hetero, IDU
East Asia & Pacific	700,000 - 1.3m	150,000 - 270,000	0.1 - 0.1%	32,000 - 58,000	IDU, Hetero, MSM
Latin America	1.3m -1.9m	120,000 - 180,000	0.5 - 0.7%	49,000 - 70,000	MSM, IDU, Hetero
Caribbean	350,000 - 590,000	45,000 - 80,000	1.9 - 3.1%	30,000 - 50,000	Hetero, MSM
Eastern Europe & Central Asia	1.2m -1.3m	180,000 - 280,000	0.5 - 0.9%	23,000 - 37,000	IDU
Western Europe	620,000 - 680,000	30,000 - 40,000	0.3 - 0.3%	2,600 -3,400	MSM, IDU
North America	790,000 - 1.2m	36,000 - 54,000	0.5 - 0.7%	12,000 - 18,000	MSM, IDU, Hetero
Australia & New Zealand	12,000 - 18,000	700 -1,000	0.1 - 0.1%	<100	MSM
Total	40 million (34m -46m)	5 million (4.2m - 5.6m)	1.1% (0.9 - 1.3%)	3million (2.5m -3.5m)	

Source: UNAIDS/WHO (2001), AIDS Epidemic Update: December 2003, Geneva, Switzerland
*Using 2001Data.
Hetero (Heterosexual transmission) IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men)

According to UNAIDS, nowhere is the pandemic's 'feminisation' more apparent than in sub-Saharan Africa, with women making up 57% of infected adults and 75% of infected young people. (UNAIDS, 2004) In some of the worst-affected countries, 2 or more out of 5 pregnant women attending antenatal clinics in urban areas were found to be HIV-positive. (African Agenda, 2000) UNAIDS further estimates that about 10 million young people aged 15-24 years, and about 3 million children under 15 are living with HIV/AIDS. (UNAIDS, 2003) More than 23 million people are reported to have died of the disease in the last two decades, though analysts warn that official statistics represent only the tip of the iceberg, many cases going unreported. (See Annex A section D for Africa's Statistics)

Numerous conferences and summits have deliberated on how best to direct the campaign to stop the spread of HIV/AIDS, particularly in Africa. For example, the theme of the African Development Forum in Addis Ababa, Ethiopia, in December 2000 was: AIDS, the Greatest Leadership Challenge. The former Organisation of Africa Unity (OAU) now the African Union (AU), also held a summit on AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases in Abuja, Nigeria, in April 2001. At the Abuja Summit, African leaders resolved to spend 15% of their annual budgets on health services. Yet by the end of the year, only five countries had reached that goal. (UNAIDS, 2001)

A few countries, among them, Uganda and Senegal, have been able to reduce infection rates drastically through high-level political commitment and intensive campaigning. Reductions are beginning to show in Kenya and Zambia as well. (Morna, 2000; UNAIDS, 2004) Moreover, there are indications that the rate of HIV infection in Africa is stabilising, with new infections in 2000 (3.8 million) falling below that of 1999 (4 million). In the words of the UNAIDS Chief, Peter Piot: "It's not great news but it is certainly better than before". (Morna, 2000: p1)

Recognising the direct impact of HIV/AIDS on human development outcomes, the United Nations is playing a pivotal role in the AIDS campaign, alongside its fight against poverty. Its lead agency in this campaign, UNAIDS, operates on the premise that unless the spread of HIV/AIDS can be held in check efforts at human development would be futile. (UNAIDS, 2001: p.7)

Accepting that Africa occupies a special place in the HIV/AIDS agenda, the UN and its development partners set up the International Partnership against HIV/AIDS in Africa (IPAA) in January 1999 at Annapolis, USA. The Partnership promptly endorsed the urgent need for an advocacy strategy.

In addition to the Partnership, several international NGOs are working alongside public organisations and donors to extend HIV/AIDS advocacy among different social groups. (Anarfi 2000) For their part, Sub-Saharan Africa countries are enhancing their response to the fight against HIV/AIDS mainly in the following areas:

- Improved access to information and services - voluntary counselling and testing, Condom promotion, alternatives strategies for information dissemination and service provision, etc;
- Multi-sectoral efforts and multi-partners;
- Safe sex campaigns;

- Peer education mechanisms; and
- Community-based care and support systems.

One of the major bottlenecks in dealing with the HIV/AIDS dilemma is the low rate of voluntary counselling and testing (VCT). Infected persons, overcome by stigma and difficulties in dealing with it, and facing problems of access to antiretroviral (ARV) drugs, tend to remain silent about their condition. Families often cover up the real cause of illness and subsequent death, a situation aggravated by the tendency of some faith-based organizations to shun such individuals, supposedly on the basis of a theology of sin. The overall effect is that, communities, through individual and collective denial of the seriousness of HIV/AIDS in their midst, often subject their people to the silent spread of the disease.

1.2 AFRICA: WORST HIT BY HIV/AIDS

There is no doubt that one of Africa's greatest challenges in the 21st century is the AIDS pandemic. The number of deaths and extent of social dislocation threatened by the pandemic are worse than any natural disaster or war ever experienced by the continent. Close to two-thirds of the world's AIDS cases are in sub-Saharan Africa, a region with just over 10% of the world's population. (UNAIDS, 2004) "A disease virtually unknown barely two decades ago, AIDS has, to date, caused the death of about 17 million Africans, with 2.4 million of those deaths occurring in 2000 alone". (UNAIDS, 2000)

By the end of 2000, 12.1 million African children had lost one or both parents as a result of AIDS. In 2003 alone, an estimated 3 million people in the region became newly infected, while 2.2 million died of the disease. Among young people 15- 24 years of age, 6.9% of women and 2.1% of men were living with HIV by the end of 2003. (UNAIDS, 2004)[3] Yet against this background, it needs to be emphasised that roughly 90% of Africans are HIV-free. The big challenge, as pointed out by UNAIDS (2003), is how to keep the 90% *permanently* free and, indeed, how to improve the ratio.

HIV/AIDS and Human Security

"There is a world of difference between the root causes of terrorism and the impact of AIDS on security. But at some deep level, we should be reminded that in many parts of the world, AIDS has caused a normal way of life to be called into question. As a global issue, therefore, we must pay attention to AIDS as a threat to human security, and redouble our efforts against the epidemic and its impact". (Peter Piot, UNAIDS Executive Director, n.d.)

HIV/AIDS has alerted humanity to new dimensions of security. Recognising that many more people are dying of AIDS than from armed conflict, UNAIDS has established an Office on AIDS, Security and Humanitarian Response. (UNAIDS, n.d.)

With most of the world's poorest nations located in sub-Saharan Africa, the chances that the continent can, on its own, find quick solutions to the AIDS crisis look bleak. Declines in labour supply and absenteeism from work due to morbidity will hamper production and food security for many households, where this is not already happening. This is particularly significant in countries like Ghana, where over 50% of staples consumed by households come from their own produce. (GSS, 2000) Poorly resourced health delivery systems, weak educational infrastructure and widespread political crisis - civil strife, war, displacement

[3]UNAIDS and WHO have revised their global estimates of the number of adults living with HIV, particularly in the sub-Saharan region. These new estimates are the result of more accurate data from country surveillance, additional information from household surveys, and steady improvements in the modelling methodology used by UNAIDS, WHO and their partners. This has led to lower global HIV estimates for 2003, as well as for previous years. Although the global estimates are lower, this does not mean the AIDS pandemic is easing off or being reversed. The pandemic continues to expand.

and migration - constitute further handicaps. Average life expectancy, which is one of the cornerstones of the human development index, now stands at only 47 years in sub-Saharan Africa, rather than the projected 62 years. (UNAIDS, 2001) Regrettably, opportunities for mobilising the external support required to drive the campaign and treatment are reduced by a growing focus of the world's leading industrial powers (the G8 members) on their internal needs, and more recently, on the war on terrorism.

1.3 HIV/AIDS: THE HUMAN DEVELOPMENT CHALLENGE IN GHANA

Turning to Ghana, it may be observed that HIV/AIDS threatens to spark a human development crisis by weakening the very foundation of human development - human capital base of the country. In addition, the cost of treatment and general management of the disease impose an extra burden on both public and private institutions, including the family. The gravity of the human capital loss is manifest, given the fact that the vast majority (about 90%) of AIDS cases and the majority of AIDS deaths in Ghana, as elsewhere, are in the productive age group of 15-49 years. (Ministry of Health, 2000) Indeed, children are among the worst-hit, not only as victims of the disease but also as orphans and premature care-givers following AIDS-related deaths. Clearly, unless something drastic happens to alter the situation, the trends in reported child infections signal labour shortages in the next few decades.

The country acted quickly even before the first HIV/AIDS case was reported in 1986 with the setting up of the National Advisory Committee on AIDS (NACA) in 1985, though some would argue that it was slow to recognize the enormity of the problem. The National AIDS Control Programme (NACP)[4] and the Ghana AIDS Commission (GAC) were later established in 1987 and 2000, respectively. Policy documents and guidelines have since been developed to guide intervention in this area including for example, the National Strategic Framework on HIV/AIDS (2001- 2005). From the point of view of the report, the focus should now turn to how best to implement the strategic framework. It is suggested here that we need to identify the critical point at which to break the HIV/AIDS chains. A few thoughts on this dilemma are explained below.

Breaking the Chain at Various Stages:

1. The infected person not passing the virus on;
2. The period between HIV infection and AIDS after diagnosis;
3. At the beginning, before infection (for the non-infected).

The Infected Person Not Passing The Virus On

Some people are advocating for anti-retroviral (ARV) drugs for treating AIDS patients. The basis of the use of these drugs is that some of them inhibit the division or replication of the virus and therefore reduce viral load. Advocacy includes requesting for the drugs to be provided more cheaply and for people to be trained to administer them. The availability of human resource to administer these antiretroviral drugs is a drawback at present. Apart from the issue of affordability, which is a socio-economic issue, there are other issues related to antiretroviral therapy (ART). Should the source of these drugs continue to come from other countries? Is it possible to produce them locally and thereby cut costs? Even more importantly, is it possible that some of

[4]This also refers to the National HIV/AIDS/STI Control Programme and may be used interchangeably with National AIDS Control Programme or National AIDS/STD Control Programme

the herbal preparations being used locally can do more than treat opportunistic infections? These herbal preparations have been evaluated only as treating opportunistic infections. Some chemical compounds that inhibit replication of viruses have been isolated from plants in other countries. If Ghanaian scientists could concentrate efforts on finding out the effects of these herbal preparations on viral load and immune status of the AIDS patients who take them, this nation may be on its way to discovering plant (derived) preparations which have antiretroviral properties. The potential gain in terms of profiting from indigenous knowledge and cost-reduction in health care cannot be over-estimated.

The Period Between Hiv Infection And Aids After Diagnosis

The (incubation) period between infection with the virus and the overt symptoms of AIDS could be long and, indeed whether the HIV infection will lead to AIDS or not depends on a number of factors including good nutrition and reduced incidence of infection and treatment. Breaking the chain at this point is also possible through the food we eat and the environment we keep. Sanitation then becomes critical for all, especially for those who care for infected persons.

At The Beginning, Before Infection (for The Non-infected)

The non-infected person is a key element in breaking the chain. The onus here is on the non-infected person to break the chain. Since there is no cure, prevention must be through behaviour change. The "ABC" slogan may not be enough and additional strategies may be required in breaking the chain. One possibility is extensive formal education in the science of HIV/AIDS in schools, especially at secondary and tertiary levels of education.

The Ghana Campaign

The campaign in Ghana has come a long way from the early focus on policy and medical concerns to focus on development and public health. Thus, as spelt out by GAC, the Ghana Response Initiative is based on the following types of campaigns:

- promoting abstinence and faithfulness,
- encouraging the delay of sexual activity among adolescents,
- promoting the consistent availability and use of condoms, including female condoms,
- strengthening programmes for the control of sexually transmitted diseases (STD), and
- encouraging voluntary counselling and testing (VCT).

It is observed, nevertheless, that the major behavioural changes needed to slow down transmission rates have not yet occurred. In many parts of the country ambivalent cultural attitudes and practices relating to sexual networking, polygyny and fertility put little pressure on men and women to take precautions in sexual unions. For instance, pregnancy and childbearing are regarded as blessings not to be interfered with, which at once limits the likelihood of popularising condom use in the short term. For these reasons, the success of the control of HIV/AIDS will depend, in part, on finding innovative ways of influencing cultural attitudes to encourage people to become more protection-oriented in their sexual relations.

Paramount among current strategies for behavioural change is the promotion of condom use, which has steadily improved. Innovative marketing strategies such as those adopted by the Ghana Social Marketing Foundation (GSMF), the Planned

Parenthood Association of Ghana (PPAG) and others have carried condoms to the people, using street-level distribution outlets such as tabletop vendors, kiosks, container shops and drinking bars, among others. (NACP, 2001) As a result condom sales rose by 80% from 1999 to 2000. In spite of this, however, overall usage of condoms has been disappointing, particularly in view of the over-90% level of awareness of the disease. The rate of condom use is estimated to be about 6% among men and 2% for women, rates that are not high enough to make any significant impact on the HIV-prevalence rate. A factor contributing to low female patronage is the rather subdued publicity about the female condom.

As a departure from previous approaches, there have been calls on NGOs engaged in HIV/AIDS education to focus their activities on building the capacity of households rather than the organisation of public workshops and seminars. In the meantime, the Ghana AIDS Commission is now laying more emphasis on both care for AIDS orphans and home-based care for People Living With HIV/AIDS (PLWHAs).

It should be noted that this pressure on the government to expand its response to HIV/AIDS occurs at the same time as Ghana struggles with the two-pronged problem of achieving accelerated economic growth, while trying to improve human development outcomes. By 2002, resources mobilised to address the challenge of HIV/AIDS amounted to US$60 million, only half of the estimated total requirement of US$120 million. (UNAIDS Event, 2002) With an already large poverty burden (40%) and modest economic growth rate (about 5%), it is not surprising that human development targets have been slow to achieve. (See GSS 2000; UNDP/ISSER, 2001; Aryeetey et. al. 2000; ISSER, 2002) From this perspective, it would appear that HIV/AIDS threatens to "imprison" the Ghanaian society. This is epitomised by the traditional Ghanaian *Adinkra* symbol, '*Epa*' or the handcuff, which is translated in Twi as "*Onni a ne pa da wo nsa, na n'akoa ne wo*", literally: *"you are a slave to him whose handcuffs you wear."*

Across the country, complacency about the relatively low prevalence of the disease has now given way to heightened concern, in response to new information and projections on HIV/AIDS that show how quickly a society can move from moderate to grave levels of infection. A downward trend in the late 1990s had given way to a rising trend by 2000, the median prevalence rate in the country rising from 2.3% in 2000 to 3.6% at the end of 2003. (GHS, 2003) The language of the campaign messages has, therefore, been getting more precise and urgent over the years, as is shown in the following examples: 'IT PAYS TO WAIT'; 'STOP AIDS, LOVE LIFE'; 'IF IT IS NOT ON, IT IS NOT IN'; DRIVE PROTECTED; WO NKWA HIA (Your life is Precious).'

Moreover, an HIV/STI Sentinel Surveillance System was introduced in 1990, and surveys have been conducted annually since 1994. (GHS, 2003) The system currently includes four public health reference laboratories.

From about 335,000 Ghanaians living with HIV infection by the end of 2002, it is projected to increase to about 365,000, by the end of 2004. At six sentinel sites out of 23, the prevalence rates were found to be up to 5%, with the national range being 0.6% to 9.5%. (GHS, 2003) Certain categories of people have much higher rates. Among commercial sex workers, for instance, the

rate shot up from 2% in 1986, when it was first reported in Ghana, to nearly 40% in 1991. By 1997, the prevalence rate among sex workers tested in Accra had reached a staggering 73%. (UNICEF, 2000)

Over 80% of HIV transmission in Ghana is through heterosexual sex, followed by mother-to-child transmission[5] and through blood products. An HIV/AIDS epidemiology summary of Ghana indicates that HIV prevalence among women tested at antenatal clinics at selected urban sites - Adabraka and Korle Bu - increased from 1% in 1990 to 3% in 1998. (UNICEF, 2000) The situation is expected to improve somewhat with the recent launch of a programme to distribute antiretroviral drugs, though limited coverage may delay the widespread impact of the programme.[6]

It is not only individuals and families that suffer the losses caused by HIV/AIDS. Business firms face the risk of losing experienced workers and having to find extra funds to train fresh recruits. (Bollinger, 1999b) In addition, increased medical costs are incurred for taking care of sick employees.

Positive changes in attitude to the management of HIV/AIDS through new treatment possibilities are bringing hope to PLWHAs in poor countries like Ghana. However, the hope of widespread and sustained drug therapy to be borne largely at public expense remains a dream mainly because of the cost of the drugs. (NACP, 2001) The question of affordability of AIDS drugs is complicated by the manipulation of the international patent system under the Trade Related Intellectual Property Rights (TRIPS) Agreement of the World Trade Organisation (WTO). Through this manipulation, the multinational drug companies, with backing from their home governments, place restrictions on the right of poor countries to develop and produce or to import cheap generic drugs.

More generally, owing to the high costs associated with allopathic medicine for the management of HIV/AIDS, several African countries are beginning to pay attention to herbal medicine, which the WHO has recognised as an important alternative health care delivery system for most of the world's infected population. (See Chapter 5) By virtue of their role in health care delivery and also their social status in the communities, traditional healers are credited with knowledge of the cultural beliefs and practices of people in their communities, which helps them to communicate effectively. There have been several claims in Ghana of successful management of a large number of diseases, including cancer and HIV/AIDS, using plant medicine. (UNDP/ISSER, 2001) Some of these claims are being monitored and verified by the Ministry of Health through collaboration with selected herbalists, the Noguchi Memorial Institute for Medical Research (NMIMR) at the University of Ghana, and the Centre for Scientific Research into Plant Medicine (CSRPM), Mampong.[7]

Many stakeholders now appreciate that HIV/AIDS threatens to reverse the modest social and economic gains made in Ghana. Health service delivery, for example, is projected to come under increasing stress, with an estimated 90% of hospital beds going to AIDS patients by 2010. (Asamoah-Odei et al., 1995) To counter this, more intense and sustained measures have to be implemented. Campaign leaders and the general public need broad-based as well as specialised information on the socio-

[5]This is the transmission of the AIDS Virus from a mother to her child during pregnancy, labour and delivery and breastfeeding.

[6]UNAIDS (2003) estimates that only about 1% of people who require antiretroviral treatment in Africa receive it.

[7]The Ghana Human Development Report 2000 addresses these issues in Chapter Four.

cultural, economic, political and religious climate within which HIV/AIDS occurs. While information on the epidemiology of the disease is important for surveillance and management, that is already reasonably well-documented (see NACP, 2000), and continues to engage the attention of many HIV/AIDS gatherings.[8] To complement this, the Ghana Human Development Report 2004 focuses on the less widely addressed essentials, particularly, socio-economic effects, involving care issues and the political dimensions of the disease.

1.4 STEPPING UP THE CAMPAIGN TO BREAK THE HIV/AIDS CHAIN

Experience and research have indicated that a multi-strategy and multi-sector approach is the most effective way of fighting the AIDS pandemic. HIV/AIDS affects every sector of society and, therefore, has to be factored into all government policy, planning and implementation. Equally important, success depends, in part, on the work of foot soldiers and civil society. The challenge facing government is how to create positive synergy among major role-players in health, education, welfare, labour and civil society to support each other for maximum success against the disease. Another challenge is how to manage those already infected and affected by the disease. However, the greatest challenge of all is to get people to modify their behaviour in sexual networking. Abstinence is best, but failing that, protection is sensible. While the message is simple, it comes up against age-old traditions and perceptions about relationships, sex and contraception. How can the cost of doing little or nothing be brought home to people to make them sit up and take note?

The fight against HIV/AIDS must include both a personal-level strategy and a collective strategy. A teenage girl in a remote rural community, for example, should be empowered to say 'no' to sex or unprotected sex, while governments and civil society groups confront multinational giants against profiteering from antiretroviral drugs. A central aspect of the campaign is collaboration between neighbours within borders and across borders. This is fully recognised by the Government of Ghana. In its address to the UN World Summit on Sustainable Development (August 2002), the Government of Ghana prescribed as the way forward to:

- Make fighting HIV/AIDS a major presidential initiative in all African countries;
- Recognise the combined impact of lifestyle and poverty;
- Affirm HIV/AIDS as a regional integration problem;
- Strengthen the position of HIV/AIDS in the New Partnership for Africa's Development (NEPAD) programme as a human resource/capacity issue; and
- Make HIV/AIDS a personal, visible, national issue.

Several actions already initiated locally, need to be stepped up. These include:

- Making antiretroviral treatment available for those living with HIV/AIDS;
- Scaling up grassroots workshops on prevention and information about the virus and other sexually transmitted diseases;

[8] The recent HIV/AIDS Conference in Ghana organized by the Ghana AIDS Commission from 11th 13th February 2004 at the La Palm Royal Beach Hotel, devoted a lot of time to current medical research on the topic.

- Accelerating the frequency of messages from the pulpit and other religious and social gathering, to promote abstinence and faithfulness through counselling, persuasion of congregations, and training of leaders;
- Adoption of a more dynamic and attractive approach to moral education and reproductive health studies in the formal school system;
- Making condoms more affordable, improving health information, and pursuing more concerted efforts at STD treatment;
- Intensifying care for AIDS orphans, PLWHAs and home-based care for PLWHAs; and
- Designing training programmes for non-medical personnel and volunteers to participate in counselling.

The magnitude of the AIDS crisis calls for everyone to be involved in the campaign to halt the spread of the disease. Yet not all agree on how to proceed. A sharp difference has emerged between religious bodies and their secular partners in this campaign. While orthodox religious bodies have insisted on preaching the old doctrine of abstinence, the secular partners argue that the campaign should also be about protection through the use of condoms, as propagated by the National AIDS Control Programme's abstinence [A], faithfulness [B-be faithful] and condoms[C] use campaigns.

Cynics have argued that it has been difficult to prove how abstinence or faithfulness could affect the rate of infection, because of the near impossibility of measuring these variables. The fear is that most people are unable to attain such moral heights. Many AIDS control programmes are left with little choice but to seek more practical solutions to the problem, i.e., increased use of condoms, encouraging VCT for individuals to be responsible for their health.

Whatever the approach adopted to fight HIV/AIDS, half the battle would be won when a country and its people recognise that the disease threatens their collective survival. At the same time, accepting that there is a human rights issue at stake, stakeholders need to make provision for those living with HIV/AIDS, so that they can continue to contribute to society for as long as possible. However, to be successful at implementing any ameliorative programmes, people need information about the nature of HIV/AIDS and how it is affecting livelihoods, social relations and policy decisions on resource mobilisation and distribution. In short, people need a report that addresses the challenge posed to human development by HIV/AIDS.

MAIN FEATURES OF THE GHANA HUMAN DEVELOPMENT REPORT 2004

The GHDR 2004 discusses the general status of HIV/AIDS in Ghana, including a look at the pattern of the disease, how it is regarded by society, its potential impact on the well-being of Ghanaians and the way it is being managed by both the public and private sectors. The underlying argument is that attempts to accelerate development in Ghana, to achieve local developmental aspirations as well as the Millennium Development Goals will amount to little unless the state and society at large take direct steps to curb the devastating spread of the disease. The experience of other African countries demonstrates clearly how easy it is to reach the stage when the disease

spirals out of control. The report is made up of seven chapters, including this section. Chapters Two to Seven are briefly outlined below.

Chapter Two: The State Of Human Development in 2003 is devoted to the basic human development indicators of education, health and livelihoods, and an insight into the HIV/AIDS prevalence in Ghana in order to situate the discussion of HIV/AIDS in its socio-economic context. The discussion highlights trends in basic education and health and the possible explanation for these trends. New initiatives that have been taken by both the state and other agencies to improve the delivery of services in these areas are given special attention. Under both education and health, special attention is given to new programmes that are directed at empowering children and adults to cope with the HIV/AIDS threat. In the section on livelihoods and the economy, besides discussing general trends, the point is made that income insecurity, which confronts many Ghanaians, undermines the sustainability of both prevention and treatment programmes.

Chapter Three: Social And Ethical Challenges Of HIV/AIDS in Ghana focuses on the way people living with HIV/AIDS (PLWHAs) and others affected by the condition, such as family members, are treated by society. The chapter examines this issue from the perspectives of human security and rights, stigmatisation and discrimination. Orphanhood is given special attention while some of the risk factors increasing susceptibility to HIV/AIDS infection, such as multiple sexual networking, migration, poverty and vulnerability are addressed.

Chapter Four: Economic Challenges Posed By HIV/AIDS in Ghana examines the potential medium- to long-term effects of the HIV/AIDS pandemic on economic life in Ghana, with emphasis on human capital, production, trade, and service delivery. How all these affect macroeconomic stability and growth in the long run is also addressed.

Chapter Five: Health Care Response to the HIV/AIDS Pandemic discusses the evolution of care and support for PLWHAs in Ghana. The chapter focuses on the capacity of the public health care system to manage the disease, through improving the safety of blood transfusions, prevention of mother-to-child transmission, voluntary counselling and testing (VCT), bringing down the cost of treating HIV/AIDS, home-based care for PLWHAs and herbal treatment. While acknowledging that treatment offers new hope to PLWHAs, the chapter cautions that the cost of treatment implies that only a handful of people in need of assistance will receive it through the public health system. At the same time, the chances that individuals on their own can support treatment are rather remote, given the low incomes of most Ghanaians.

Chapter Six: Confronting the HIV/AIDS Challenge in Ghana: Reclaiming the Future looks closely at the institutional framework, including policies and guiding principles that have been put in place in Ghana to provide a management structure to cope with HIV/AIDS. The chapter pays considerable attention to the role that non-state stakeholders are playing in this process.

Chapter Seven: Conclusion and Policy Implications outlines the main messages emanating from the Report.

The rest of the Report is made up of annexes of relevant statistical tables on human development and HIV/AIDS in Ghana.

CHAPTER TWO

THE STATE OF HUMAN DEVELOPMENT IN 2003

Kpando Torkor RC Primary School
Picture by: Andrews Addoquaye Tagoe (GAWU)

CHAPTER TWO: THE STATE OF HUMAN DEVELOPMENT IN 2003

2.0 INTRODUCTION

Human development in Ghana today remains a multi-faceted challenge. The goal to make the country a middle-income one with all the associated benefits for the well-being of the people continues to dominate the pronouncements of policy makers and development practitioners. Towards this end, since the beginning of the current century, the state and its development partners have adopted economic policies and social programmes that are intended to help Ghana leapfrog into increased prosperity and equity. For example, Ghana prepared a Poverty Reduction Strategy and accepted a Highly Indebted Poor Country (HIPC) status in order to benefit from the windfall associated with debt relief. Another important dimension to the development agenda is unfolding, namely, increasing sensitivity to human rights codes. It is fair to say that development initiatives in the country are increasingly becoming anchored in international standards and codes, as well as constitutional provisions (1992 Ghana Constitution) on the rights of the citizen. The overriding vision implicit in this process is one in which a rights-based approach guides agenda-setting, implementation, distribution and management of goods and services for the benefit of all peoples. The kinds of principles that underpin this development process include for example, the principles of participation, equity, non-discrimination, sustainability and wealth creation.

The reality, however, points to a major challenge ahead if Ghanaians are to reach the point of middle-income livelihoods. Development analyses from different sources confirm that while macroeconomic indicators are improving, people's lives and prospects are at least in the short-term less promising; poverty levels, for example, have come down since 1993, yet remain very high.[9] A regional-based analysis of the human poverty index (HPI) for Ghana shows that overall poverty has declined from 51.7% in 1997/98 to 41.0% in 2002/03[10] as shown in Table 2.1. (See calculation formula in Annex A section C). In all the regions, except in the Greater Accra Region, the HPI improved but remained over 30%, and went as high as 66% in the Upper East Region. Interestingly, the Greater Accra Region though it had the lowest HPI scores experienced a deterioration in deprivation between the two periods (from 21.7% to 24.3%).

The Ghana MDGs Report of 2004 acknowledges that Ghana is not yet on track to achieve the targets. The only goals probably achievable are those of halving poverty, achieving universal access to primary education and halving the proportion of people without access to safe drinking water by 2015. The others are reported to be only potentially achievable or unlikely to be achieved! (See Table 2.2)

[9] ISSER, 2004; Aryeetey, E.; Harrigan, J.; M. Nissanke (Eds.) 2000; Aryeetey and Kanbur, (Eds.) 2004.

[10] The Human Poverty Index for the 10 Regions in Ghana measures deprivation in the three basic dimensions of human development, namely long and healthy life, knowledge and secure livelihoods. The data for the regional HPI was taken from the Core Welfare Indicator Questionnaire (CWIQ) surveys of 1997 and 2003. See also GSS 1992 and GSS 2000 - Ghana Living Standards Surveys for poverty analysis.

Table 2.1: GHANA HUMAN POVERTY INDEX

REGION	HP1-1: 1997/1998	HP1-1: 2002/2003	DIFFERENCE
NATIONAL	51.7	41.0	-10.7
Western	55.1	44.7	-10.4
Central	52.0	37.9	-14.1
Greater ACCRA	21.7	24.3	+2.6
Volta	49.1	46.0	-3.1
Eastern	53.0	38.8	-14.2
Ashanti	49.3	34.3	-15.0
Brong Ahafo	55.3	45.9	-9.4
Northern	74.4	64.4	-10.0
Upper East	77.3	66.2	11.1
Upper West	69.5	63.7	-5.8

2.2: STATUS AT A GLANCE - GHANA'S PROGRESS TOWARDS THE MILLENNIUM DEVELOPMENT GOALS

GOAL	WILL GOAL BE REACHED?	STATE OF SUPPORTIVE ENVIRONMENT
Goal 1: Eradicate Extreme poverty and hunger *Halve the proportion of people below the poverty line by 2015*	*Probably*	Strong
Halve the proportion of people who suffer from hunger	Unlikely	Fair
Goal 2: Universal primary education *Achieve universal access to primary education by 2015*	*Probably*	Fair
Goal 3: Gender equality *Eliminate gender disparity in primary and junior secondary education by 2005*	Unlikely	Fair
Achieve equal access for boys and girls to senior secondary by 2005	Potentially	Fair
Goal 4: Under-five Mortality *Reduce under-five mortality by two-thirds by 2015*	Potentially	Strong
Goal 5: Maternal Mortality *Reduce maternal mortality ratio by three-quarters by 2015*	Unlikely	Fair
Goal 6: HIV/AIDS & Malaria *Halt and reverse the spread of HIV/AIDS by 2015*	Potentially	Fair
Halt and reverse the incidence of malaria	Lack of data	Weak but improving
Goal 7: Ensure environmental sustainability *Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources*	Potentially	Weak but improving
Halve the proportion of people without access to safe drinking water by 2015	*Probably*	Fair
Goal 8: Global Partnership for development *Deal comprehensively with debt and make debt sustainable in the long term*	Potentially	Strong

Source: Ghana MDGs Report, 2004

On the following declining scale:
Will the goal be achieved? Probably/Potentially/Unlikely/Lack of data
State of supportive environment: Strong/Fair/Weak but improving/Weak

Ghana's Human Development Index (HDI) has been improving since 2000 as shown in Table 2.3 but the country has slipped further down the medium HDI ladder

TABLE 2.3: GHANA'S HUMAN DEVELOPMENT INDEX (HDI) AND GENDER-RELATED DEVELOPMENT INDEX (GDI) SCORES COMPARED TO THOSE OF SELECTED COUNTRIES (2000 TO 2004)

Country (1)	HDI Value	GDI	HDI Value	GDI	HDI Value	GDI	HDI Value	GDI	HDI Value	GDI
	2000		2001		2002		2003		2004	
High Human Development										
Canada	0.935	0.932	0.936		0.941	0.938	-	-	0.943	0.941
Norway	0.934	0.932	0.939	0.836	0.942	0.941	-	-	0.956	0.955
Antigua and Barbuda	0.833	-		0.540	0.800	-			0.800	-
Latvia	0.771	0.770	0.791		0.800	0.798			0.823	0.823
Medium Human Development										
St. Kitts and Nevis	0.798	-	-	-	0.814	-			0.844	-
Costa Rica	0.797	0.789	0.821	0.813	0.820	0.814			0.834	0.823
Ghana	**0.556**	**-**	**0.542**	**-**	**0.548**	**0.544**			**0.568**	**0.564**
Cameroon	0.528	0.518	0.506	0.496	0.512	0.500			0.501	0.491
Low Human Development										
Pakistan	0.522	0.489	0.498	0.466	0.499	0.468			0.497	0.471
Madagascar	0.483	0.478	0.462	0.456	0.469	0.467			0.469	0.462
Tanzania		0.410	0.436	0.432	0.440	0.436			0.407	0.401
Sierra Leone	0.252	-	0.258	-	0.275	-			0.273	-

Source: Global Human Development Reports, 2000 to 2004.

Note:
(1) The list of countries was selected based on the first two highest ranked and lowest ranked HDI values in 2000. In addition, GEM values were added for each category. In the case of the medium human development the first two highest ranked and Ghana and the lowest ranked in the category were selected. Some of the countries have since 2000 risen to higher categories (St.Kitts and Nevis; Costa Rica; Latvia) while others have fallen to lower categories (Pakistan)

A careful examination of the economy helps to understand the current stalemate in development outcomes in Ghana. On the whole, the economy has been characterized by the absence of structural change in spite of steady growth, and the social sector has been marked by largely modest improvements, as well as stagnation and decline in some basic education and health indicators over the past four years. The absence of structural change has meant difficulty in generating productive employment for a rapidly growing labour force.[11] There have been important strides in governance, though public institutions and regulatory bodies are still confronted with obvious lapses relating to accountability, transparency and corruption, issues which the National Governance Programme (NGP) has included in its strategic plan. The NGP now has another issue to confront - the danger that poor employment opportunities and social accountability practices could fuel ethnic conflict and civil strife, which would directly threaten the stability of the country, as indeed has happened in the countries surrounding Ghana.

Another aspect of the reality of Ghana's development challenge is its relatively weak human capacity base. Only 10% of the economically active population has secondary school education or higher, (GSS, 2000) suggesting that the country is poorly positioned to take part meaningfully in the knowledge economy currently taking over the world. At the policy level, there is much talk about improving educational outcomes and basic health indicators. This is followed through in such matters as school improvement programmes and public health outreach work, especially among children and the youth. How far these initiatives have affected the state of human development and in what directions they are leading the process are addressed in this chapter. Indeed the fundamental role of human capital in human development has tended to dominate discussions on human development in Ghana. It is already clear that parental or guardian poverty and inequities in public sector subsidies to education have seriously compromised the quality of education received by children from poor rural households.[12]

One thing is certain however: none of these efforts or aspirations will yield dividends for the future of Ghana unless the control of the spread of HIV/AIDS disease through behavioural change, and the treatment of affected peoples, are made priority issues ingrained in all national development endeavours. Such interventions would have to be implemented from national to the community level to make the necessary impact. As implied by the theme of the 2004 GDHR, and as has been noted by several country reports on HIV/AIDS, the disease and its effects will undo all development gains and human rights platforms, if it goes unchecked. Therefore, the need to mainstream efforts to confront the challenge it poses to human development cannot be overemphasized. The rest of Chapter Two outlines first, the current state of HIV/AIDS in Ghana to establish the context of 2004 Ghana Human Development Report. This is followed by an analysis of the progress and difficulties that have faced Ghana in her efforts to improve human development outcomes in the core areas of education, health and livelihoods. Issues emerging from these experiences, especially those that influence the pattern of HIV/AIDS in the country are highlighted.

[11] Aryeetey et. al. 2000

[12] MoE, 2002

SECTION A: HIV/AIDS PREVALENCE AND RELATED ISSUES

2.1 SEXUALLY TRANSMITTED INFECTIONS AND THEIR PREVENTION

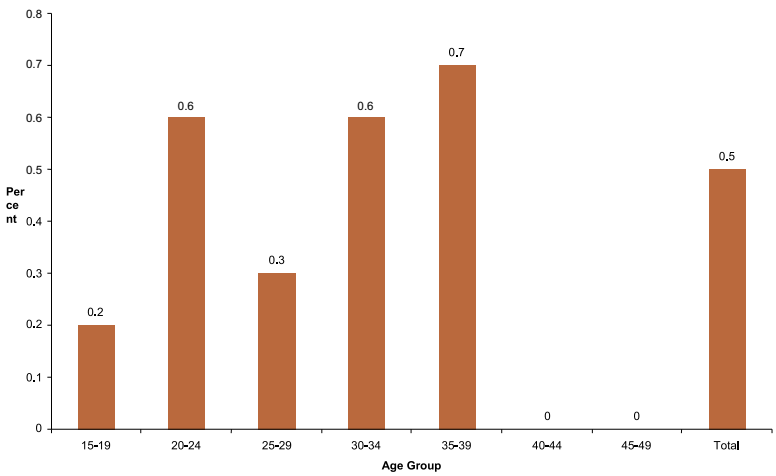
Sexually transmitted infections (STIs) are associated with HIV transmission; the risk of HIV transmission has been found to be higher for persons with untreated STI engaging in unprotected sex. As most people have inadequate knowledge of STIs, many of those infected do not seek proper care and treatment (MoH, 2001), and information on the prevalence of STIs in the general population is therefore, incomplete.

In recognition of the close links between STIs and HIV/AIDS, the public health service has scaled up activities aimed at reducing the rate of STI in the country. An FHI IMPACT study was conducted in 2000, using WHO standards to assess the proper diagnosis and treatment of STIs among men and women reporting at clinics and pharmacies. The study reported that the management of STI in Ghana was based largely on the syndromic approach (treatment by disease symptom complex) rather than by microbiological aetiology (treatment based on laboratory testing). The reasoning was that, by skipping the testing phase, treatment would be expedited, thereby avoiding further spread of the disease.

The study also revealed a very low quality of management of sexually transmitted diseases. In 590 client-provider encounters, only 4% of health providers were shown to take an adequate history, conduct an adequate examination and provide adequate treatment. In addition, only 26% educated the patients on condom use, though 50% of health providers advised partner notification. Health providers that relied on aetiological diagnosis generally practiced better management of STDs than those that relied on syndromic diagnosis. This highlights the importance of efforts being made to make affordable laboratory testing facilities available to the general public, including rural dwellers.

It has been observed that stigma and discrimination can stop persons with STI from seeking professional help. From the 2003 Ghana Demographic and Health Survey (GDHS), about 8.3% of women and 4.3% of men reported that they had STI/discharge/genital ulcer. Among women, 56% sought treatment, while 69% of men sought treatment. Women seeking treatment would usually go to a hospital or clinic, while men tended to use the pharmacy. By implication, a significant number of persons with STI however, never seek professional help (women 44%; men 31%). (GSS, 2003) The National AIDS Control Programme reports that syphilis has been diagnosed among both young and older adults in Ghana. Figure 2.1 provides a rough indication of the prevalence of syphilis.

FIGURE 2.1: SYPHILIS PREVALENCE BY AGE GROUP



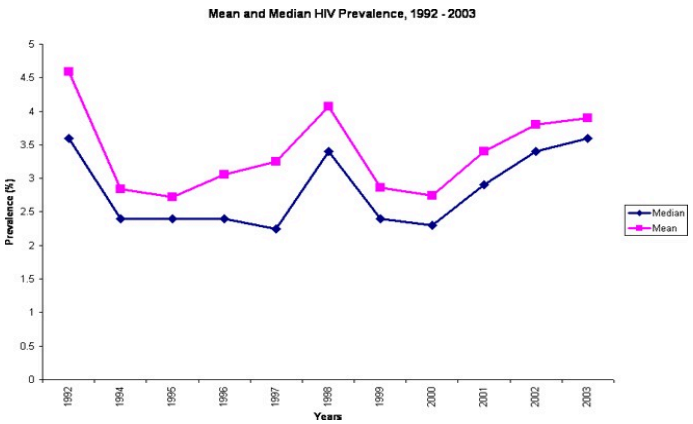
Source: Ministry of Health,

2.2 HIV/AIDS: TRENDS, CURRENT STATUS AND PROJECTIONS

Trends and Present State

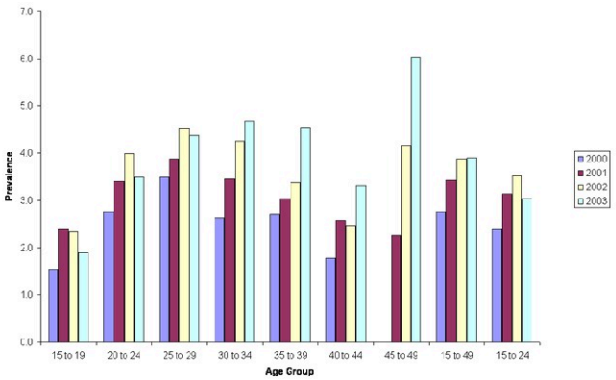
Since the first reported case of AIDS in 1986, HIV infection has spread steadily throughout the country. The Ghana Health Services (GHS) through the NACP manages a sentinel surveillance system for people aged between 15 and 49 years, using prevalence from antenatal sites within that age group. The data reveal a persistent increase in the median HIV prevalence rate in the past three years, rising from 2.3 % in 2000 to 3.6% in 2003, an increase of about 57%. (Fig. 2.2)

Figure 2.2: HIV Prevalence In Ghana



Source: NACP, 2004

Figure 2.3: Mean HIV Prevalence by Age and Year (2000 - 2003)



Source: NACP, 2004

The data, broken down by region, age, geographical belt, sentinel sites and year show variations in the HIV prevalence. (See Annex A section D for details)

Breaking down the data further, a consistent decline is recorded for ages 15-24 from 2002 to 2003 after an initial increase in prevalence rates in 2000 and 2001. On the other hand, a steady increase is observed for the older age groups (30-49) in 2003 with the highest prevalence observed in the 45-49 year group, having shot up from as low as 0% in 2000 to 6% as shown in figure 2.3. Could it be that the targeting of prevention programs to the younger age groups has been particularly effective?

By gender, however, the HIV prevalence rate was consistently higher for females than males for all age groups (with the highest rate being 4.7% for women in the 35 - 39 age group) except for the 40 - 44 age group for men which was 4.1% as shown in figure 2.4.

Interpretation of the sentinel survey data should be approached with great caution, since pregnant women, the main sample tested, may not be representative of the larger Ghanaian population or even of all pregnant women. That being said, it needs to be noted that studies comparing HIV prevalence levels at antenatal sentinel surveillance sites with levels recorded in population-based studies have found antenatal data a good estimator of HIV prevalence in the general population, provided a good proportion of pregnant women use public antenatal clinics where these surveys are typically conducted. In any event, despite their shortcomings, sentinel survey results are the best we have, and can still provide useful leads.

Epidemiological Projections

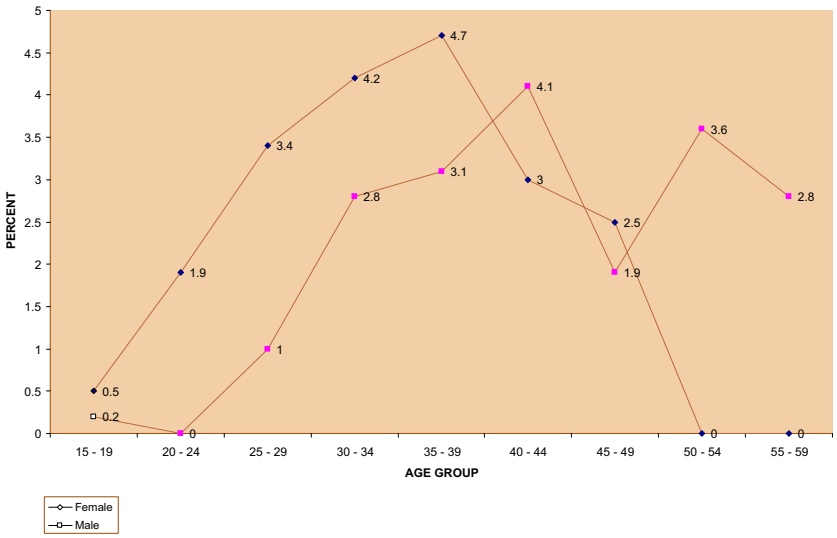
The NACP anticipated that at the current pace of infection, the prevalence rate is likely to increase in the short term before any signs of decline are observed. The estimated number of PLWHAs was about 335,000 in 2002, expected to increase to about 514,000 in 2015, excluding those who would have died from HIV/AIDS over the period. (*Figure 2.5*) Graduation from HIV to AIDS will also continue steadily, with annual new cases of AIDS projected to rise from 21,940 in 2000 to 48,940 in 2015.

2.3 HIV AND TUBERCULOSIS (TB)

Although much of the discussion has focused on HIV/AIDS, it has to be recognized that we are faced with what the health establishment describes as a dual pandemic of HIV/AIDS and Tuberculosis (TB). There are indications of high prevalence of TB and its link to HIV as the most common opportunistic infection for people who are HIV-positive and the leading cause of AIDS-related deaths, with the UNAIDS and WHO estimating that one-third of all individuals living with HIV will eventually contract TB. Owing to the contagious nature of TB, its relationship to HIV, thus, poses a special threat to the entire population. The treatment of TB is very expensive, and any pandemic is likely to put a heavy strain on the health budget.

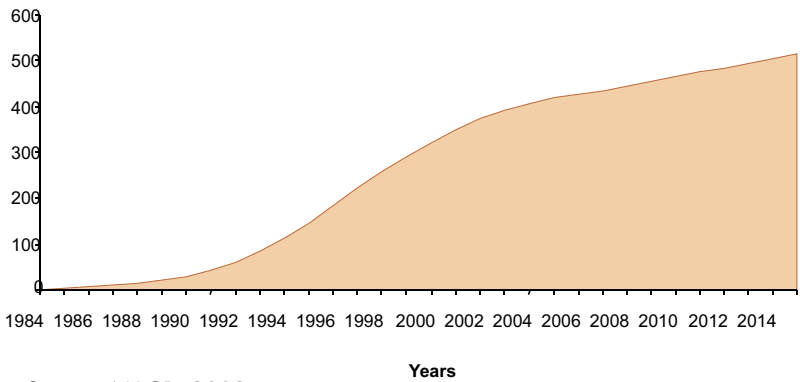
There are indications that TB prevalence in the country has been rising steadily, from an estimated low mean rate of 18% in 1989 to 42% in 2003. (Figure 2.6)

Figure 2.4: HIV Prevalence By Gender And Age Group



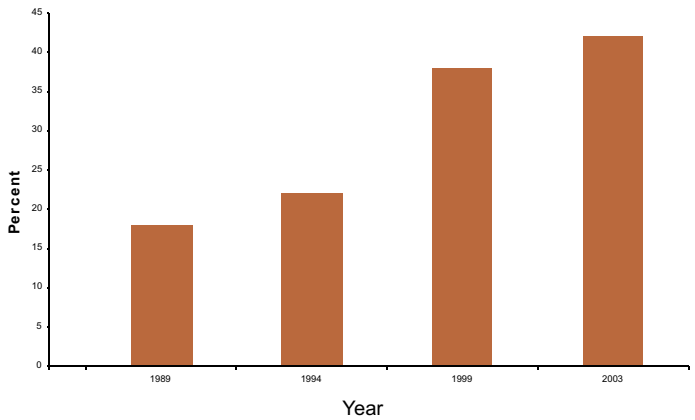
SOURCE: Ghana Demographic and Health Survey, 2003

Figure 2.5: Projected Number Infected With AIDS (Thousands)



Source: NACP, 2003

Figure 2.6: Trend in Tuberculosis Prevalence,1989-2003



Source: Ministry of Health, 2003

Going by the experience of other countries, the impact of the HIV/AIDS epidemic health sector is bound to be detrimental. First, the heavy dependence of the sector on human resource means that infection of its workers will burden the Service and compromise the quality of health care delivery. Second, infection in the general population is likely to put undue strain on an already overstretched Service".

Dr. Frank Nyanortor, Director PPME, Ghana Health Service)

Popular Knowledge and Attitudes Relating to HIV/AIDS

Among the general population the high level of awareness of the disease caused by the HIV virus is not matched by personal knowledge of deaths from AIDS. On the whole 37% of women and 38% of men respectively know of someone who has the disease or who has died from the disease. (GSS, 2003) A lot more people were shown to know appropriate preventive methods (over 70%).

When it came to acceptance of PLWHAs based on four measures,[13] however, only 8.5% of women and 14.8% of men would accept PLWHAs. Overall, just over 7% of men and women had ever tested for the virus.

2.4 IMPACT OF HIV/AIDS ON THE HEALTH SECTOR

The Ministry of Health initially took the lead in the fight against the HIV/AIDS pandemic. However, a new multi-sectoral strategy has involved other sectors and the community. The possible impact of the HIV/AIDS pandemic in the health sector includes: increased demand on already overstretched health services; higher staffing levels, as well as training and replacement costs; declines in quality of care and increases in the cost of treatment of opportunistic infections. These issues are taken up in Chapters Four and Five.

SECTION B: EDUCATION

2.5 GENERAL TRENDS IN EDUCATION

The goal of the education sector is to provide core skills, general knowledge and expert training so that Ghanaians can be more productive and innovative, leading to general improvements in well-being. For the disadvantaged in particular, education is a key factor in ensuring social mobility and a relatively secure livelihood. In line with this goal, the Ministry of Education, Youth and Sports (MoEYS)[14] has been implementing a Programme aimed at achieving universal primary school enrolment and raising the quality of education, a much less ambitious policy than the constitutionally-mandated free Compulsory Universal Basic Education (fCUBE). Indications are, however, that progress towards achieving even this more limited objective has been slow. The targets of this programme have been set out in the Ministry's Strategic Document, which has adopted enhanced access to quality basic education as one of its medium-term policy objectives in accelerating movement towards the MDGs and GPRS goals. This section reviews the performance of the education sector in relation to school enrolment, quality of education and learning outcomes, as well as financing, teacher availability and capacity.

2.6 ACCESS, PARTICIPATION AND EQUITY

This section reports on access, levels of participation and equity at the basic, senior

[13] These are willingness to care for family member with HIV at home; willingness to buy fresh vegetables from a vendor with AIDS; Belief that HIV - positive female teacher should be allowed to continue teaching and also that a HIV - positive status of a family member does not need to remain a secret.

[14] MOEYS is now the Ministry of Education and Sports (MOES).

secondary and tertiary levels.

Availability of Basic Schools

There has been an increase in the number of basic education schools since the 2000 GHDR. The number of primary schools increased from 12,326 (11,236 public and 1,090 private) in 1998 to 15,285 (12,335 public and 2,950 private) in 2003. In the same period, the number of junior secondary schools (JSS) increased from 6,020 (5,571 public and 449 private) to 7,582 (6,414 public and 1,168 private). (MoEYS, 2003) Despite these increases, many primary school buildings remain in a state of disrepair, as was indicated in the 2000 GHDR. To address the problem, government has adopted a policy of constructing new projects instead of rehabilitating old schools. The new projects are based on a concept of improved school facilities, where the infrastructure includes facilities other than classrooms and offices. In 2003, 685 unit classroom blocks, each with toilet facilities, teachers' common room, store and library, were built across the country. This was in addition to other construction projects undertaken by the Social Investment Fund (SIF) and the Ministry of Local Government and Rural Development (MLGRD) in 2003.

Pre-School Education

With the recent government declaration to formally incorporate pre-school or early childhood education into the basic school concept, it would be useful to make a few remarks about pre-school here. (see also GHDR 1998) The UN Education for All Global Framework recognised the importance of good pre-school education for attainment among children, and declared early childhood education to be a basic right. The 2003 Core Welfare Indicators Questionnaire (CWIQ) Survey revealed that indeed pre-school has become an important component of education in Ghana, especially among urban families; this was confirmed by the 2000 Census which reported that 44% of children between ages 3 and 5 years were enrolled in pre-school. In the urban areas the majority of pre-schools are privately owned, whereas in the rural areas the public sector is the main provider of pre-school. Table 2.4 shows the pattern of early childhood education around the country based on the 1997 CWIQ.

TABLE 2.4: PROPORTION OF CHILDREN ATTENDING PRE-SCHOOL BY RESIDENCE, IN PERCENTAGES.

AGE OF CHILD	RURAL	URBAN
3 years	25%	35%
4 years	46%	62%
5 years	60%	73%

Source: MoEYS/GoG, Education Sector Review, 2002: 7 (based on CWIQ, 1997)

The lowest pre-school attendance was found in the Northern parts of Ghana, where only 21% of children aged 4 to 5 years were found to be in pre-school. The new Early Childhood Care and Development Policy recently launched by the Ministry of Women and Children's Affairs (MOWAC) addresses the issue of pre-school education as one of its policy objectives. There is general concern that supervision in the pre-school system is weak, which sometimes exposes children to inappropriate programmes. For example, only about 11% of Kindergarten teachers were reported to be trained.[15]

Primary School Enrolment

The national gross primary enrolment ratio (GPER), a general indicator of the level of participation in primary school, rose only

[15] MOWAC, 2004; MOE, 2002.

marginally between 2002 and 2003. Indeed the GPER seems to have stagnated around 75% to 79% since 1986. At this rate of growth, neither the GPRS primary school enrolment target (88.5% by 2005), nor the Millennium Development Goal (universal primary school enrolment by 2015) are likely to be achieved. The system is also plagued with the problem of over-aged enrolment especially in rural areas, where pupils enter class one sometimes at 10 to 15 years of age, or when they are old enough to walk long distances to school by themselves. In this otherwise gloomy picture, the significant improvements in the ratios in the deprived northern regions represent a very bright spot. (Table 2.5)

The factors that account for low enrolment include poverty and distance from schools. What is worth special mention here is the threat posed by HIV/AIDS to school enrolment. As the number of child-headed households rises, children drop out of school to nurse sick parents and others. Not only does this prejudice their preparation for the world of work, but such children, lacking adequate care and direction, may look for ways to survive on the streets, thereby exposing themselves to the risk of HIV

Table 2.5: Summary of Priority Education Indicators, 2002 - 2003

Indicator	2002 Level	2003 Level	2005 GPRS target
A. Participation Indicators *Gross primary enrolment ratio (GPER)*			
National	**79.5**	**81.1**	**88.5**
Northern	64.8	67.7	70.0
Upper East	69.5	72.2	79.0
Upper West	63.1	69.6	63.0
Gross primary enrolment for girls			
National	**77.0**	**77.7**	**88.5**
Northern	55.0	59.1	70.0
Upper East	69.0	72.1	79.0
Upper West	63.0	70.3	63.0
Junior Secondary School enrolment ratio:			
National	**61.6**	**62.3**	**65.0**
Northern	38.0	38.8	
Upper East	37.3	37.4	
Upper West	42.6	43.2	
B. Quality Indicators			
Proportion of trained teachers in primary schools	**69.9**	**73.5**	**81.3**
Pupil: Teacher ratio-primary school	32.9:1	31.3:1	33.1:1
Proportion of trained teachers in JSS	87.5	88.1	89.2

Source: MOEYS, Performance Report, 2003

infection and other dangers. (See Chapter 3)

Gender Parity in Primary School Enrolment

Progress towards the achievement of gender parity in education shows a similar trend to that of enrolment in general. At the national level, primary enrolment for girls scarcely improved from its 2002 level. However, the three northern regions showed improvements. (Table 2.5) This positive trend in female participation in enrolment in the three northern regions can be attributed to the implementation of a number of schemes targeted at those regions. These include material support, such as supply of school uniforms, stationery, school bags and food rations. Perhaps, learning from this, the Ghana Education Trust Fund (GETFund) allocated about 9 billion in 2003 to the provision of, among other things, scholarships for needy girls at the pre-tertiary level, with a view to enhancing girls' enrolment. (GoG Budget Statement, 2003) In sum, the lesson to be drawn from the stagnation of GPER at the national level, in contrast to the improvements in the deprived regions is that, without broadening the coverage of such support measures, neither the GPRS objectives nor the Millennium Development Goals for primary school enrolment would be achievable.

Junior Secondary School

Enrolment ratios at the junior secondary school (JSS) level are lower than for primary schools. (Table 2.5) Despite wholesale promotion from primary to junior secondary school, a fair proportion of children still drop out. The factors behind school drop-out are financial difficulties, lack of interest among pupils and parents/guardians, and unattractive school environments. The statistics on drop-out over the years have been quite disturbing. About one-third of pupils entering primary one do not complete primary 6. For basic education roughly half of pupils entering primary one do not complete JSS 3. On the transition from JSS to Senior Secondary School (SSS), only about one-third of JSS students cross that bridge! (MoE, 2002)

Senior Secondary School

With the number of senior secondary schools (SSS) standing at 512 (474 public and 36 private) in 2003 access to quality senior secondary school education remains highly competitive, especially for rural candidates. The 2003 Core Welfare Indicators Questionnaire (CWIQ) survey reported that whereas 82.4% of respondents in urban areas were satisfied with the quality of secondary education, the corresponding proportion for rural areas was 67%. With regard to participation in senior secondary education, the CWIQ estimated the enrolment rate in 2003 to be 50.4 % in urban areas and only 28.7% in the rural areas. (GSS, 2003)

As part of the medium term priority of ensuring equity in access to quality education at the SSS level, government has embarked on a programme to provide at least one model senior secondary school in each district. Thirty-one deprived senior secondary schools have so far been selected for upgrading into model schools, with a total of 48 billion cedis so far disbursed to implement the project.

Tertiary Education

There are currently 15 public (5 universities, 10 polytechnics) and 27 accredited private tertiary institutions operating in the country. The tertiary sub-sector saw significant increases in enrolment in 2003. University admissions increased from 40,673 in 2002 to 53,895 in 2003 (a 30.5% increase), while the polytechnics went from 18,459 in 2002 to 23,717 in 2003 (an increase of 28.5%). Despite this trend, which has been going on since 1990, more than 50% of qualified applicants still fail to gain admission to tertiary education especially in the universities. On gender parity, the

The key long-term solution would be to reach out to children and the school environment provides us the opportunity to do so. The challenge is for us to keep the children in school and to make gender equality more obvious in school enrolment and opportunities. Out of school, it is very difficult to get children in an organised manner.

Prof. F. T. Sai (Presidential Advisor on HIV/AIDS)

universities now have 50: 50 targets, but are yet to achieve this goal. For students not gaining admission to institution based tertiary education the alternatives are limited as the culture of correspondence courses and distance learning in general is poorly developed. Nevertheless, recent initiatives to boost distance education are worth noting.

Distance Education

Efforts to introduce distance tertiary education appear to be yielding results. A number of tertiary institutions now offer distance education. These include the University of Cape Coast (UCC), Kwame Nkrumah University of Science and Technology (KNUST), the Institute of Adult Education (IAE) of the University of Ghana (UG), University College of Education (UCE), and Ghana Institute of Management and Public Administration (GIMPA). As a result, enrolment in distance education grew from 750 in 2002 to 3,618 in 2003. This increase was in part supported by an allocation of 839.3 million from the GETFund to facilitate the co-ordination of the service. (GoG Budget Statement, 2003) An incidental benefit of the increase in the distance education enrolment was that the MoEYS was able to reduce by half the number of teachers on paid study leave in 2003 (from 10,000 to 5,000) (MoEYS, 2003), as many could undertake studies without leaving their posts. With new resources coming into distance learning from the President's Special Initiative on Distance Learning (PSI-DL) under the MoEYS and the Ministry of Information, it is expected that the scope and breadth of this mode of education will expand significantly over the next few years.

2.7 QUALITY OF EDUCATION

The full impact of expanding access to education can only be achieved if education is of good quality and parents and guardians perceive good returns on the investment in their children's education. The factors enumerated in the 2000 GHDR as affecting the quality of education in Ghana have not changed much. These include poor school facilities, poor quality of teaching and learning, teacher absenteeism, poor supervision of schools and low motivation of students. At the same time, there is evidence that, though a lot more remains to be done, efforts to improve the quality of teachers in primary schools are yielding results. Thus, the proportion of trained teachers in primary schools increased by 3.6 % in the period, 2002 to 2003. (See Table 2.5) To improve efficiency further, government is aiming at an average pupil-teacher ratio (PTR) of 35:1 in primary schools by 2010, though it recognises that more teachers must be produced to avoid too high PTRs. The PTR currently stands at 32.9:1 (see Table 2.5), though the ratios differ across regions and between rural and urban areas.

At the JSS level, the rapid improvement in the proportion of trained teachers noted in the 2000 GHDR seems to have slowed down. The percentage increased only marginally, from 87.5% in 2002 to 88.1% in 2003.

Issues of teacher training, development and deployment are critical to the successful delivery of quality education. Among factors affecting the availability of qualified teachers are the large numbers of trained teachers who go on study leave annually, those refusing postings to deprived areas, and teacher attrition (the average teaching life of a teacher is estimated to be no more than 4 or 5 years). In addition to this, the MoEYS is faced with shortfalls in teaching staff in some specific subjects including science, mathematics, French, and Ghanaian languages, as well as vocational instructors for the JSS workshops. [It was noted in the GHDR of 2000 that entry requirements to teacher training colleges

had been raised in the attempt to improve the quality of teachers. (UNDP/ISSER 2001) The situation is simply that, SSS graduates are not attracted to teaching, as it is no longer seen to be a lucrative or even respectable profession.

The challenges facing the education sector are, thus, how to ensure the retention of teachers and how to attract teachers to work in deprived areas. Measures taken to tackle these include the revision of the criteria for paid study leave to favour teachers in deprived districts; implementation of distance education and sandwich programmes to reduce the number of teachers applying for study leave; provision of material incentives for teachers in deprived districts; and the sponsorship of teacher trainees by district with the beneficiaries of district teacher-training programmes required to return to their districts after training. How effective these measures will be, remains to be seen.

The challenge facing the Ministry is how to produce at least 7000 newly trained teachers each year till 2010, in the bid to achieve a Gross Enrolment Ratio of 100% by this time. Apart from this, new teachers will be needed annually to replace those leaving the service. This brings the total estimated requirement for new teachers to about 22,000 annually. The current system of teacher training produces about 6,000 qualified teachers a year. In the meantime, untrained teachers (pupil teachers) continue to make up some of the shortfall. Roughly 3000 are recruited annually by the GES to work in primary schools. (MoE, 2002) Recruitment problems exist also at the tertiary level, with retiring lecturers being re-engaged to make up for the shortfall.

Once again we need to remind ourselves that progress made in any of these areas could be quickly eroded in face of the HIV/AIDS pandemic. As will be detailed in Chapter 4, the education sector is among the most vulnerable, as it is made up of sexually active students and teachers, most of them falling in the peak age group of the disease. Apart from the age profile, the posting of teachers without their families, as well as the possibility of male teachers using their power and status to exploit female workers and students increase the susceptibility of teachers and other education workers.

2.8 LEARNING OUTCOMES

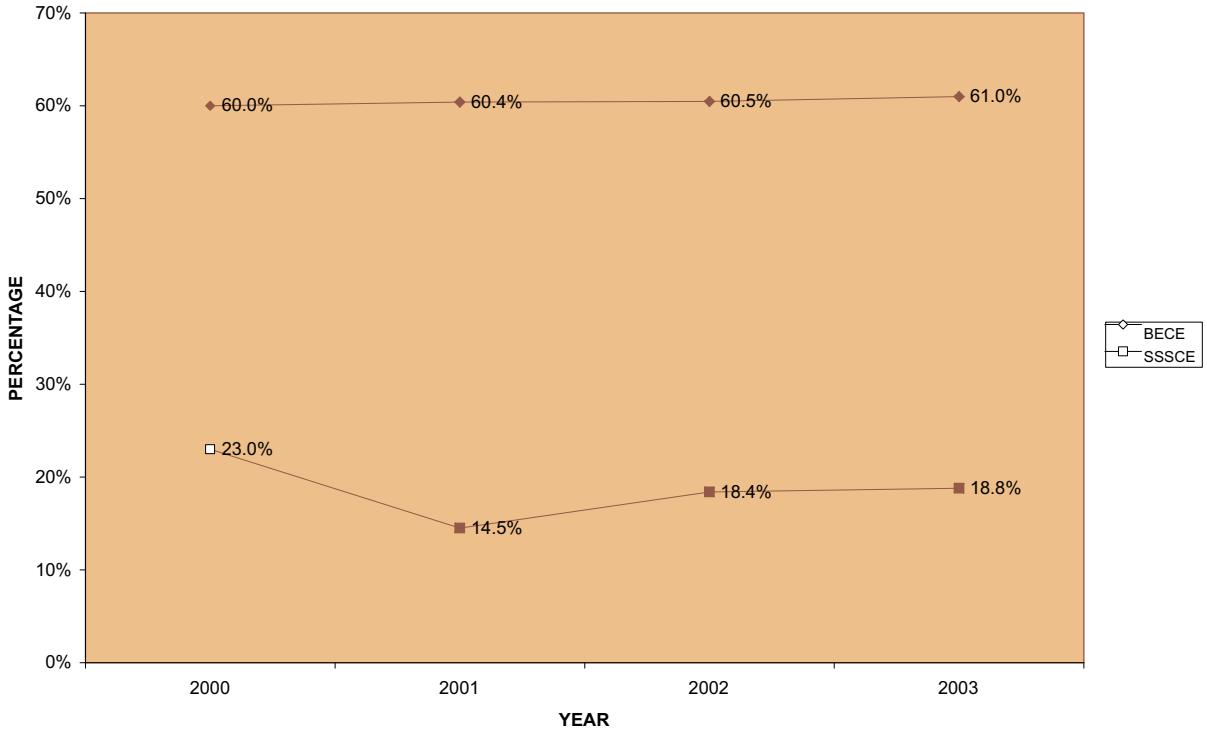
Apart from terminal examination results at JSS and SSS levels, the monitoring of student performance at the pre-tertiary level is more or less on hold. The Ministry of Education, Youth and Sports (MoEYS) has not conducted the Criterion-Referenced Test (CRT) and Performance Monitoring Test (PMT) since 2000. Instead, it is developing a single set of Minimum National Standard Tests.

For the moment, learning outcomes at JSS and SSS levels, as measured by reference to performance in the JSS terminal examination, the Basic Education Certificate Examination (BECE) and the pass rate in the SSS Certificate Examination (SSSCE), show little improvement. The proportion of candidates passing the BECE has remained fairly stable over time, while the pass rate for the SSSCE has declined from 23.0% in 2000 to 18.8% in 2003, a most disturbing development. (Figure 2.7)

A major challenge facing the education sector is the lack of resources to achieve equitable access to education, quality of education, educational planning and management, and science, technology and technical/vocational training (for skills development).

Mr. A. A. Afranie, Director, PPME, MoEYS

Figure 2.7: Trends in Pass Rates for BECE and SSSCE, 2000-2003



Source: West Africa Examination Council, Accra, 2003.

BECE-performance includes all candidates with aggregate 6-30
SSSCE- pass rate includes all candidates passing at Grade E or above

Table 2.6: Proportion of Students that Obtained a Pass in Core Subjects in BECE, 2003.

Subject	Proportion that Passed (%)
Mathematics	59
English	60.3
Science	59
Social Studies	61

Source: GoG, 2004. The Budget Statement and Economic Policy of the Government of Ghana for the Financial Year 2004. Accra. P123.

The modest level of passes in core subjects at the BECE level, as is shown in Table 2.6, is further cause for concern. In all the core subjects, less than 65% of students obtained the pass mark. These include some of the subjects in which the MoEYS reports that it has teacher deficits.

As has been observed in relation to the CRT, private schools generally perform better than public schools at the BECE. The Ministry of Education, Youth and Sports acknowledges that a poor foundation in reading and arithmetic at the primary school level handicaps most JSS students throughout their education. (MoE, 2002)

What is not obvious from Figure 2.7 and Table 2.6 is the huge difference that strong passes at the JSS or SSS levels make to the educational opportunities open to students after graduation. Due to pressures on the better-endowed senior secondary schools, most of them refuse admission to students with BECE aggregates greater than 15 points. Similarly, nearly all the public universities and polytechnics have admission cut-off scores of a maximum of 24 points at the SSSCE, though in practice their operative cut-off range is from about 8 to 16 points, depending on particular programmes. The data on results, therefore, needs to be further disaggregated to reflect these distinctions. Evidence elsewhere shows that about two-thirds of JSS students drop out of the formal education system after the BECE, partly for financial reasons, and partly as a result of poor graduation results. A number of communities, indeed whole districts, have been known to record zero passes at the BECE, implying that at least in those communities, hundreds of students simply do not progress to any formal system of learning after their basic education!

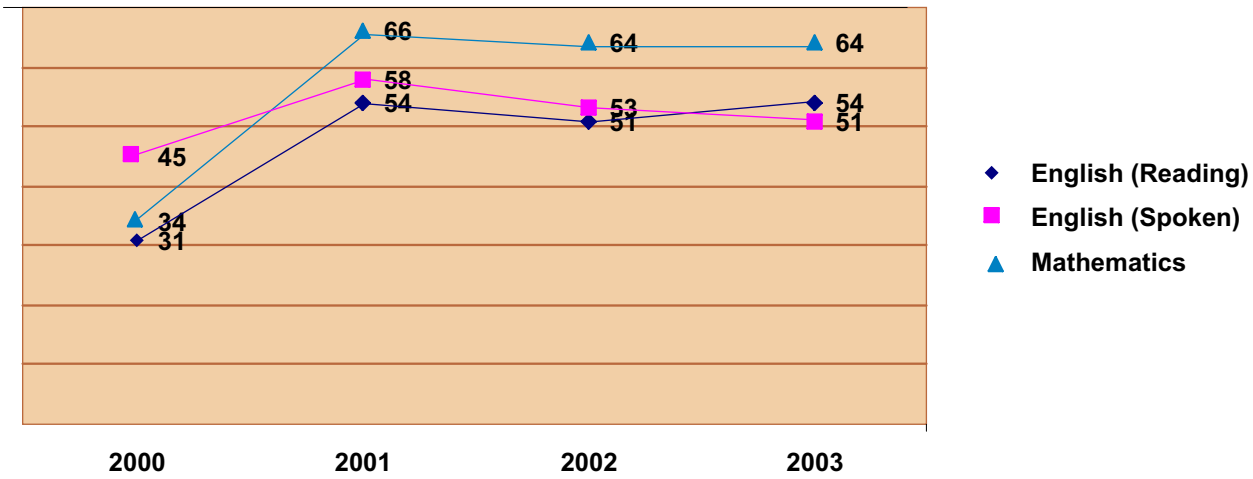
It is fair to say that many efforts have been made since the introduction of Educational Sector Reforms in the late eighties to improve the quality of education in Ghana. One is inclined however, to observe that MoEYS and the GES have not paid adequate attention to key lessons that have emerged from the several pilot projects introduced over the years to try and improve teaching and learning in the public school system.[16] A good example is ***the Quality Improvement in Primary Schools/Improving Learning Through Partnership (QUIPS/ILP)*** Project which was launched as a pilot by GES in 1997 with the following features: it combined teacher education and student motivation, and community empowerment to monitor school performance. Special components on girls' education and HIV/AIDS prevention were later added. By the time the project ended in September 2004, approximately 368 schools and 440 communities spread throughout the 110[17] districts of Ghana had participated in QUIPS/ILP activities. (Manu, 2004)

Results from a monitoring exercise that involved a sample of QUIPS/ILP partnership schools indicated quite marked improvements in learning outcomes. Over the 4-year period, mean scores in English and Mathematics showed a clear upward trend: from 31% to 54% in English reading, 45% to 51% in spoken English, and 34% to 64% in Mathematics. (See Figure 2.8) In addition to this improvement in mean scores in the core subjects, the monitoring team also reported a lower drop-out rate of 3% among QUIPS/ILP schools compared to the national average of 9%. The team also observed that School Management Committees and Parent/ Teacher Associations (see GHDR, 1998) showed more interest in the education of their children; for example, they provided school

[16] These include: the Whole School Development Project teacher support; ASTEP local language books for primary 1-6; School Feeding by Catholic Relief Service, World Food Programme and World Vision; District Level Scholarships; Infrastructure Facilities school and teacher accommodation; Science and Mathematics improvement teacher training; Community mobilization for school improvement training of rural education volunteers; School for Life and Shepherd Schools for hard to reach children (see MoE, 2002).

[17] The number of districts under the Local Government Structure has been increased from 110 to 138.

Fig. 2.8 STUDENT MEAN SCORES IN ENGLISH AND MATHEMATICS (2000-03): SELECTED QUIPS PARTNERSHIP SCHOOLS



Source: Manu, 2004

supplies (uniforms, books, fees) to the children and incentives to the teachers. Of critical importance is the finding that under the rigorous supervision regime of the QUIPS/ILP, teaching and learning materials were better prepared, with the proportion of teachers preparing comprehensive lesson notes, for example, increasing from 20% to 77%. At the same time the proportion of teachers using appropriate and adequate teaching and learning materials increased from 23% to 68%. In addition, there was an increase in monitoring capacity and activities of the districts. (Manu, 2004)

A new phase of the QUIPS/ILP project, Improve Quality of and Access to Basic Education, is proposed for the period 2004-2010. This will cover five key areas, including improved access for girls in underserved areas; improved instructional system; improved management and accountability; increased community advocacy and contribution to quality education; and improved HIV/AIDS prevention in the educational sector. (USAID, 2004)

Thus the preliminary assessment of QUIPS/ILP pilot project shows that it has had a significant impact on educational outcomes in the partnership schools. While the overall impact on the educational system is quite limited, as is evident from the BECE results (see Figure 2.7), the preliminary assessment of the project suggests that, with proper supervision, emphasis on teaching and learning materials, community empowerment, the public school system can be significantly improved to generate more human capacity for Ghana.

While it is crucial to maintain the emphasis that is placed on academic achievement in schools, the school environment is no longer seen as a place for academic work alone; it is a captive audience that can be taken advantage off to groom young children and

adolescents. This has become even more pressing with the HIV/AIDS crises. As a result sex education has assumed great significance for protecting the future of young persons and their families, and the investments that are being made in them.

2.9 SCHOOL HEALTH EDUCATION PROGRAMME (SHEP) AND HIV/AIDS

The MoEYS has a School Health Unit that is in the process of designing a school health policy for Ghana[18]. This Unit is presently responsible for the School Health Education Programme or SHEP. The main focus of the SHEP so far has been:

- Provision of water and sanitation facilities in schools and colleges
- Averting epidemics in schools
- Seeking collaboration with all stakeholders on improving health and nutrition of school children and
- Establishing linkages between good health practices and environmentally friendly activities

Together with the Population and Family Life Education (POPFLE), the SHEP provides an avenue for implementing activities in relation to HIV/AIDS as is described below. On the whole, the SHEP has suffered from inadequate attention and lack of resources from the system. It has been suggested that the Ministry of Health has to take more interest in this programme since it presents an opportunity for socialising young persons in the ways of healthy living, free from HIV/AIDS and other communicable diseases.

Sex Education

Sex education has gained special significance in the past few years with the growing concern about HIV/AIDS. A number of studies in Ghana suggest early initiation of sexual activity among young people (15-24 years). One study estimates a mean age of the start of sexual relations as 16 years for females and 17 years for males. (Adomako-Ampofo and Yeboah, 2003) At these young ages, many JSS and SSS students become increasingly exposed to HIV infection, particularly the girls, who are known to have higher HIV/AIDS infection rates than boys.

Schools now provide some sex education aimed at giving students accurate information and skills to guide them in their intimate relationships, and to help them make informed choices about sex and family issues. In Primary Six, at JSS and SSS levels, the subject is introduced as part of the curriculum on healthy living, life skills and science respectively. It is, therefore, necessary to ensure that teachers and other educators have the requisite HIV/AIDS knowledge and competence to manage such programmes. New programmes are being designed to inform and better equip teachers and students alike.

The Education Strategic Plan 2003 - 2015, recognizes the importance of promoting school education on HIV/AIDS, and has outlined measures to review institutional and teacher-training curricula to include aspects of HIV/AIDS awareness, prevention and management, with emphasis on behaviour change. (See Box 2.1 on Teacher Capacity Building on HIV/AIDS) An issue that is yet to be tackled, and which the MoEYS needs to investigate, is how to reach children in the age bracket of 5 to 10 years, widely viewed as the 'window of hope' in the campaign to save future generations.

[18] MoE, 2002

Box 2.1: Teacher Capacity Building on HIV/AIDS

With a workforce of 170,000 workers who have oversight responsibility either directly or indirectly over 7,000,000 (seven million) learners nationwide the Ghana Education Service is strategically positioned to influence the course of the HIV/AIDS epidemic in the country. It plays a significant role in the formation of character and implicitly that of behaviours and attitudes. But studies conducted to inform the Education Sector HIV/AIDS Strategic Framework indicated the existence of a significant knowledge gap about the nature of the HIV/AIDS epidemic among GES personnel.

In response to the above situation, the GES has initiated a number of programmes aimed at building the HIV/AIDS competence of its personnel and pupils/students. The programmes include:

- The School Health Education Programme (SHEP);
- Population and Family Life Education; and
- The Africa Youth Alliance initiative aimed at capacity building to handle club activities in schools.

Specific HIV/AIDS related activities currently being undertaken nationwide by the agency include:

- Advocacy sections for Senior Management Personnel;
- HIV/AIDS education for staff;
- Recruitment of Peer Educators to further the development of workplace HIV/AIDS programmes; and
- The development of HIV/AIDS training manuals for teachers in basic schools.

Source: Ghana Education Service, 2003

2.10 FINANCING EDUCATION

Government continues to be the main investor in education, providing, on average, 90% of education financing. In 2003, the shares of the national discretionary recurrent budget and the Gross Domestic Product (GDP) devoted to education were 26% and 5%, respectively, while the establishment of the GETFund in 2000 has had a pronounced impact on the provision of educational infrastructure and facilities at all levels of education. (See Box 2.2)

Despite the undoubted progress, however, existing education infrastructure and facilities have not kept pace with the growth in demand. Given general agreement that Government cannot alone fill the gap, and that non-state resources need to be mobilized to support education, the challenge is how to promote support through private sector provision while ensuring that the basic needs of the poor, who may not be able to afford fees charged in private education, are met.

Box 2.2: Ghana Education Trust Fund (GETFund)

The GETFund was established by an Act of Parliament in August 2000 to provide finance to supplement government's effort in the provision of education at all levels (Basic, Second Cycle and Tertiary).

Mode of Disbursement
Disbursement of monies is made through the Ministry of Education, Youth & Sports (MoEYS), the National Council for Tertiary Education (NCTE), the Scholarship Secretariat, and the Social Security and National Insurance Trust (SSNIT)

Source of Money for the fund
The sources of money for the fund are as follows:

(a) An amount of money, equivalent to two and one half percent out of the prevailing rate of the Value Added Tax to be paid by the Value Added Tax Service to the Fund or such percentage not being less than two and one half percent of the Value Added Tax rate, as determined by Parliament;
(b) Such other monies as may be allocated by Parliament for the Fund;
(c) Monies that accrue to the Fund from investments made by the Board of Trustees of the Fund;
(d) Grants, donations, gifts and other voluntary contributions to the Fund; and
(e) Other monies or property that may in any manner become lawfully payable and vested in the Board of Trustees for the Fund.

Areas that Benefit from the Fund:

(a) Essential academic facilities and infrastructure
(b) Gifted but needy students as a grant/scholarship to study in second cycle and accredited Tertiary Institutions in Ghana
(c) Loans schemes for students in accredited tertiary institutions.
(d) Training of brilliant students as members of faculties and researchers
(e) Education activities and programmes of relevance to the nation

Source: Ghana Education Trust Fund, 2003

Indications are that the support of households through the provision of finance, motivation and supervision for their children's education is essential to the effectiveness of any improvements in educational facilities and teacher training. (See GDHS 1998) Signs of increasing financial distress in poor households, as appears from the 2003 CWIQ results, therefore, raise questions about the prospects of success of the education programme.

There has been a growth of interest in support for needy students in several District Assemblies since 2000, with many setting up their own scholarship funds to support such students. In addition, traditional authorities and NGOs are establishing scholarships and in-kind support for needy children, including the provision of uniforms and school feeding programmes. School uniforms, stationery and school bags were supplied nationwide to about 5,500 students, of whom 80% were girls. Again, 700 bicycles and food rations were provided to schoolgirls in remote areas. (GoG, 2004) Among the best known of these private initiatives are the Otumfuo Educational Fund and the Northern Trust

Fund. It is worth noting that NGOs like the Catholic Relief Services have for several years now been engaged in providing this kind of support to schools in severely deprived areas, especially in Northern Ghana.

Government has maintained a subsidy for schools in Northern Ghana since Independence, as a means of bridging the gap in educational standards between the North and South. Nevertheless, there have been problems with this scheme in recent years. Funds have been described as woefully inadequate and the disbursements are often released late in the school calendar, causing serious management problems for the administrators of the schools.

2.11 FOCUSING ON PROBLEM AREAS

The major challenges facing education continue to be those of access, quality and equity. After a review of the fCUBE Programme, government has launched a new Education Strategic Plan (ESP) to cover the period 2003- 2015. The ESP is designed to provide a strategic framework for the development of the education sector and also a basis for the adoption of a sector-wide approach to education financing. It also gives renewed significance to sex education in the context of the HIV/AIDS pandemic. Aspects of the impact of the HIV/AIDS pandemic on the education sector are addressed in Chapter 4.

SECTION C: HEALTH

2.12 GENERAL TRENDS IN THE HEALTH OF GHANAIANS

The importance of health to the quality of life, the level of productivity and life expectancy has long been recognized in development circles. For individuals and families, health is the basis of personal development and economic security. At the societal level, health constitutes a critical input into economic growth, poverty reduction and long-term socio-economic development.

Social indicators of health in the 1990s point to qualified success in the effort to improve the health status of Ghanaians. Although health status indicators like infant and childhood mortality rates declined between 1992 and 1998, there were marked geographic disparities, especially with respect to the three northern regions and the Central Region.

A focus on health is now reflected in all major development frameworks. For example, the Ghana Poverty Reduction Strategy (GPRS) gives prominence to improving the health status of Ghanaians by enhancing access to, and efficient delivery of, basic health services, with special emphasis on disadvantaged regions. The medium term strategies for achieving this objective are to include the:

- replacement of the cash-and-carry system of payment for health care with a national health insurance scheme;
- provision of one model health centre in each district; and
- acceleration of the provision of safe water and adequate sanitation in the rural areas.

While these interventions are necessary for improving the health conditions of the population, the challenge posed by the HIV/AIDS pandemic may compromise any gains from these other interventions. This section, therefore, reviews trends in the health sector in 2003, leaving for Chapter 4 the potential impact of HIV/AIDS on the health sector in the coming years.

An assessment of movements in the priority health indicators against the GPRS targets for 2005 shows that, whereas by 2003 some of the indicators were close to their GPRS targets, others had declined since 1998.

Table 2.7: Summary of Priority Health Indicators, 1998-2003

Indicator	1998 level	2003 level	2005 GPRS target
Infant mortality rate (per 1000 live births)	57	64	50
Under-5 mortality rate (per 1000 live births)	108	111	95
Maternal mortality rate (per 100,000 live births)	190	170	160
Percent antenatal care coverage	89.0	92.0	98.0
Percent supervised deliveries coverage	44.3	47.1	55.0
Percent immunization coverage (DPT 3)	87.9	91.1	90.0
Proportion of under-5 malnourished (underweight)	26.0	35.8	20.0
Total fertility rate	4.6	4.4	4.2

Sources: GDHS, CWIQ and Health Sector Programme of work in Ghana-facts and figures.

(See Table 2.7) Indicators on track include antenatal care coverage, supervised deliveries, immunization coverage (DPT 3), total fertility rate and, to some extent, the maternal mortality rate; those that have worsened are mortality among children and childhood malnutrition.

The Ghana Health Service, in furtherance of its Primary Health Care Programme, adopted the Community-based Health Planning and Services (CHPS) strategy in 1998. This followed successful testing of the strategy for four years by the Ministry of Health and the Navrongo Health Research Centre Project on Community Health and Family Planning. CHPS is devoted to sharpening the community health skills of health providers, as well as building capacity for community participation. It uses a model known as Community Decisions System (CDS), under which Community members, District Health Management Teams, (DHMTs), health education teams and Community Health Officers will be given training. Using this approach, the Ghana Health Service hopes to increase its coverage, relevance and effectiveness, which is expected to translate into more equitable and affordable health care for the poor. No doubt this structure will contribute greatly to the grass roots campaign on HIV/AIDS, as it creates an opportunity for information sharing among different categories of stakeholders.

2.13 INFANT AND CHILDHOOD MORTALITY

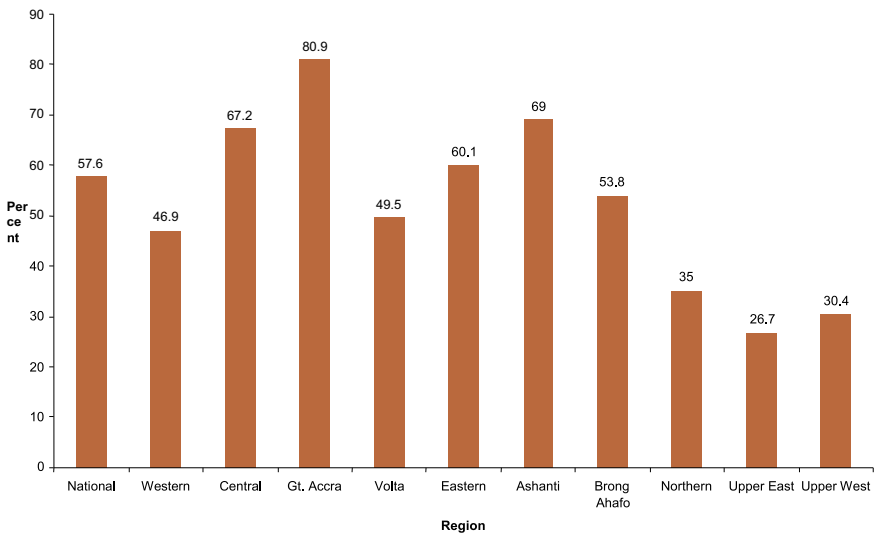
There are indications that the improvements recorded in infant and childhood mortality rates in the 1990s are being eroded. Comparison of the 1998 and 2003 Ghana Demographic and Health Surveys (GDHS) shows that infant mortality increased from 57 per 1000 live births in 1998 to 64 per 1000 in 2003, while child mortality rose from 108 per 1000 live births, to 111 per 1000 - instead of falling towards the GPRS

targets of 50 and 95, respectively, by 2005. (Table 2.7) Given the sensitivity of these indicators to living conditions and the general health status of the population, their decline over the past five years bodes ill for the general outlook for poverty reduction. Moreover, efforts to reverse the current trend may prove difficult in the face of the rising incidence of child malnutrition (see section on child malnutrition, below) and mother to child transmission of HIV/AIDS.

Many factors account for the observed increases in infant and child mortality. These include poor access to health services (including lack of money to cover health expenses) and child malnutrition. The proportion of people with access to health care remains low, with a national average of just under 60%, and even lower in the three northern regions. (See Figure 2.9) As already noted, strategies adopted under the GPRS to increase access to health care include replacing the cash-and-carry system with a National Health Insurance Scheme (NHIS) and providing one model health centre in each district. Further, fifteen additional Health Centres and two District Hospitals were completed in 2003. In addition, fifteen health centres were expected to be completed by January 2004.

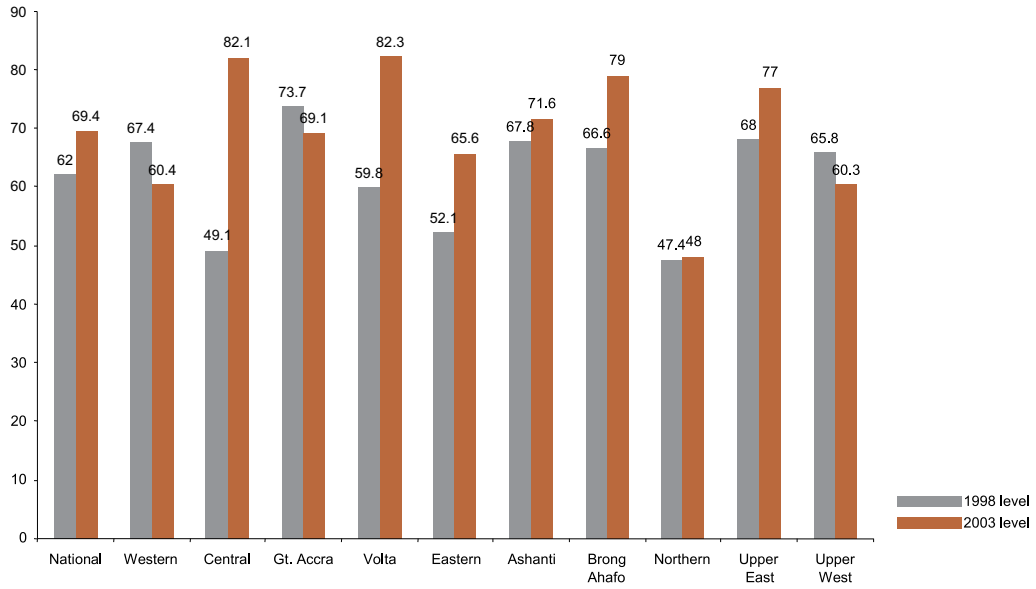
It is important to note from Figure 2.9 that five out of ten regions have health services access rates below 50% of the population. This, coupled with the shortage of doctors and other health professionals in most health institutions, paints a gloomy picture of the situation faced by the average Ghanaian, especially outside the major cities of Accra, Kumasi and Takoradi.

Figure 2.9: Access to Health Services by Region,2003



Source: CWIQ 2003 Report

Figure 2.10: Immunization Coverage by Region, 1998 and 2003



Source: GDHS 2003 Report

2.14 CHILD HEALTH AND NUTRITION

Two key areas of child health in Ghana are vaccination against the six childhood killer diseases (polio, measles, whooping cough, diphtheria, tetanus, tuberculosis) and nutrition, and to these we now turn.

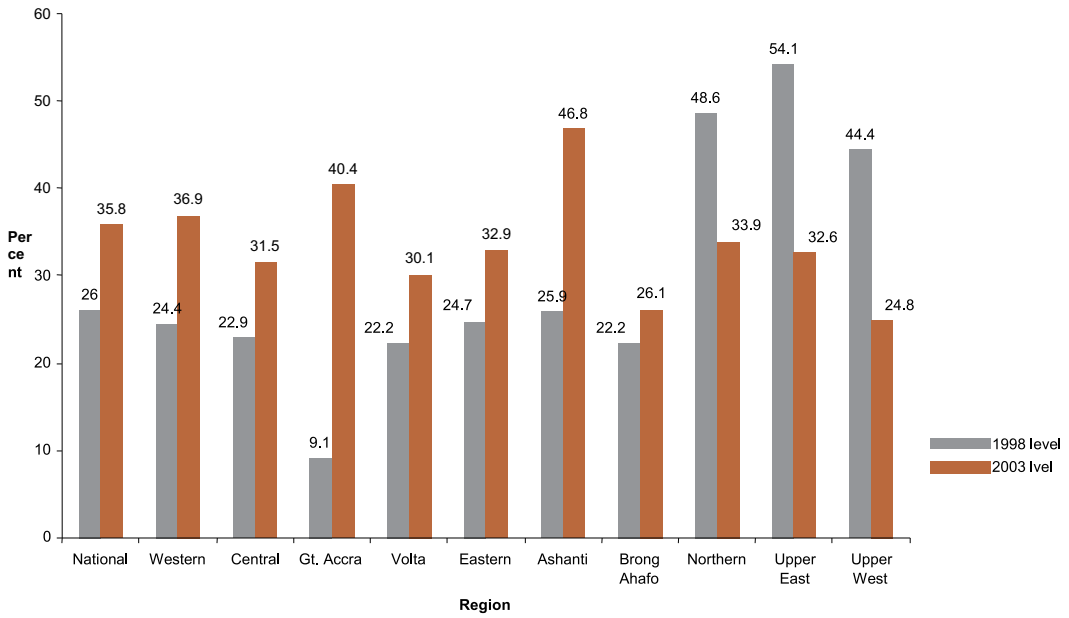
Immunization Coverage

The overall immunization coverage for children 12-23 months old improved in 2003 from the 1998 level. The proportion of children fully vaccinated increased from 62% in 1998 to 69.4% in 2003. (Figure 2.10) However, regional differences in coverage persist, thus, while coverage has increased significantly in the Central, Volta and Brong Ahafo regions, it has declined in the Gt. Accra, Western and Upper West regions.

Malnutrition among Under-Five Year-Olds

The level of child malnutrition, as measured by the proportion of children underweight, has increased by almost 10% in the last five years, with particularly marked rises in Greater Accra and Ashanti. (See Figure 2.11) This deteriorating nutritional status of children marks a serious loss of ground in our development efforts, and suggests the failure of nutritional programmes and/or increasing household poverty. Indeed over half of the survey respondents in the 2003 CWIQ survey reported that their household economic conditions were worse at the time of the survey than the previous year. The decline in nutrition status calls for increased collaboration between the agencies responsible for child welfare in its various dimensions. Malnutrition also makes children exceptionally vulnerable to ill-health and death, with malaria as one of the major causes in this age group. We, therefore, enter a brief review of malaria control.

Figure 2.11:Level of Child Malnutrtion (underweight) by Region, 1998 and 2003



Source: CWIQ 2003 Report

2.15 CONTROL OF MALARIA

Poor environmental sanitation and lack of vigilance in reducing the habitat of the malaria-causing mosquito lies at the heart of the malaria pandemic in Ghana. According the World Health Organization (WHO), about 40% of the global population, mostly in the poorest countries, are at risk of contracting malaria. In Ghana, malaria affects about three million people each year, with the worst-hit groups being pregnant women and children under five years old. It continues to be one of the major causes of adult and child morbidity, accounting for a high proportion of hospital/clinic outpatient attendance, though the Ministry of Health reports that malaria-related fatalities in under-5 year-olds declined from about 6.4% of deaths to about 4.4% (MoH, 2003).

A number of scientific studies have shown that one of the best ways to avoid malaria is to sleep under an insecticide treated net (ITN). To reduce the high incidence of malaria, the Ministry of Health is, therefore, promoting the use of ITNs for pregnant women and children under five. The target is to ensure that 60% of pregnant women and children under five years old slept under insecticide treated nets by 2005. Regrettably, by 2003 Ghana had recorded only 3.3% use, one of the lowest rates in Africa, ownership of any net is equally low at about 18%; more rural households (24%) than urban households (10%) own nets. One of the key reasons for the low use of bed nets is probably the general feeling that sleeping under a bed net is an old-fashioned remedy for mosquito bite control. It is, therefore, necessary to intensify

education about the ITN, especially among the high-risk groups through the Radio and T.V. since more than 70% of people receive their messages about malaria from these sources. (GSS, 2003)

The current interventions under the Roll Back Malaria (RBM)[19] initiative include

- the promotion of the proper use of insecticide-treated nets (ITNs);
- the promotion of a home-based approach to the management of malaria;
- the Intermittent Preventive Treatment (IPT) for pregnant women and
- a new anti-malaria drug policy among others.

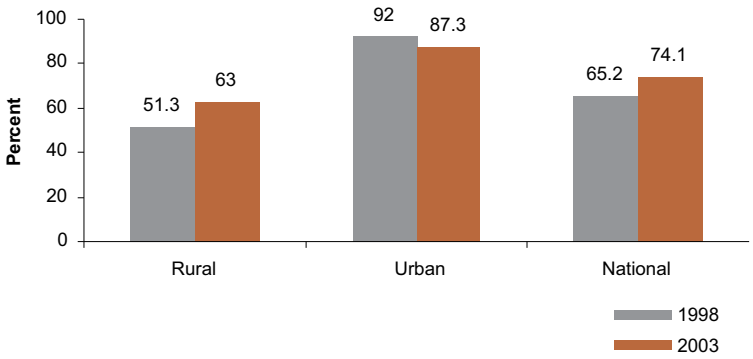
In Ghana, the production and airing of the He Ha Ho (Healthier Happier Home) radio drama has been a successful effort at educating listeners on malaria and other childhood illnesses among others.

Currently, the treatment of uncomplicated malaria with chloroquine has been changed to the use of Artesunate together with Amodiaquine. And to ensure compliance, efforts are being made to put the two drugs together as a single tablet.

There are also subsidies on the ITNs with some regions benefiting immensely from the sale of highly subsidized nets like the Northern regions and a pilot voucher scheme in the Volta Region. The RBM programme however faces a major challenge of affordability and availability with regards to preferred drugs.

The RBM initiative has made considerable progress but there is the need for more concerted effort to sustain the momentum in the fight against the disease and minimize its devastating effects. Efficient use of the Global Fund and the 1% of the DACF allocated for malaria will help in this direction.

Figure 2.12: Access to safe water, 1998 and 2003



2.16 ACCESS TO SAFE WATER AND SANITATION

One strategy for rapidly achieving improvements in overall health in Ghana for both the young and the old is to improve water quality and availability, as well as sanitation. Particular emphasis needs to be placed on guinea worm endemic areas, in line with the GPRS and the MDGs.

Access to Safe Water

The rural population with access to safe water has increased over the past five years, while the urban areas experienced a decrease in the population with access to safe water. (Figure 2.12) The positive trend in access to safe water in the rural areas is the outcome of increased coverage in the provision of water infrastructure, especially new boreholes, in rural communities. It is the case, nevertheless, that the demand for facilities is far in excess of the resources available to meet the needs of communities, both urban and rural.

The two main organizations responsible for providing safe water are the Ghana Water Company Limited (GWCL), responsible for urban water supply, and the Community Water and Sanitation Agency (CWSA), responsible for the rural areas. Over the past three years, efforts have been made at the major treatment plants at Kpong, Weija,

[19]The Roll Back Malaria (RBM) Initiative was launched in 1998 with the objective of halving the global malaria burden by 2010. The Initiative is a global partnership of the founding partners UNDP, UNICEF, WHO and the World Bank and malaria endemic countries, civil society organisations and the private sector.

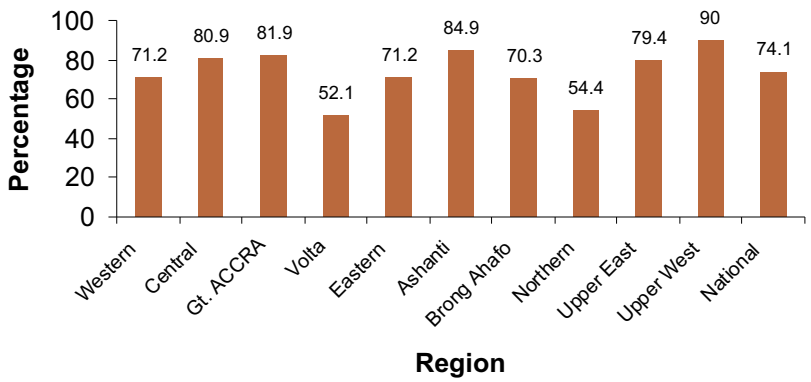
Barekese, Abesim, Daboase/Inchaban, Winneba, Akwapim Ridge Water Supply, and West Accra District Water Supply to provide potable water to the urban centres. Some old and minor water treatment plants, including the New Tafo Water System have also been rehabilitated. (GoG, 2004)

The Community Water and Sanitation Agency (CWSA) has undertaken many projects in the countryside since 2001. These include:

- 660 new, and about 1,000 rehabilitated boreholes;
- 350 new, and 500 rehabilitated hand-dug wells;
- 16 new mechanized community pipe systems; and
- 10 gravity pipe systems.

Other measures underway include the construction of over 3,000 household, and 88 institutional places of convenience country-wide, and the training of 1,330 Water and Sanitation (WATSAN) Committees, 2000 hand pump caretakers, 400 area mechanics and 100 artisans to manage rural water and sanitation facilities.

FIGURE 2.13 ACCESS TO SAFE WATER IN 2003



Source: GSS 2003, CWIQ Report

The CWSA faces major challenges in its efforts to meet the GPRS and MDG targets. Apart from inadequate finances, the CWSA programme is handicapped by the lack of qualified staff to implement its programmes, as it competes with the private sector for technical people. In the longer term the Agency also has to keep an eye on the sustainability of ground water resources on which it has become heavily dependent.

A particular difficulty arises from the request of some of the funding partners that in addition to the 5% contribution to capital costs by local communities, District Assemblies should also contribute 5% to every community application. In some districts in the Ashanti Region it has been observed that this is already causing long delays in the processing of community applications because the districts are unable to satisfy all the requests they receive. Thus, by including this demand on District Assemblies, funding agencies are effectively limiting the ability of the Assemblies to use their discretionary powers to single out for assistance particularly distressed communities (e.g., guinea worm areas). While some development partners insist on this condition,[20] others do not. The situation needs to be clarified to ensure that deprived communities are not penalised as a result of lack of counterpart funding from the Assemblies.

In spite of these measures, some of the perennial water problems persist in both urban and rural areas, and are likely to affect the health status of Ghanaians, in particular those who do not have access to potable water. For example, while the Accra-Tema area needs about 990,000 cubic metres of water a day, the GWCL currently pumps 670,000 cubic metres, less than 60% of what is needed. In areas where residents are dependent on rainwater as their source, they face serious problems during the dry season. Further, there are still substantial

[20] There is concern among some development partners that district assemblies may use their discretionary powers to serve political ends; others argue that the districts would use the DACF more efficiently if they were compelled to devote some of it to community water and sanitation (personal communication with various staff of district assemblies; observations made at workshop on cost-sharing in the CWSP).

TABLE 2.8: TRENDS IN THE REPORTED CASES OF GUINEA WORM

YEAR	REPORTED CASES	PERCENT INCREASE OVER PREVIOUS YEAR
2001	4,738	----
2002	5,545	17.0
2003	8,000	44.3

Source : MoH, 2003 Performance reports

regional variations in access to safe water, with just over 50% in the Volta Region and the Northern Regions. (Figure 2.13)

Incidence of guinea worm infections

Data from the Ministry of Health (MoH) indicate a disturbing trend in the reported number of Guinea worm infections, which increased by 44.3% between 2002 and 2003. (Table 2.8) Indeed, Ghana has the unenviable record of being the second worst affected country in the world, after the Sudan. The worst affected endemic areas in the country are in the Volta, Northern and Brong Ahafo regions. In an effort to arrest the increasing incidence of Guinea worm infection, an amount of 29.2 billion was released by the government in 2003 for the construction of 245 boreholes in guinea worm endemic areas.

Hygiene Education

It has been observed that poor hygiene knowledge and practices besides leading to diseases associated with environmental sanitation such as diarrhoea, typhoid, malaria etc. aggravate the risk of HIV/AIDS infection in Ghana. Since 2000 the Community Water and Sanitation Agency and the Ghana T.B. Control Programme have stepped up their public health messages through especially school hygiene programmes and a nationwide hand-washing campaign. The media is being used to disseminate information on the dangers of indiscriminate spitting, sneezing and coughing. PLWHAs and their caregivers have been called upon to take extra precautions through safe hygiene practices to avoid inadvertently infecting others.

2.17 HEALTH CARE FINANCING

Reflecting Government's objective of improving the level and distribution of health resources, the proportion of non-wage recurrent public expenditure on health increased from 10.5% in 2002 to 11.8% in 2003. In spite of this, access to modern health care remains inadequate, as indicated earlier in this report. Perhaps the most critical factor in the utilization of health services, apart from physical access, is the ability to pay at the point of service.

To achieve the goal of sustainable health care financing that protects the poor, the following policy measures have been introduced:

- a health insurance scheme to replace the cash-and-carry system; and
- extension of exemptions to include maternity delivery.

National Health Insurance

The National Health Insurance Act was passed in 2004. Forty-five districts have

been piloting the scheme for some time now. Out of that number,

- 10 are managing benefits and claims
- 15 are at the stage of registration of members and collection of contributions
- 7 are coding streets and houses
- 8 are sensitising their communities, and
- 5 have started stakeholder consultations.

In addition, an amount of 41.6 billion of HIPC funds was released to 108 districts, including 12 sub-metros in Kumasi, Accra and Sekondi-Takoradi, to facilitate the implementation of 120 District Mutual Health Insurance Schemes.

Other notable measures taken in 2003 to enhance the implementation of the Health Insurance Scheme include the preparation of instruments for the accreditation of health institutions and stakeholder consultations on a minimum benefits package for the scheme.

Exemption from Fees

The exemption policy was developed to protect the poor and vulnerable. The recurrent budget spent on exemptions doubled from 12.8 billion in 2002 to 24 billion in 2003. An additional amount of 17.2 billion was provided by Government to cover exemptions in the Northern regions and the Central Region. Despite these increases, the impact of the exemption policy is less than obvious. This is because the problem of poor targeting and screening in the implementation of this scheme has persisted since it was noted in the 2000 GHDR. This has been partly blamed on low capacity to implement the scheme and low demand due to ignorance on the part of eligible beneficiaries.

SECTION D: LIVELIHOODS AND THE ECONOMY

2.18 GENERAL TRENDS IN LIVELIHOODS

The state of human development in relation to HIV/AIDS related diseases, education and health have been summarised in Sections A, B and C above. This section discusses livelihoods within the economy since the publication of the Ghana Human Development Report, 2000. Livelihoods are affected by macroeconomic policies, particularly those relating to productivity and income earning capacity. Poverty reduction strategies have been the main instruments for improving livelihoods since 2000. Under the Ghana Poverty Reduction Strategy (GPRS), government has pursued policies aimed at reducing poverty and improving people's livelihoods - but to what effect?

The concept of livelihoods captures the capabilities, assets and activities that a household requires to earn a living. A household has a secure livelihood if it is able to cope with, and recover from, shocks such that it is able to maintain its current and future assets and capabilities (cited at www.livelihoods.org/info/info_guidancesheets.html). The concept of a secure livelihood is therefore dynamic as it refers not only to how much individuals are able to earn in the current period but also whether such earnings can be sustained or improved. This section provides a brief assessment of current livelihoods of Ghanaians, with a view to understanding likely trends over the medium term, which would have implications for HIV/AIDS. For instance, understanding the factors that drive the demand for good health services is important in any policy to combat the HIV/AIDS problem. A household's *effective demand*[21] for health services in the medium term is a function of their current and future income, which is, in turn, determined by

[21] This refers to demand that is backed by purchasing power

their investment in human and physical capital. These factors are affected by national socio-economic policies employment creation, access to utilities such as good sanitation, water and electricity, and industrial policy. Other factors that are not a direct result of government policy but can also affect the livelihoods of households include remittances from abroad.

The analysis of livelihoods in Ghana that follows, examines trends in GDP growth, inflation, the exchange rate and interest rate developments, and seeks to assess how developments in these areas affect the poor. This is followed with a sub-section on the performance of the different sectors of the economy for a similar assessment. Since low incomes have been a major barrier to many households getting access to services such as education and health, subsequent sub-sections will examine wages and income distribution within the country. The section also discusses income transfers, particularly migrant worker remittances and how they serve as income support to poor households. This is followed by an outline of employment trends over the past few years, and the final section examines access to utilities namely, electricity, water, sanitation, as well as transport.

2.19 MACROECONOMIC TRENDS

Real GDP growth increased from about 4.4% in 1999 to 5.2% in 2003, after decreasing to about 3.7% in 2000. (See Table 2.9) On average, the real GDP growth over this period was about 4.4%. With the population growing at an average rate of about 2.7% over the period, real GDP growth in per capita terms averaged about 1.7%. This is generally seen as too low to propel the country towards a middle-income status by 2013 as proposed by government's Coordinated Programme for Economic and Social Development over 2003 - 2013. Besides, attaining higher growth rates is threatened by the impact of the HIV/AIDS pandemic.

While most estimations of a required growth rate in order to achieve the MDGs suggested an 8-9% annual growth of GDP, it is obvious that this will require substantial structural change to make it possible. The current rates of domestic savings (7%) and investments (21%) are deemed to be inadequate. Obviously a significant portion of investments in Ghana is financed from foreign sources. The volatility of such financing is likely to affect any future investment programming in the absence of structural change, which will affect adversely the programme for poverty reduction.

TABLE 2.9: GDP GROWTH AND INFLATION RATES (%)

	1999	2000	2001	2002	2003
Real GDP	4.4	3.7	4.2	4.5	5.2
Real GDP per capita	1.8	1.2	1.6	1.9	2.1
Nominal GDP	19.0	31.9	40.2	28.3	33.6
Inflation rate (end of period)	11.8	40.5	21.3	15.2	23.6

Source: IMF Staff Estimates
Note: The figures are in Annual Percentage changes

Economic growth is more likely to have a significant impact on poverty reduction if it is driven largely by growth in the sectors that employ most of the poor, i.e., the agricultural sector, hence our looking at sectoral performance in the next sub-section.

Other relevant macroeconomic indicators for assessing livelihoods include changes in the rate of inflation. The end-of period annual inflation rate was brought down from 40.5% in 2000 to 15.2% in 2002 (Table 2.9). However, there was a reversal in this downward trend with the annualised inflation rate rising from 16.3% at the end of January 2003 to 30% by the end of April 2003. By the end of December 2003, however, the rate had fallen back to 23.6%. Inflation affects low-income consuming households more through the rises in transportation, food and housing costs.

2.20 SECTORAL PERFORMANCE.

It is important to note that the last decade has seen little change in the sectoral composition of GDP and growth rates. This may be related to the absence of direct attempts to induce structural change.

Agriculture

The agricultural sector grew by 6.1% in 2003. This was much higher than the 4.4% and 4.0% growth rates recorded for 2002 and 2001, respectively. (Table 2.10) The

TABLE 2.10: TRENDS IN GROWTH PERFORMANCE BY SECTOR (%)

	1998	*1999*	*2000*	*2001*	*2002*	*2003**
AGRICULTURE	**5.1**	**3.9**	**2.1**	**4.0**	**4.4**	**6.1**
Agriculture and Livestock	4.4	4.7	1.1	5.0	5.3	5.3
Cocoa Production and Marketing	11.1	-0.5	6.2	-1.0	-0.5	16.4
Forestry and Logging	10.0	6.8	11.1	4.8	5.0	6.1
Fishing	1.8	1.0	-1.6	2.0	2.8	3
INDUSTRY	**3.2**	**4.9**	**3.8**	**2.9**	**4.7**	**5.1**
Mining and Quarrying	6.1	3.0	1.5	-1.6	4.5	4.7
Manufacturing	4.0	4.8	3.8	3.7	4.8	4.6
Electricity and Water	-10.0	7.8	4.5	4.2	4.1	4.2
Construction	5.0	5.5	5.1	4.8	5.0	6.1
SERVICES	**6.0**	**5.0**	**5.4**	**5.1**	**4.7**	**4.7**
Transport, Storage and Communication	5.5	6.0	6.0	5.5	5.7	5.8
Wholesale and Retail Trade, Rest. and Hotels	6.0	6.5	4.0	5.1	5.6	5
Finance, Insurance, Real Est. and Bus.Services	6.5	4.0	5.0	4.5	5.5	5.2
Government Services	6.2	4.0	6.0	5.0	3.6	4
Community, Social & Personal Services Producers of Private non-profit Services	5.9	5.9	6.9	6.5	4.4	4.1

Source: Budget Statements, 1998-2003

significant jump in the growth rate in 2003 was due mainly to a 16.4% growth in the cocoa sub-sector. This was followed by forestry, crops and livestock, and fishing, in that order.

With over 60% of the population engaged in agriculture, it is important to understand how this growth is distributed. While cocoa saw the most significant growth, only a small proportion of farmers are engaged in the cocoa sub-sector. Food crop farmers, who form the majority, are the poorest in Ghana. Hence, a large number of farmers are not likely to have benefited much from the improvements in the total figure.

The main constraint facing agricultural development remains the remarkably low productivity of the sector as a result of a lack of investment in such items as irrigation, new technologies, R&D, feeder roads, etc. Only about 0.4% of arable land in Ghana is irrigated. It is important for conscious policy effort to be made to increase land under irrigation.

Industry

Industrial sector output grew by 5.1% in 2003 compared to 4.7 in 2002 and 2.9% recorded in 2001. The various sub-sectors experienced growth rates ranging between 4.2% and 6.1% as shown in Table 2.10. The manufacturing sub-sector experienced a 0.2% decline from the previous rate of 4.8%. Since manufacturing accounts for about 56% of industrial activity, under-performance here has serious repercussions for employment and incomes in Ghana.

Services

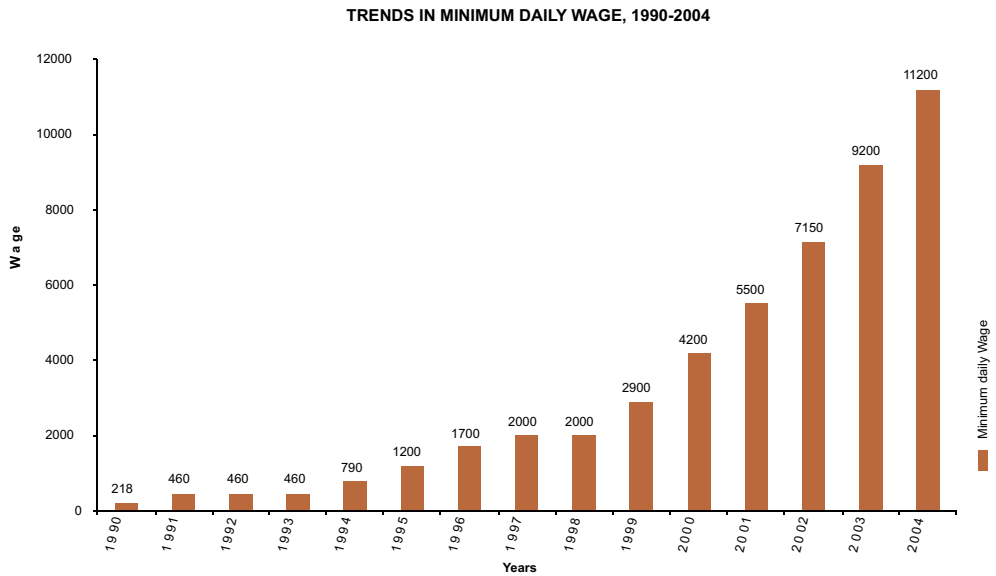
Again, near stagnation trends were observed in the services sector between 2000 and 2003. Growth in the services sector in 2003 was the same as in 2002 at 4.7%. There was a marginal improvement in the transport, storage and

Table 2.11: Real Minimum Wages

Period	Nominal daily minimum wage	CPI Combined	Real Minimum wage
2001 Dec	5500	226.77	2425.37
2002-Dec	7150	261.17	2737.68
2003-Jan	9200	266.47	3452.55
2003-Feb	9200	300.57	3060.85
2003-Mar	9200	308.00	2987.01
2003-Apr	9200	312.68	2942.31
2003-May	9200	316.34	2908.26
2003-Jun	9200	318.85	2885.37
2003-Jul	9200	321.17	2864.53
2003-Aug	9200	320.24	2872.85
2003-Sep	9200	318.68	2886.91
2003-Oct	9200	317.27	2899.74
2003-Nov	9200	318.79	2885.91
2003-Dec.	9200	322.70	2850.95

Sources: Bank of Ghana Statistical Bulletin December 2003 and Labour Department

FIGURE 2.14: TRENDS IN MINIMUM DAILY WAGES, 1990-2004



Source: Labour Department, Ghana.

communications and government services sub-sectors as shown above in Table 2.10. These marginal increases in the service sector are indicative of limited capacity to generate employment.

Current income trends (per capita income in US $) would suggest that there is no significant improvement. However, growth rates from the budget statements would suggest otherwise but the pattern and source of growth also matters.

- Dr. Abena Oduro, Centre for Economic Policy Analysis

2.21 WAGES AND INCOME DISTRIBUTION

The minimum daily wage was increased from 5500 at the end of 2001 to 7150 at the end of 2002 and then to 9200 in 2003. However, in real terms, the minimum daily wage declined consistently from January to June 2003. (Table 2.11) The minimum wage has remained above a dollar a day throughout 2003.

This trend was reversed after July with the improvement in the rate of inflation. However this was not enough to push up the real minimum wage to the level achieved in the first quarter of 2003. The implication here is that workers whose earnings followed the trend in the minimum wages experienced a decline in their purchasing capacity. However, what must be noted is the nominal wages increased at a faster rate from the year 2000 than in the 1990's (Figure 2.14)

There are interesting gender dimensions to wages. Due to the fact that women tend to occupy lower positions in employment because of lack of skills, there are differences in wages of men and women. Men earn, on average, 6.8 million[22] per year against 4.5 million per year for female workers. On average the formal sector worker earns 17.7 million compared to 4.5 million by his counterpart in the informal sector, almost four times the wage of the worker in the informal sector. Even within the formal and the informal sectors, the 2000 Ghana National Labour Market Survey reveals huge differences.

In the formal sector, the male service-sector worker takes the lead with 37.9 million a year, while the female agricultural worker receives only 0.8million[23] a year.

[22] 1,000,000 Ghana Cedis equals 183 US Dollars and 105 Euro in 2003

[23] In 2003, the Danish Trade Union Congress International Development Committee (DTUCIDC) conducted a useful assessment of the legal regime for Ghana's labor market. DTUCIDC, 2003, p. 37-38

(DTUCIDC, 2003) In the informal sector, the transport and communication worker is paid the most, 10.8 million, while the worker in the financial sector is paid the least, 0.7million.[24] Incomes in the agricultural, mining and quarrying and manufacturing sectors are especially low.[25] These three sectors employ about 65 per cent of the total workforce and are major contributors to export earnings. A wage rise in these sectors would mean an important improvement for a large proportion of Ghanaian workers.

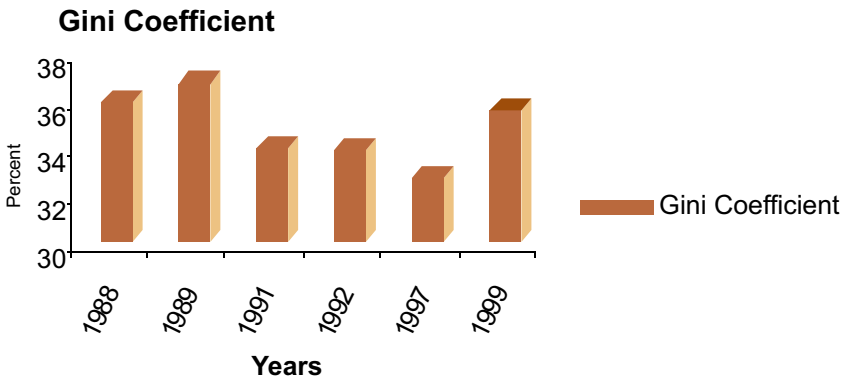
Data on income inequality[26] are not up to date, with the most current year being 1999. Figure 2.15 shows that inequality declined between 1992 and 1997 but increased significantly between 1997 and 1999. The trends observed above for the sectoral growth performances suggest it is unlikely that inequality has been reduced significantly in more recent years, since it is not the sectors that employ the majority of the very poor in Ghana that have registered significant growth.

2.22 INCOME TRANSFERS (REMITTANCES)

Private inward remittances have become a useful source of income to Ghanaians particularly in times of macroeconomic shocks. Total inflows increased from approximately US$1.4 billion in 2002 to US$2.2 billion in 2003, an increase of 57.48% (Bank of Ghana). These volumes of inward remittances have helped to partially stabilize the cedi against the major currencies.

The increasing remittances have had some implications for poverty reduction. It may be noted from the Ghana Living Standard Survey (GLSS) 3 and 4 data that the regions in the forest belt that saw the sharpest declines in poverty were also those in which households showed a significantly larger portfolio of their assets in remittances. There is obviously a relationship between the remittance flow and migratory trends. Associated with that is the issue of the "brain drain".

Figure 2.15: Income Inequality



Although statistics on the brain drain in Ghana are hard to come by, an often-cited example is the significant number of nurses and doctors leaving the country. On the one hand, there are costs imposed on the economy as a result of the brain drain. On the other hand, there are benefits, particularly to poorer households in the form of remittances from friends and family. While increased remittances from relatives and friends abroad may help improve access to health services for poor households, this will have to be weighed against the eventual reduction in the effective supply of health services as staff leave.

2.23 ACCESS TO UTILITIES

The regulatory body responsible for pricing electricity and water in urban areas, the Public Utilities Regulatory Commission (PURC), attempts to include subsidies for the poor through lifeline tariffs on electricity and water.

Electricity

Despite the effort to reduce poverty, increases in power tariffs over the past three years seem to have affected the poor adversely as both domestic and

[24] Ibid
[25] Ibid
[26] Using the Gini coefficient - The Gini Index measures the extent to which the distribution of income among households within an economy deviates from a perfectly equal distribution.

commercial users are greatly affected by significant tariff increases. There was an average tariff increase of 115% for domestic electricity consumers in May 2001. For the lifeline domestic consumers, the increase was 95%. (Table 2.12) However, the increases in the tariff rates coincided with improvements in access to electricity in Ghana. Access to electricity in urban areas other than Accra increased from 58% to 72% between 1992 and 1999, and the trend is upwards (see GLSS 3 and GLSS 4). In addition, a comparison of the 1997 and the 2003 Core Welfare Indicators Questionnaire (CWIQ) shows that access to electricity by households has increased from 37% to 51% over the same period. (Joint Annual Report on Ghana-EU Cooperation, 2003; p-6)

The increase in access to electricity is also associated with a decline in the use of fuel

Table 2.12: Electricity Tariffs Approved By Purc Effective May 2001

CUSTOMER CLASSIFICATION	UNITS CONSUMED	EXISTING RATE (CEDIS/KWH)	RATE APPROVED BY PURC	% INCREASE OVER EXISTING RATE
Domestic	**Lifeline (0-50)**	**4000**	**7800**	**95**
	51-150	**120**	**242**	**102**
	151-300	**150**	**1000**	**103**
	Above 300	**220**	**570**	**159**
Non-Domestic				
	0-300	**220**	**436**	**98**
	Above 300	**320**	**645**	**102**
Small Scale Industries				
Low Voltage				
Energy Charge	**(cedis/kVAmth)**	**180**	**342**	**101**
Capacity Charge		**10000**	**34000**	**240**
Medium Voltage				
Energy Charge	**(cedis/kVAmth)**	**170**	**350**	**106**
Capacity Charge		**10000**	**30000**	**200**
High Voltage				
Energy Charge	**(cedis/kVAmth)**	**150**	**340**	**101**
Capacity Charge		**10000**	**28000**	**180**

Source: Public Utility Regulatory Commission, 2004

Table 2.13: Water Tariffs Approved By Purc Effective May 2001

CUSTOMER CLASSIFICATION	EXITING (¢S PER 1000 LITRES)	RATES APPROVED BY PURC, (¢S PER 1000 LITRES	% INCREASE OF PURC RATES OVER EXISTING RATES
Domestic			
Consumption between			
0-10,000 litres	**500**	**990**	**98**
Consumption above			
10,000 litres	**1,300**	**3600**	**177**
Stand pipes	**400**	**1000**	**150**
Commercial/ industrial	**220**	**436**	**98**
0-40	**1820**	**4000**	**120**
41-450	**2,230**	**4000**	**79**
Above 450	**2,230**	**4000**	**79**
Government			
Departments/Institutions	**1,560**	**3600**	**131**

Source: Public Utility Regulatory Commission, 2004

wood. Fuel wood consumption among households declined from 67.4% to 62.5% within the period 1992 and 2000, whilst charcoal usage rose from 24.9% to 30.6% over the same period. One would expect a possible increase in the usage of fuel wood and charcoal consumption given the price increases in kerosene and liquefied petroleum gas (LPG) over the 2000 and 2004 period. The distribution of households by locality and use of basic energy utilities shows that 91% of households in Accra use electricity for lighting purposes as compared to 72% in other urban areas. Overall, 39% of Ghanaian households used electricity as a source of lighting, while 60% used kerosene. (GLSS 4)

Ability to Pay for Water and Sanitation Facilities

The availability of safe water was discussed in some detail in Section C. One of the major issues concerning access to potable water is obviously affordability, particularly among the poor. Through PURC's lifeline tariffs, standpipe tariffs and domestic consumption of between 0 and 10,000 litres attracts lower tariff rates and increments than the tariffs for domestic consumption of 10,000 litres and above, as shown in Table 2.13.

For instance, tariffs on domestic consumption of between 0 and 10,000 litres and standpipe tariffs increased by 98% and 150%, respectively, whilst that of

domestic consumption of above 10,000 litres experienced an increase of 177%. In terms of approved rates, domestic consumption of less than 10,000 litres attracts about one-quarter of the charges for domestic consumption above 10,000 litres (990 per 1,000 litres as against 3600 per 1,000 litres).

Despite this lifeline provision, quite a large number of Ghanaians are unable to pay their water bills on time as a result of low incomes coupled with the tariff increases (Table 2.13), and this has had serious consequences on livelihoods, apart from the mass disconnection exercises frequently carried out by the Ghana Water Company for non-payment of bills.

Communication Technology

Under the current Ghana Poverty Reduction Strategy, improvement in communications for the creation of wealth and human development is one of the main objectives, which has been pursued with the greatest commitment. This sector has focused on negotiating with the existing telecommunications agents to introduce more competition and accelerate access to telephones, Internet and information technology throughout the country. Since 2001, measures have been put in place to provide information and communication technology (ICT) to schools and expand telephone facilities outside urban areas. Ghana Telecom has initiated a programme to roll out additional 400,000-fixed lines within three years. This is intended to support the extension of broadband connectivity to towns with senior secondary schools and training colleges to facilitate the extension of computer literacy in the schools. As at the end of 2002, only limited progress had been made with respect to providing ICT for schools, except the extent that the additional fixed lines could facilitate Internet connectivity (GPRS, 2002 Annual Progress Report).

As at the end of 2003, about 68,600 new lines had been completed. This has helped to improve teledensity in the country from less than 1% as at December 2000 to 5% by December 2003. Akatsi, Teshie Nungua, Sekondi, Kwame Nkrumah University of Science and Technology and its environs, Akyem Swedru, Dormaa Ahenkro, Dompoase, New Edubiase and Navrongo are the beneficiary communities. (2004 Budget Statement) Teledensity of 5% is still on the low side, and only within the reach of people in the middle and upper income brackets. Those whose livelihood is of concern are within the lower income brackets.

Housing

One of the biggest problems for many urban dwellers is their poor housing situation characterised by poor quality of structures and high room densities. While many Ghanaians would like to own their homes, many do not. GLSS 3 and GLSS 4 indicate that housing ownership numbers did not change much in the 1990s. In GLSS 3, the majority of urban dwellers lived in their homes rent free (43%), followed by renting (39%). In rural areas, the majority own their houses (48%), followed by rent-free occupation (43%). Housing by income groups revealed that the lowest quintile was concentrated in the rent-free category (53%) followed by owning (35%). Among the top quintile, 39% owned their houses followed by rent-free occupation (32%) and renting (28%). A similar trend is observed for GLSS 4.

A special housing package, Housing the People Scheme which focuses on low-income housing, urban renewal and rural housing has been established by government. Under the scheme, there is home ownership mortgage insurance and improved facilitation of land acquisition and provision of basic infrastructure facilities to support housing development. (2004 Budget Statement) Construction finance is being sourced for members of the Ghana Real Estate Developers Association so as to increase housing for both rental and home-ownership. This is expected to create over 30,000 jobs. Another US$50 million

loan package is being sourced for land servicing development and construction of rental and homeownership housing. This package is aimed at assisting personnel in the security agencies to own houses as part of the overall housing programme. Rents for single-bedroom houses currently range from 120,000 to 500,000 per month in the cities. The effect is heaviest on those within the lowest income brackets. Poor infrastructure in many low-income areas has led to the development of slums in large urban centres.

Transport Services

Transport fares increased sharply in 2003 mainly as a result of the 90% increase in petroleum prices in February 2003. However, the government's mass transport programme is perceived to have helped somewhat in mitigating the problems in urban transportation. The Metro Mass Transit system, which was introduced in Accra, has been extended to three more cities namely Kumasi, Sekondi-Takoradi and Tamale. The fleet increased from 17 buses in October 2002 to 296 buses by December 2003. In addition, in the area of Inter-City passenger transport, the Inter-City STC Company was allocated 48 buses to augment its fleet. The most significant problem facing urban transport users remains the relatively high cost and the frequency of price changes. For rural dwellers the problem remains the poor state of roads, and hence few vehicles.

2.24 EMPLOYMENT TRENDS

In the Ghana Human Development Report 2000, it was observed that the number of the unemployed doubled between 1992 and 1999, despite an increase in formal employment. In the absence of new data, we make inferences on employment trends based on the number of jobseekers who registered with the Labour Department against reported vacancies and placement. The government, with the aim of getting a clearer picture of the unemployment situation, conducted a registration exercise of job seekers in 2001. Vacancies announced by industrial establishments increased from 7,058 in 2001 to 7,487 in 2002 and then to 7,682 in 2003 (Table 2.14). Compared to the number of jobseekers these vacancies were obviously inadequate. In 2001 alone the number of registered job seekers was about 35 times the number of vacancies. It needs to be pointed out that the 2001 figure was itself not representative of those who were jobless in the economy as those who registered with the labour department were less than a quarter of the number that registered during the government registration exercise in the same year. Of the number that registered in 2001 and 2002, less than 3% got jobs. However, in 2003, due to the low number of people that registered for jobs, the proportion of jobseekers who were employed increased to 40.6%.

The pattern observed here suggests that the rate at which jobs are being created is very low compared to the rate at which the

Table 2.14: Employment & Unemployment

Year	Vacancies	Registration of Job Seekers	Placement	Unemployed	Proportion Employed (%)
2001	7058	245579	6363	21807	2.6
2002	7487	241864	6510	42769	2.7
2003	7682	18452	7498	10954	40.6

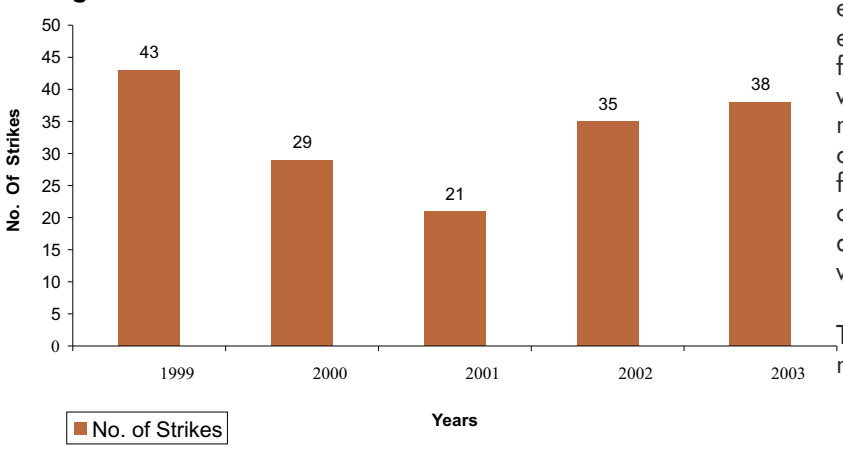
Source: Labour Department

labour force is growing. Other sources confirm this picture. As at 2002, only 77,500 new jobs were reported by 1,393 firms that registered with the Ghana Investment Promotion Centre (GIPC). These jobs were created over the period of September 1994 to December 2002. Assuming these trends came close to the true labour absorption rates in the industrial sector, then the unemployment situation can only deteriorate and livelihoods will be adversely affected.

The problem is compounded by the phenomenon of under-employment, which is prevalent in many developing countries. The labour force employed in the public service in Ghana is generally perceived to be too large and significantly under-employed. In the 2004 budget, personnel emoluments absorbed about 25.7% of the total government expenditure, and this is expected to increase to about 26.7%. [27]

Is formal labour satisfied? The Labour Department (LD) continued to receive complaints from workers under Labour Regulations 1969 (LI 632). A total of 974 cases were handled between 2000 and 2003. Most complaints were against non-payment of terminal benefits at the end of employees' contracts. Eighty-one (81) Collective Bargaining Certificates (CBCs) were issued during the year 2000 in line with Section 3 of Industrial Relations Act, 1965 (Act 299) compared to 33 in 1999.

Figure 2.16: Number Of Labour Strikes In 1999 - 2003



Source: Labour Department

This is an indication of an increase in awareness of labour regulations in Ghana. It is also indicative of the increased level of co-operation between employers of such establishments and their workers by improving the level of workers' participation in decisions affecting their conditions of service. This promotes social justice, social progress and national development.

Twenty-Nine (29) strikes were recorded in industrial establishments in 2000 (Figure 2.16). This figure shows a decrease of 13% compared to the previous year. The causes of these strikes range from the demand for better conditions of service, wage increases, payment of accumulated wages and salaries, and for payment of additional duty allowance. There were other issues such as higher placement of graduate teachers on the Ghana Universal Salary Structure (GUSS) of the public service, for representation of the National Association of Graduate Teachers (NAGRAT) on committees of the Ghana Education Service; for admission of trade unions in the private sector; and for inhuman treatment of workers by management in the private sector.

Informal Sector Employment

As formal sector employment accounts for only 14 per cent of the total number of persons employed, the informal sector is by far the major source of employment. Ghana ranks very high on the Key Indicators of Labour Market (KILM) 7 indicator, used by the ILO to measure urban informal sector employment as a percentage of total urban employment. Statistics also show that almost four times as many men as women are in wage employment. In contrast, twice as many women as men are self-employed outside agriculture, or employed as unpaid family workers. In the urban areas, one out of three persons is employed in "trading", and no fewer than 49 percent of urban women are in trading.

The informal sector in Ghana includes mainly the rural agricultural sector, small-

[27] This figure actually excludes transfers to households such as pensions, gratuities and social security.

scale gold and diamond winners, popularly known as galamsey', small-scale garages and repair workshops. It also includes small-scale shoe-manufacturing businesses, private lotto operators, private arms manufacturers, small traders of various categories such as street vendors, hawkers, and occupational groups such as providers of commuter services in major cities (trotro), private taxi services, food processors, providers of small time savings schemes (susu), the illegal and underground economy such as traders in illicit drugs, drug trafficking, prostitution and informal financial marketers. A study by Ahadzie and Botchie (2003) found that the poor within the informal sector were predominantly farmers.

The informal sector is by far the major source of employment, with almost nine out of ten employed Ghanaians according to the GLSS 4. It was established that there were substantial differences between the formal and the informal sector. On average, a worker in the formal sector earned almost four times the wage of the worker in the informal sector. Informal training through apprenticeship is characterized by lack of uniformity, the absence of underlying curriculum and the absence of rigid start and end dates. The thrust is usually on practical skills, with minimal or no instruction on the theory of the trade. Training may occur within the family setting or within the community, in the streets or during the working process.

The results of the survey of about 3,500 apprentices done by the Ghana Statistical Service (Table 2.15) show that the most prominent trades that are learnt in the informal apprenticeship system are tailoring (including dressmaking), and mechanical trades. It is worth noting that, as the largest training system, the apprenticeship system needs assistance to build its capacity to transform its trainees into entrepreneurs who can generate income and employment to further improve livelihoods.

Table 2.15: Distribution of Apprentices by main trade learnt, sex and locality (%)

TRADE LEARNT	URBAN			RURAL			GHANA		
	Male	Female	All	Male	Female	All	Male	Female	All
Carpentry	16.0	0.4	8.5	15.7	-	9.0	15.8	0.2	8.8
Masonry	8.5	-	4.4	11.4	-	6.6	10.2	-	5.7
Tailoring	13.2	64.4	37.8	12.5	68.1	36.6	12.8	66.4	36.8
Blacksmithing	4.0	-	2.1	3.4	-	2.0	3.6	-	2.0
Mechanical	17.2	0.3	9.1	11.2	0.4	6.6	13.6	0.3	7.7
Electronics/ electrical	8.9	-	4.6	5.0	-	2.9	6.5	-	3.6
Painting/Spraying	8.9	1.1	3.0	3.1	0.7	2.1	3.7	0.9	2.5
Other	4.8	33.7	30.5	7.7	30.8	34.8	33.6	32.1	33.0
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source:GLSS 4

2.25 ACCESS TO FINANCIAL SERVICES

The financial sector has grown rapidly over the past three years, with new financial products being introduced such as Automated Teller Machines (ATM), electronic cards and Government of Ghana Index Linked Bonds. In addition to these are the other forms of financial instruments such as savings deposits, time deposits, foreign currency deposits and treasury bills. There has also been a shift

from short-term financial instruments towards long-term instruments over the past three years. The Ghana Stock Exchange (GSE) is still growing, even if slowly. Another development in the financial market is the improvement in money transfer facilities for both local and foreign transfers. Some of the major banks have also networked their branches in the major urban centres.

The increase in formal financial services is reflected by the large increase in total domestic credit (in nominal terms). It increased from 12.223 billion in 2001 to 12.711 billion in 2002 and then to 15.626 billion in 2003, an increase of about almost 4% for the period 2001-2002 and 23% between 2002 and 2003. However, in real terms, total domestic credit has declined continuously since 2001. In addition, while the central government's share in total domestic credit declined from 49% to 32.5% between 2001 and 2003, the private sector's share went up from 36.6% to 53.3% in the same period. This is a positive signal that could stimulate private sector growth and spur on job creation.

In terms of the allocation of credit to the various sectors of the economy, the share of Domestic Money Bank (DMB) credit to all the sectors between 2001 and 2003 showed a decline except for the Others' category comprising of electricity, gas and water, import, export, and domestic trade, transport, storage and communications, services and cocoa marketing. The share of DMB credit to agriculture has hovered between 9.4% and 9.6% since 2001, while the share of DMB credit to manufacturing increased from 19.3% in 2001 to 21.1% in 2002, and declined thereafter to 20.7% in 2003. Further, DMB credit to the mining sector decreased from 4.0% in 2001 to 2.9% in 2003. The share of DMB credit to the construction sector also declined substantially from 6.8% in 2001 to 5.0% in 2003. Meanwhile, the Others' category accounted for 62% of DMB credit to the various sectors in 2003 recording an increase of 1.7 percentage points between 2001 and 2003. The decline in the shares of DMB credit to the pro-poor sectors of the economy, namely, agriculture and manufacturing has serious implications on livelihoods in the economy.

Despite the financial innovations, formal sector credit has been less targeted at the poor, and in particular, issues of collateral requirements, documentation and bureaucracy make it a less attractive source of credit for the poor. Thus, poor households continue to rely on informal sector credit and increasing micro finance. The significance of informal sector credit is highlighted in the GLSS reports (3 and 4) where it was indicated that although credit from formal financial institutions declined between 1992 and 1999, the percentage of households in debt increased over the period - a clear indication of the importance of informal sector credit. However, the high interest rate charged by informal sector operators and the short-term nature of their lending portfolio makes it a less attractive source of long-term capital.

There are about 70 regulated and unregulated micro finance institutions in Ghana and, according to the Ghana Micro-finance Institutions Network (GHAMFIN), they are currently serving over 26,000 clients. Micro finance institutions in Ghana consist of NGOs, cooperatives and rural banks. Users of micro finance services have expressed dissatisfaction with the interest rates charged on loans. The 2003 Country Assistance Strategy (CAS) consultations of the World Bank revealed that micro finance institutions were not charging micro interest rates'.

The fact of HIV/AIDS obviously represent a major threat to an economy that already faces many constraints. It also puts the lives of PLWHAs at risk as they are not likely to receive adequate care and support from family members who are struggling to make ends meet. There is concern that in the midst of this development crunch, PLWHAs and their families are exposed to stigma and lack of support. Part Two draws attention to these kinds of issues in the theme of the report.

PART TWO

SOCIAL, ECONOMIC AND GOVERNANCE ASPECTS OF HIV/AIDS AND DEVELOPMENT

CHAPTER THREE
SOCIAL AND ETHICAL CHALLENGES OF HIV/AIDS IN GHANA

CHAPTER FOUR
ECONOMIC CHALLENGES POSED BY HIV/AIDS IN GHANA

CHAPTER FIVE
HEALTH CARE RESPONSE TO THE HIV/AIDS PANDEMIC


Reach
Out
Show Compassion
to people living with HIV/AIDS today
Stop AIDS
Love Life

CHAPTER THREE: SOCIAL AND ETHICAL CHALLENGES OF HIV/AIDS IN GHANA

30 INTRODUCTION

"HIV/AIDS has succeeded in joining people around the world in a common consciousness about its threat and implications. It is the only disease to have a dedicated United Nations organization UNAIDS charged with the single aim of confronting it. It is the first epidemic where the long-term implications could be recognized as they happen. This provides better appreciation of the nature of risk and its social, spatial and temporal distribution." (Barnett and Whiteside, 2002 *p.* 4)

In other words, challenges posed by HIV/AIDS require looking beyond an individual or sectoral approach, to a multi-facetted coordinated effort requiring social, economic and ethical considerations. It requires looking at health as more than just medicine, to understanding the concept of 'well-being'. The HIV/AIDS challenge is about long-term effects of large-scale death and illness on the survival of society, social relations as we know it and human capital. (Barnett and Whiteside, 2002, p.2)

Confronting the social and ethical challenges of HIV/AIDS will involve:

- protecting HIV/AIDS infected and affected persons from societal harm and abuse;
- providing HIV/AIDS infected and affected persons with necessary care and support services;
- protecting the non-infected, both the living and yet-to-be born, from infection;
- developing and maintaining human capacity and abilities through education and health care; and
- rethinking and reviewing customs, values, norms, beliefs and socio-cultural practices in general that have the potential for influencing the control and management of HIV/AIDS.

Chapter Three concentrates on the social, legal and ethical issues posed by HIV/AIDS. The general message is that every one is at risk from HIV/AIDS- it does not discriminate on the basis of race, religion or gender. It is colour blind and not bound by age. As noted earlier, due to the multiple modes of HIV transmission, babies, children and adults are all at risk. It is important to recognize that the risk is two-fold. First is the risk of being infected, similarly traumatic is the risk of being affected by the disease as a spouse, child, other relation, friend or colleague. All of these associations with HIV/AIDS are laden with challenges of stigmatization and discrimination which directly influence levels of care and support that is given to PLWHAs. For many people who end up with the condition, deprivation and destitution is a real possibility.

Invariably, however, there are special risk groups for whom simple preventive measures such as condom use are not obvious options. From a livelihood perspective, the poor (who are less able to manage the disease through drug therapy), often find their way into activities that are seen to be high risk, such as commercial sex (mainly among women). Poor men and women for example, see the extra expense involved in purchasing condoms for protection as a luxury. Gender plays an important role in vulnerability. By their biological make-up, as well as social status, women and girls are at a greater risk of infection than men. Further, in most cultures, women, by virtue of their subordinate status, are unable to negotiate for safe sex with their partners and, are therefore, frequently the victims of sexual abuse. This fact was highlighted by the UNAIDS Report on the Global HIV/AIDS Epidemic, 2004.

In Ghana as has been found elsewhere HIV/AIDS creates or deepens vulnerability among those infected or affected by the

disease. Studies have shown that unlike their healthy relatives and neighbours who can rely on their own resources to meet their daily needs, only about half of PLWHAs can rely on their own resources for their daily needs. (Anarfi, 1995) Besides, in addition to own resources, PLWHAs usually consume a disproportionate share of the health care expenses of a household, and require more attention from care-givers as their condition worsens. (Bollinger et. al. 1999) Invariably, it is female relatives, sometimes young girls, who are called upon to devote extra time to infected persons. Studies have confirmed that a substantial proportion of AIDS patients (33%) in Ghana received direct assistance from the extended family. Some families have had to sell property or borrow money to care for sick relatives. (ibid) Given the relatively high incidence of poverty, it is reasonable to assume that many PLWHAs live in precarious circumstances. (GSS, 2000) Again widespread stigma suggests that some PLWHAs are liable to be abandoned by their families.

Vulnerability of PLWHAs is worsened by their susceptibility to opportunistic infection and other illnesses, which take advantage of the weakened immune system. As noted in Chapter Two Section C, Tuberculosis (TB) is the leading HIV-associated opportunistic disease in developing countries, and has been found to cause 30-40% of deaths of HIV-infected people. A study done at the Komfo Anokye Teaching Hospital in 1997 showed that about 23% of TB patients tested positive for HIV. (NACP, 2001) This implies that combating tuberculosis should be a key aspect of the AIDS campaign.

The rest of this chapter discusses the nature of social challenges posed by the disease, and initiatives that have been taken by the state and societal agents including community based groups and NGOs towards managing the social and ethical challenges of HIV/AIDS. These issues are addressed in sections A - Social Challenges of HIV/AIDS and Effects on Human Security, and B - Legal and Ethical issues.

SECTION A

3.1 SOCIAL CHALLENGES OF HIV/AIDS AND EFFECTS ON HUMAN SECURITY [28]

HIV/AIDS has added yet another dimension to the social landscape and challenged established behaviour patterns and customs. These include power and gender relations, economic relations, sexual behaviour, marriage and family, religion and morality, rights, duties and obligations, and care and support systems, among others. The implication is that strict adherence to traditional social structures and practices in the face of HIV/AIDS threaten human security and survival.

In an HIV/AIDS baseline survey conducted by Family Health International (FHI) in the Yilo and Manya Krobo districts in the Eastern Region of Ghana in January 2002, more than 60% of the respondents described the future of individuals, families and communities as 'bleak and gloomy", believing that HIV/AIDS will make families and communities lose credibility, breadwinners and experienced people. Respondents also foresaw that the disease would lead to more misery, stigmatisation and neglect of individuals, families and communities. (FHI, 2002)

In what follows, we examine how HIV/AIDS undermines the social system through stigmatisation, family instability, poverty and vulnerability, migration and human insecurity.

Stigmatisation

Besides the multiple channels of

[28] "What do we mean by human security? We mean in simple expression, all those things that men and women anywhere in the world cherish most: enough food for the family; adequate shelter, good health; schooling for the children; protection from violence whether inflicted by man or by nature; and a state which does not oppress its citizens but rules with their consent". (Louise Frechette 1999-UN Deputy Secretary-General)

BOX 3.1: FEARS OF STIGMATISATION AND DISCRIMINATION AMONG PLWHAs

A student in the study stated that, "I will not waste money to educate myself if I get to know that I have fallen victim of HIV/AIDS. After all I will die even if I complete the school".

One PLWHA said, "I have isolated myself. I live alone because people gossip a lot and I don't want them to talk about me. Some of them will gossip that I have grown lean. Stigma attached to the disease is so great here that people do not want to associate with us (PLWHAs)".

Post-Disclosure Experiences of Discrimination:

"I belonged to "mmoa kuw" (local association) but since it became known that I am HIV positive no one wants to associate with me".
"My very close friend will not get near me again. When I get closer to her, she physically draws away".
"A nurse in a hospital I attend once stopped her child from playing with my child and actually dragged her child away. The nurse knows I have the disease".
"Since it became known to others that I have AIDS, my customers no longer patronize my wares".
"I used to work in a private company. When my employers heard that I have contracted AIDS they terminated my appointment even though I am still strong enough to work".
"I was prevented from inheriting my late uncle because it is known that I am HIV positive even though I was the most rightful successor".

Source: Family Health International (FHI), 2002; Appiah and Afranie, 2000)

transmission, the incurable nature of the disease and the disfiguring of infected persons through attacks of opportunistic infections; HIV/AIDS infection has been associated with shame. Since no community or family wishes to carry the stigma, HIV/AIDS constitutes a major source of discrimination, social exclusion, denial of political and cultural rights, health insecurity and psychological harassment. (Box 3.1)

Attitudinal studies have confirmed that PLWHAs are seen in quite uncomplimentary terms by those around them. Community members described PLWHAs as the "least important persons, outcasts, prostitutes, the unfortunate/unlucky ones, dangerous people, and devils". (Appiah and Afranie, 2000; FHI, 2002) People indicated that they would avoid close contact with such persons, particularly in relation to eating, sleeping, working, travelling on same vehicle, sitting or allowing wards to sit in same classroom with PLWHAs, and using the same public facilities. PLWHAs were likened to the infectious cocoa disease, swollen shoot, which can only be "treated" by destroying infected trees. (Ahinsan 1993 in Appiah and Afranie, 2000) By implication, PLWHAs might as well be dead. (Box 3.2)

The idea that PLWHAs should be isolated or confined came up quite clearly in a study of attitudes at the border town of Aflao recently. Many of the people interviewed (53%) endorsed the idea that PLWHAs should be kept away from healthy people, for fear that they could spread the disease through food and by contaminating the air. (Hope for Life (CBO), 2004) Even more difficult to deal with are the spiritual interpretations of HIV/AIDS infection, where people and religious leaders have linked it

BOX 3.2: EXTREME CASES OF STIGMATIZATION AND DISCRIMINATION AGAINST PLWHAS

A participant at a focus group discussion (FGD) said, "You need to have courage to associate with AIDS patients. When one man in this community contracted the disease his own parents shunned him".

When community members in a study were asked whether they would accept membership of a person they knew to be HIV positive, some responded: "Community associations are meant to support what is good but not what is spoilt. These are already dead so what is the point in accepting them".

Most community members in various studies expressed the belief that PLWHAs must not be allowed to occupy any political office or inherit the property of other relations for fear that the PLWHAs would sell the property to manage their health. Again, as the PLWHA would soon die, there was no need to allow such a person to inherit property. Of course, people argue that it is a disgrace for the dead to be inherited by PLWHAs or for communities to have PLWHAs occupying political office.

Extracts from focused group discussions, Appiah and Afranie, 2000.

to evil spirits and sinful behaviour. A recent study on Familiarity with HIV/AIDS confirmed that misconceptions about modes of transmission are still common. (Bortei-Doku Aryeetey, Agyei and Addoquaye Tagoe, 2004)

The implications of stigmatisation attached to being a PLWHA are dire, and are expressed in various forms of anti-social behaviour including the following:

- PLWHAs do all that they can to conceal their HIV status
- Some PLWHAs avoid going to hospital for treatment
- PLWHAs resort to social disengagement
- Some members of the community refuse to go to hospital when they are sick for fear that they may be diagnosed HIV positive and become victims of stigmatisation.

The same fears of rejection are also likely to inhibit workplace programmes. In a workplace HIV/AIDS study conducted by UNFPA and the Ghana Employers' Association in 2003 some workers opposed voluntary testing for HIV/AIDS, since they might have difficulty keeping their jobs if found HIV-positive. The workers also argued that if they knew that they were HIV-positive, their morale would drop and their overall performance affected. Besides, most workers expressed concern that disclosure of their HIV-positive status would undermine a company's corporate image.

There is a need to sustain civic education to explain and protect the rights and dignity of PLWHAs. This process should be led by state institutions like the National Commission on Civic Education (NCCE), the Information Services Division (ISD) of the Ministry of Information (MoI), the Ministry of Education, Youth and Sports, non-governmental organisations, as well as the print and electronic media. This is not likely to make much impact however, without the appropriate legislation. The Ghana AIDS Commission has acknowledged that this is an area that had not received adequate attention in its National Response Strategy. The Commission's The Work Place Policy Development programme, aimed at protecting employees and other high-risk

groups from HIV/AIDS, is seen as a step towards closing this gap. In this regard, the recent adoption of the National HIV/AIDS/STI Policy should be seen as a major step forward.

Family and Community Pressures Resulting from HIV/AIDS (Threat to Care System)

As already noted in Chapter Two, HIV/AIDS affects mostly adults (15 to 49 years) who are the most sexually active and productive in society.

"Despite millennia of pandemics, wars and famine, never before in history have death rates of this magnitude [caused by HIV/AIDS] been seen among young adults of both sexes and from all walks of life".
(Barnett and Whiteside, 2002, p.3)

With the present large adult component in AIDS-related deaths in Ghana (75%) it is projected that by the year 2014, 128,000 mature adults in Ghana will be dying from AIDS each year. (MOH/NACP 2001) The age profile of AIDS victims suggests that parents and other breadwinners (who are at the same time the key agents of socialisation), are the hardest hit. Invariably this has direct adverse effects on household income, nurturing and the supervision of children. In extreme situations family resources are sold to meet the cost of care. Support for non-infected members of the family, in terms of education, health, nutrition, etc., tends to be sacrificed in the interest of care for the sick. These factors begin to explain why some people resent PLWHAs. Under the circumstances one finds that aged and weak parents and grandparents with limited resources are forced to resume caring roles for PLWHAs or the families they leave behind.

Against this background family structures are being re-moulded. The UN predicts that the number of child-headed households could rise alarmingly. (United Nations Children Fund publication 1994, p.3) In addition, an increasing number of children may drop out of school to nurse sick parents and others. The fall out from this breakdown in child care arrangements is likely to be growing numbers of streetism among children and the youth. Among other things this increases their exposure to HIV infection and other dangers. Worse still, the presence of the disease is contributing to the growing pool of orphans in Ghana, as is addressed later.

Care and Support Options for PLWHAs and Orphans and Vulnerable Children (OVCs)

Though the options for care for PLWHAs and OVCs is now seen to include community-based programmes only a few of such initiatives are currently being carried out in Ghana, and most people are not aware of them. They include counselling services offered by community health workers, NGOs and CBOs such as the Krobo Queenmothers' programme. The situation is partly due to the following:

- lack of community initiators
- PLWHAs in the communities remained anonymous for fear of stigmatisation and isolation and
- Widespread poverty in the communities

In recognition of the serious lapses in care and support the Ghana AIDS Commission is expanding its focus in this area while maintaining interest in the awareness campaign. In addition, the Commission is also extending its activities in the area of peer education in communities, work places and schools.

Besides support from family and other social networks, support services that should be available, accessible and affordable to PLWHAs include the provision of antiretroviral drugs, treatment of opportunistic infections, counselling, social and political empowerment, appropriate

legal and policy frameworks, welfare benefits, etc. As Chapter Five points out, to achieve these, both government- and non-government run HIV/AIDS facilities need to be upgraded, and new ones created. There must be training for medical staff in HIV/AIDS prevention and management, and the provision of diagnostic and laboratory equipment for voluntary testing.

Orphanhood

In many developing countries, the steady increase in children orphaned by AIDS[29] is putting unbearable pressure on the traditional family and community coping mechanisms. This is happening in Ghana at a time when the extended family safety nets are already under strain as a result of the tendency towards nuclear families.

Most orphans are denied material resources, skills and knowledge acquisition, often due to the poverty of their custodians, or sheer negligence. This has direct implications for their nutritional status which in turn, affects their immune system, mental functioning and, subsequently, their ability to benefit from education for future social and economic mobility. (Barnett and Whiteside 2002, p.201-202) Many are forced to take on adult roles prematurely, for which they lack the necessary experience, preparation and strength to cope, not to mention serious lack of access to resources to play the roles effectively.

A study of orphan and vulnerable children (OVCs) found that while 93% of them were cared for by the family, the quality of such care was often low. For example, AIDS orphans got less sympathy from their families and communities than did other orphans. They were also more vulnerable to stigmatisation and discrimination. (Ahiadeke et al., 2003) Box 3.3 presents a summary of the study of OVCs in Ghana.

Though some families are willing to adopt HIV/AIDS orphans on humanitarian grounds, generally low household resources make this rare, and where they occur, the conditions of the orphans are often miserable. Non-family institutions, notably NGOs and CBOs, are taking on an increasing role in the care of AIDS orphans, howbeit limited. The Krobo Queen Mothers in the Eastern Region, for instance, have founded a unique care system for OVCs based on traditional leadership structures. Their initiatives have attracted technical and financial support from various organisations.

As shown in the Figure 3.1, the number of dual and all AIDS orphans is expected to increase from about 14,200 and 47,460 in 2000 to about 44,200 and 221,380 in 2015 respectively.

A study of 20 primary schools and 12 Junior Secondary Schools in the Bawku East District shows that almost 30% of dual AIDS orphans and 27.6% of those who have lost their father have had sex more that once, compared to about 10% for all school children. Orphans were 1.7 times more likely to contract STI than non-orphans. Also, fewer orphans were able to progress to higher education and their academic performance was lower than non-orphans. (Apoya et. al., 2004) Similarly, it has been found that the number of orphans studying at all levels of education in Zambia was lower in proportional terms than the number of children with parents. (Kelly, 1999)

The Krobo Queenmothers Model fits very well into some of the new ideas in orphan care that are being tried for providing care for those infected and those affected by HIV/AIDS. They include the provision of home-based care and other forms of community-based support for orphans, in order to integrate them into families and

[29] HIV/AIDS orphans are defined as children under the age of 18 years who have lost one or both parents due to AIDS (GNCC, 2000; Ahiadeke et al., 2003). The UNAIDS definition for Ghana includes children below the age of 15 years who have lost their mothers (maternal orphan) or both parents (double orphan). There have been concerns that this is too restrictive (cuts out paternal orphans, and orphans aged 15 to 17 years) and underestimates the incidence of AIDS orphans (see Ahiadeke et al. 2003).

Box 3.3: Study Of Status Of HIV/AIDS Orphans And Vulnerable Children (2003)

The UNDP in collaboration with Ghana AIDS Commission sponsored a Study of the Status of HIV Orphans and Vulnerable Children (OVC) in Ghana Towards the Formulation of National Policy in 2003. The study was generally aimed at taking an inventory of OVC; finding out about their living conditions and providing guidelines for policy to support such children.

The study was conducted in 20 districts, two from each of the 10 regions of Ghana. The interviews were based on both qualitative and quantitative instruments and covered the following groups: orphans in households or orphanages; children orphaned through AIDS deaths; caregivers of OVC; family members involved with OVC; chiefs and opinion leaders; sex workers; street children; school children; social workers; the homeless; directors of orphanages. The research identified 4,186 orphans distributed as follows:

Male AIDS orphans	19.0%
Female AIDS orphans	16.4%
Other orphans (male & female)	5.3%
Male vulnerable children	31.6%
Female vulnerable children	27.7%

The study found 18 out of the 1,726 households being headed by 18-21 year olds. Of the total number of orphans 1,186 were identified as AIDS orphans. Most of these (71%) had lost both parents. The orphans and vulnerable children were found to be concentrated in Ashanti, Western, and Greater Accra regions. The mining towns of Obuasi and Tarkwa were found to be areas of high concentration of AIDS patients and orphans in the study. In addition, border towns seemed particularly vulnerable to high rates of infection: "...in a community like Agotime Afegame, almost every other home has children orphaned by AIDS."(Ahiadeke et. al., 2003:xi)

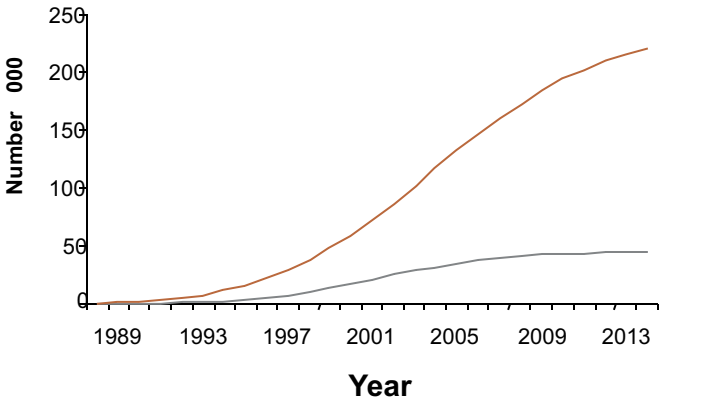
The findings of the study revealed the high sense of anxiety experienced by AIDS orphans 18% of them said they feel safe compared to 71% of all vulnerable and orphaned children. How such children are treated seems to differ from place to place, depending on local norms and beliefs. Among the Krobos in the Eastern Region, superstitious beliefs about orphans apparently check maltreatment of such children to avoid incurring the displeasure of the spirits of departed parents, and punishment from God. Caregivers who are good to the children hope to reap benefits in the form of blessings from God. In other localities the findings supported the popular view that such children are more likely to be neglected and, therefore, lured into socially unacceptable behaviour (such as stealing or prostitution) in order to survive.

Source: Ahiadeke et. al., 2003

social networks. Several strategies are currently being implemented to provide care to OVCs, including:

- support for community volunteers to mobilize resources from individuals and civil society groups to provide care and support for AIDS orphans;
- free education or scholarship schemes, as well as life skills and vocational training for orphans;
- expanding residential care such as orphanages, day-care centres and nurseries
- advocating for foster parenthood to create more family opportunities for OVCs
- capacity development for OVC

Figure 3.1: Projected AIDS Orphans (thousands)



Source: NACP and Policy Project

caregivers to enhance their roles
- enforcement of children's rights laws to protect them from abuse and harm.

Confronting Sexual Networking

As earlier mentioned, the HIV/AIDS pandemic has drawn attention to social customs and behaviour that may aggravate the risk to infection. Practices of multiple sex partners, widow inheritance and unprotected sex, which had hitherto not been issues of major worry in a polygynous society like Ghana, are now issues of major concern.[30]

Eighty percent (80%) of HIV infections in Ghana result from heterosexual contact, and the risk of infection is higher among those who have multiple sex partners, engage in unprotected sex, or have a history of sexually transmitted illness. Sexual activities that come to focus include pre-marital and extra-marital sex, as well as commercial sex. In the case of pre-marital sex, young persons are exposed to longer risk periods of infection when they engage in sex early in life.[31] GDHS 2003 does suggest that overall there is a higher incidence of HIV among people who started engaging in sex before age 16 years, compared to others (GSS, 2003) Box 3.4 shows how precarious the situation can be for adolescents.

Others conducting behaviour change surveillance among some high-risk groups (the youth, commercial sex workers (CSW), miners, and the police) in Ghana in 2002 (covering 1,345 male youth, 1,667 female youth, 600 female commercial sex workers, 437 miners and 466 policemen) observed the following pattern of behaviour (FHI, 2002):

- more than 80% of the male youth were sexually active, with median age at first sex as 19 years, compared to 75% of the female youth, with median age of about 17 years;
- more than 30% of the male youth have had sex with commercial sex workers and other non-regular sex partners within six months before the study; and
- over 10% of the female youth were involved in commercial sex work, in addition to other non-regular sexual relations within the same period.

Among adults, the pattern of sexual networking is not much different as the study of miners and policemen demonstrates. At least 7% of the miners reported that they had patronised the services of CSWs, and 18% of them had been with non-regular sex partners, within a year before the study. For policemen, the figures were 9% (CSWs), and 66% (non-regular sex partners) respectively.

The majority of the miners (72.0%) and a significant number of the policemen (34.7%) were either married or previously married. All this suggests that sexual

[30] GDHS 2003 reports that 23% of Ghanaian women and 13% of Ghanaian men are in polygynous marriages (GSS 2003: 101).

[31] By 18 years, 48% of young women and 24% of young men are sexually active (see GDHS 2003, GSS 2003)

Box 3.4: Sexual Networking Among Street Children

In a study carried out in 1997 by Anarfi among 1,247 street children aged between 8 and 19 years (mean age was 16.1 years) in Accra, 64 percent knew other street children friends who were sexually active. More than half (53%) of the respondents themselves were involved in sexual activities. About 5% of them first had sex before they were ten years while a significant number (39%) had their first sexual experience before they were 14 years. The overall average age at first sex was 14.5 years for all the respondents.

As at the time of the study, the sexually active children had number of sexual partners of from one (1) to more than four (4), but a few of them (6.8%) had had sex with too many partner that they could not count. Some of the girls themselves were commercial sex workers while the boys patronized commercial sex, not necessarily with their counterpart street girls. In the same way some of the girls also had some of the truck drivers who come to offload goods in the market as sex partners, in addition to some street boys and other commercial sex patrons. Most of the drivers who patronized the street children commercial sex also had wives and other non-regular sex partners.

Source: Anarfi, 1997

networking in Ghana creates very favourable conditions for the spread of HIV, throwing a challenge for a more effective and aggressive campaign for sexual behaviour change. (Anarfi, 1997).

At the moment the real challenge is to identify what incentives will put pressure on people to adopt behaviour change practices that will reduce their risk levels. Such incentives should have direct impact on reducing sex partners, practicing protective sex and, reporting and getting treatment by trained persons for STIs.

3.2 HIV/AIDS AND POVERTY

According to the United Nations Secretary-General, *"extreme poverty is a violation of human dignity, a threat to the right to life and a condition that prevents most vulnerable groups from exercising their human rights"*.
(Dina Dixon in WFP Journal No. 26, 1993)
Though the link between poverty and HIV prevalence is not conclusive, poverty does seem to create conditions for social and economic transactions, including sex and child labour, that make the poor more susceptible and vulnerable to HIV/AIDS infection.[32] For instance, high youth unemployment, limited job opportunities and the associated risky survival strategies all promote involvement in commercial sex work, early sexual relations and child labour - conditions that enable HIV/AIDS and poverty mutually to reinforce each other. Poverty may also undermine condom use. GDHS 2003 shows a direct positive relationship between wealth quintile and current use of male condoms among married women, with the wealthiest (5th) reporting a rate of condom use of 6.2%, compared to a rate of 0.7% among the poorest 1st quintile. (GSS, 2003)

As will be addressed extensively in Chapter Four, HIV infection is a serious threat to productivity and secure livelihoods. According to a study conducted in Thailand, a third of HIV/AIDS-affected rural families lost half of their agriculture output, and 15% had to withdraw their children from school. Half of the elderly in the families were left unsupported and uncared for. An HIV/AIDS

[32] In Ghana it is the middle or 3rd wealth quintile where the highest rates of HIV positive status is found for both men and women (GSS, 2003: 245)

impact assessment study in urban Cote d'Ivoire revealed that expenditure on education in HIV/AIDS-affected households had fallen by half, food consumption by 41%, while expenditure on health had more than quadrupled. (Anarfi, 2004) According to the World Bank (2000a), Africa will be experiencing reduction of income growth per capita of 0.7% per year as a result of AIDS. Specific studies of the South African economy also established that the country's economy will grow at 17% slower, and per capita income at 7-10% less by 2010 than would have been the case without AIDS. (Lewis and Arndt, 2000) All these point to both distinct and potential causal relationships between poverty and HIV/AIDS. Figure 3.2 below illustrates this relationship.

Women are generally more vulnerable and this results from unfavourable social and economic arrangements in the country that subjugate women. This is more pronounced in sexuality in which the woman has no say irrespective of the husband's behaviour.

- Prof. F. T. Sai, Presidential Advisor on HIV/AIDS

3.3 HIV/AIDS AND GENDER

Several studies have confirmed that HIV infection has heightened vulnerability differences between males and females. Women are known to be more likely to become infected with HIV, and are more often adversely affected by the AIDS pandemic than men. Two million more females than males carry the AIDS virus in Africa (Hamilton 2003 in Anarfi, 2004), while the trend is moving towards a balance in Ghana.

The reasons for greater female susceptibility are biological, socio-cultural, and economic. Biologically, women are said to be 2-4 times more vulnerable to HIV infection than men because during unprotected vaginal intercourse women receive more semen, which is capable of containing a higher-level concentration of HIV than a woman's vaginal secretion. Besides, the female sex organ and the cervix provide large mucosal surfaces for entry of the AIDS virus, unlike the penis.

From the socio-cultural perspective, women's higher susceptibility is attributable to differences in the prescribed role expectations and power relations between men and women. Women are generally powerless, particularly when it comes to negotiating for the use of the condom or abstinence, as compared to men. The relative power vulnerability of women is reinforced by their generally more limited access to resources - property, education, training and gainful employment - which renders them more socially and economically dependent on men.

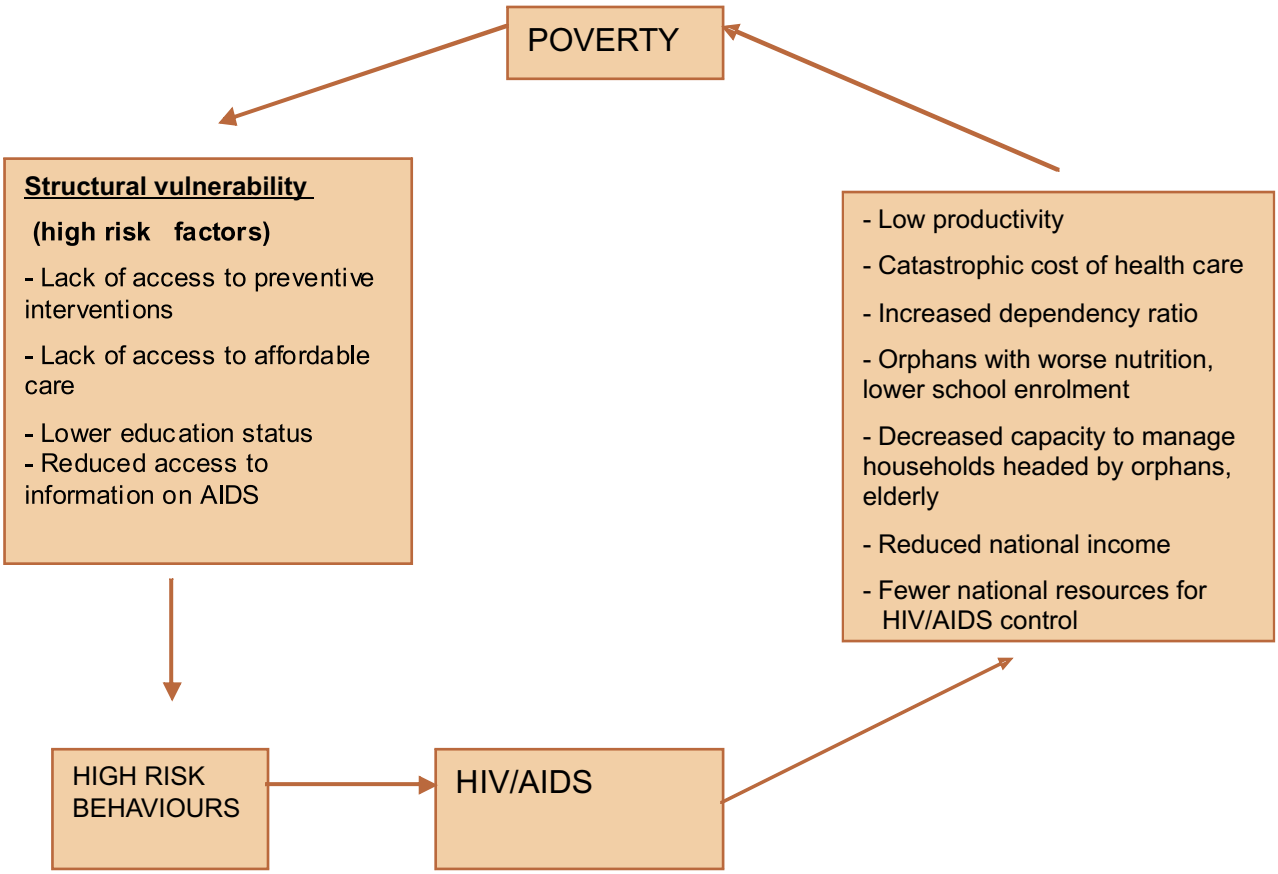
HIV/AIDS policies and programmes must, therefore, respond to the circumstances and needs of men and women separately, as well as together. Such initiatives must empower women, for instance, to be socially, economically and politically less dependent on men, so they can effectively defend their rights. This will safeguard the interest not only of women but the larger society. Similarly, specific policies and programmes should be geared towards changing men's attitudes, behaviours and understanding of their masculinity in order to make them active partners in the change process.

3.4 MIGRATION AND HIV/AIDS

The1998 International Migration Quarterly Report (IMQR) estimates that, over one hundred million persons move voluntarily throughout the world annually, while about 40 million more are forced to move (internally displaced) outside their places of origin. (IOM, 2001) Political, ethnic and religious conflicts have caused the most significant forced migrations in Africa.

Whether voluntary or forced, migrants are detached socially, economically, psychologically and politically from their places of origin and thrust into a new environment. Migration creates new

Fig. 3.2: RELATIONSHIP BETWEEN POVERTY AND HIV/AIDS SUMMARY



Source: Adapted from Anarfi and Appiah, 2004

opportunities for social interaction, and at the same time anonymity, which constitutes fertile grounds for non-conformist behaviour. It has been suggested that HIV/AIDS has become a pandemic as a result of intensified population movement, facilitated by the development of rapid and relatively low-cost transportation. The story is the same within countries. The 2000 population and housing census in Ghana showed that the population of 18.9 million included 1,475,487 people from other countries, made up of 857,780 men and 617,707 women. (See Table 3.1) This does not take account of refugees.

The report also indicates that about 30% of the Ghanaians enumerated in the census were counted outside their places of origin. It should be pointed out that the other 70% included people who had travelled back home specially for the purpose of the exercise. All this emphasises the mobility of Ghanaians.

TABLE 3.1: NATURALIZED AND NON-GHANAIAN POPULATIONS IN GHANA BY SEX

POPULATION	SEX		TOTAL
	Male	Female	
Other ECOWAS migrants	238,267	198,011	436,278
Non-ECOWAS Africans	97,431	72,551	169,982
Non-African migrants	76,968	56,963	133,931
Naturalized population	445,114	290,182	735,296
TOTAL	**857,780**	**617,707**	**1,475,487**

Source: Ghana Statistical Service 2002; 2000 Population & Housing Census

TABLE 3.2: REFUGEES AND ASYLUM SEEKERS IN GHANA AS OF 31/12/2003, BY NATIONALITY, SEX AND AGE.

NATIONALITY	SEX	0<4	5<17	18<59	60>	TOTAL
Ivory Coast	Male	11	26	48	1	86
	Female	9	13	32	3	57
Liberia Male		2,016	6,702	11,813	255	20,786
	Female	2,079	7,581	11,484	536	21,680
Sierra Leone	Male	50	154	402	1	607
	Female	55	173	312	10	550
Togo	Male	208	557	1,706	28	2,499
	Female	167	513	892	19	1,591
Others Male		13	21	78	0	112
	Female	14	16	35	1	66
Total	**Male**	**2,298**	**7,460**	**14,047**	**285**	**24,090**
	Female	**2,324**	**8,296**	**12,755**	**569**	**23,944**

Source: UNHCR, Ghana

Besides voluntary human movement across borders, conflicts in Sierra Leone, Liberia, and Cote d'Ivoire, have brought a number of asylum-seekers to the country. Table 3.2 shows that there were 48,034 refugees and asylum-seekers (24,090 men and 23,944 women), in Ghana from various countries at the end of 2003.

Such large scale movements are associated with human security threats. For example, it has been established that infectious diseases spread very quickly through population movement. Tuberculosis is reported to have spread to the towns and villages of the Southern Africa in the 1950s and 1960s through migrant mine workers in South Africa still interacting with their places of origin. (Parkard, 1989) Commercial sex work tends to flourish under such conditions and has been closely linked to the high HIV prevalence rates in countries like Zambia, Uganda and Tanzania. (Konotey-Ahulu, 1989)

Particularly where people migrate without sex partners, this creates conditions for commercial sex work or multiple sex activities. (IOM, 2001)

Typical relationships between migration and HIV/AIDS can be summed up as follows:

- infected immigrants infect local people, and local people in turn infect others, both local and across geographical boundaries,
- migrants get infected from the local population, and they in turn infect other local people,
- Migrants get infected from the local population, and in turn infect others in their places of origin upon their return.

Also worth noting are the psychological and physical stress associated with long distance migration. The often-deplorable conditions experienced by this category of migrants, such as under-nutrition, malnutrition and ill-health, call for medical attention which they often cannot afford. Consequently, they may resort to crude and unsafe methods of administering medication, and thereby run the risk, for instance, of using infected needles, which increases their susceptibility to HIV infection.

It is also important to consider migration by high-risk groups such as truck drivers, commercial sex workers (CSWs), cross-border traders and unskilled/uneducated young economic migrants. CSWs are known to travel widely in the West and Central Africa regions. In a study in Accra (Anarfi & Antwi 1995), female petty traders, themselves often migrants from other regions in Ghana, were among the circle of girls most regularly engaged as sexual partners by long distance truck drivers who come to offload goods in the major markets of Accra. Significantly, at the onset of the disease in Ghana, nearly 80% of those diagnosed had either travelled or had lived outside the country. This high risk group is a major focus of the Joint Regional STI/HIV/AIDS Project along the Abidjan-Lagos Transport Corridor involving 5 countries-Cote D'Ivoire, Ghana, Togo, Benin and Nigeria.

No matter how the disease is contracted, one of the most difficult tasks facing any democratic nation today is how to protect its citizens from discrimination resulting from their positive status, or how to prevent the spread to others. These concerns raise major moral, legal and cost concerns for both state and private sector institutions.

SECTION B

3.5 LEGAL AND ETHICAL ISSUES

With HIV/AIDS, new minority and vulnerable groups have emerged. In addition, interaction of the minority groups with the larger population gives cause for concern. Ethical and legal considerations surface in the effort to protect the interests of both HIV/AIDS-infected persons and the non-infected in society. As a recognized minority group, PLWHAs are calling for relevant measures to protect their peculiar legal and ethical interests. Specifically they are asking for measures to curb discrimination; efforts to ensure safe and healthy living conditions; strategies that give them access to employment and fair incomes, social insurance and basic health care; and ways to facilitate their participation in social dialogue at all levels.

There is a need for legal provision prohibiting discrimination against PLWHAs as well as those vulnerable to infection. Protective and proactive measures are required in relation to the following:

- HIV testing and disclosure of results,
- isolation of PLWHAs,
- Safe blood transfusion in health

facilities,
- information and education on universal precautions against infection,
- employment,
- marriage,
- wilful/negligent transmission,
- heterosexuality and HIV/AIDS coverage in the national health insurance scheme.

Others are anti-discrimination legislation, privacy protection, therapeutic goods legislation to provide the necessary health care, ethical research, freedom of expression and association. (UNAIDS, 1999)

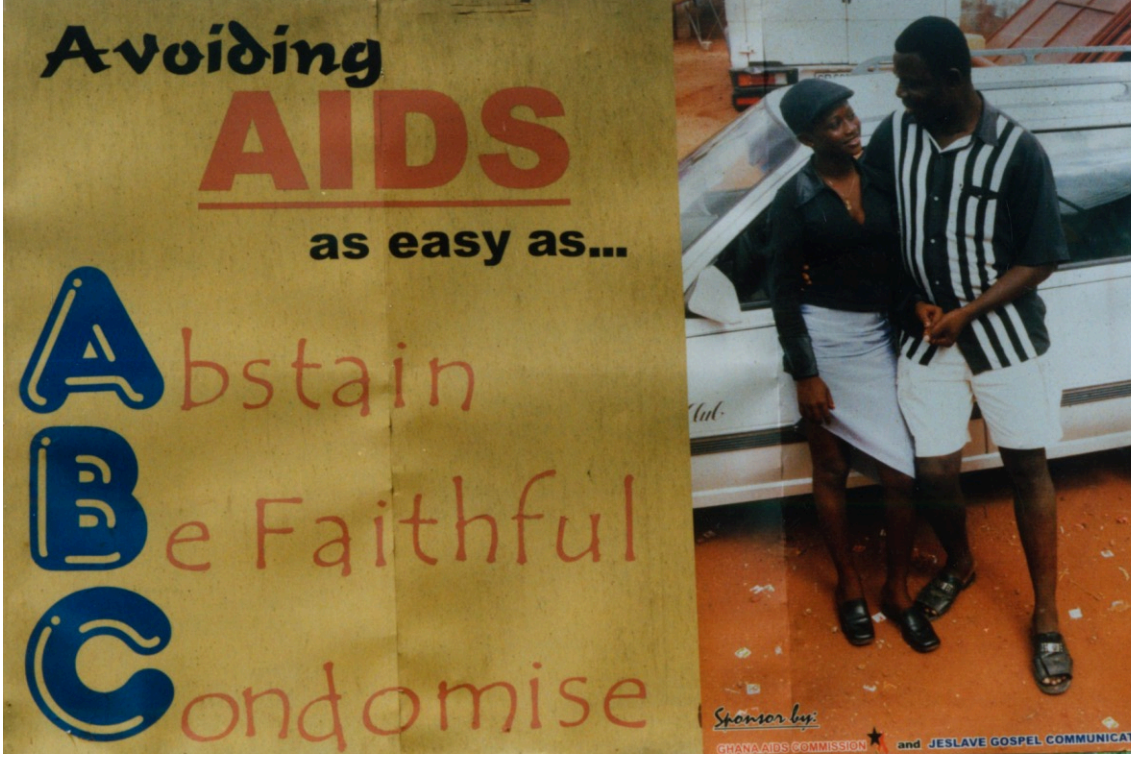
Protecting the Rights of People at High Risk of HIV/AIDS

While recognising that everyone is at risk of contracting HIV, it is important to acknowledge that some categories of persons are at greater risk than others, and therefore have greater need of protection. Chapter 5 of the 1992 Constitution of the Republic of Ghana is dedicated to and reinforces the need to respect the fundamental human rights of people, irrespective of their circumstances, race, gender, religion or political affiliation. Fear of undignified treatment of PLWHAs, for instance, renders people unwilling to find out their sero-status, thereby preventing them from participating in VCT and MTCT programmes. (Box 3.5) Confronting this challenge effectively will demystify the fears and denial surrounding the pandemic, and promote effective HIV-prevention programmes.

BOX 3.5: CASES OF INFRINGEMENT ON THE RIGHTS OF PLWHAs IN GHANA

1. Yaw (PLWHA), was suspected to have been poisoned to death by a family member who thought that when news of his positive status got to the community, it would bring shame and dishonour to the family.
2. Gladys used to work with a construction company as a caterer. She suspected that health personnel from the hospital where she was tested HIV positive informed her employers of her status. The employers consequently dismissed her without compensation. Her sister who was also working in the same company was made to take the HIV/AIDS test involuntarily, and when she was proved negative she was warned not to be seen to be associating with Gladys.
3. Vincent used to work with a Gold mining company. He suspected that an official from the hospital where he was tested positive disclosed the information to his employers, who compensated him with 3,000,000 and dismissed him. He got another job in Tema, but the news got to his new employers and they also sacked him.
4. Bertha gave birth to a baby boy but the father of the baby refused paternity because Bertha was tested HIV positive when pregnant. The case went to the Federation of Women Lawyers (FIDA) before the father accepted paternity.
5. Ama was asked by her half sisters to vacate her room given to her by her late mother because she was suspected to be HIV-positive.
6. Cecilia was staying with her Auntie's family. When tested HIV positive she was thrown out from the house because it was a disgrace for the family to accommodate PLWHAs. She went back to the hospital, voluntarily to be admitted.

Source: Appiah and Afranie (2000)



Some of those who get to know their HIV positive status refuse to be open about it, and consequently fail to access whatever little available care and support services for fear of being recognised. The experience of abuse of rights of PLWHAs, and the strong potential for this, as appears from the views of community members in studies described under the section on stigmatisation, are clear evidence of the need for laws and codes of ethics to protect the basic human rights of PLWHAs. To make these effective, it is necessary to intensify public debate on the subject. Instances of discrimination and abuse of rights of PLWHAs are set out in Box 3.6.

BOX 3.6: NEGATIVE ATTITUDES OF HEALTH WORKERS TOWARDS PLWHAs

1. "The smallest thing then they say, "test". Everything they ask for test, and they will let everybody hear that you have AIDS" (PLWHAs)
2. "They don't even pamper you. They stretch their hands and drop the drugs in your hands. They don't want to touch you". (PLWHAs)
3. "They disgrace us. They shout, stupid, you don't stay at home. You roam about, now you have AIDS". (PLWHAs)
4. "The Doctor should be able to keep secrets. We trust them, that is why we tell them, so they should not tell others". (PLWHAs)
5. "When they (PLWHAs) went to Abidjan to bring their clothes they did not give it to the community. It is only their family members who enjoyed and they can help them" (Health Worker)

Source: FHI (2002)

Now in terms of legal challenges …Doctors also come to talk to us about health rights of patients. They have a dilemma…Their dilemma is one of confidentiality The existing policy says that they should encourage the PLWHAs to disclose their sero status to spouses and relations. I think in critical situations the confidentiality code of ethic should be reviewed if Doctors see that another person's life is at risk.

- Ms Ester Amoako-Executive Director, AIDS Alert Ghana (NGO for Legal Challenges of HIV/AIDS)

The Ghana HIV/AIDS Strategic Framework Document (2001-2005, p.11) acknowledges that:

"On account of the threat of stigmatisation and discrimination associated with HIV/AIDS, it is absolutely crucial to put in place an environment that promotes fundamental human rights and work ethic. These will require empowering PLWHAs and people affected by AIDS to stand up for their rights; increasing awareness of the general public on issues of human rights particularly to the extent that it affects PLWHAs; and mobilizing the legal system to be supportive of, and responsive to HIV/AIDS related human rights abuses. The area has received very little attention and needs to be emphasized".

Making Ethical Choices to Support PLWHAs

Quite clearly the choice between spending resources on PLWHAs or on OVCs and the rest of society is not an easy one. Adequate and affordable health care is one of the major concerns of PLWHAs. In a country with about 40% of its population below the poverty line, like Ghana, this is not an easy choice. The choice to attend to PLWHAs is bound to impose a heavy burden on the health sector and to crowd out resources for the management of other diseases. Among health staff, stigmatisation and discrimination often lead to sub-standard treatment of PLWHAs (see Box 3.5), further aggravating their plight. The absence of a national policy on treatment of PLWHAs creates conditions for abuse of the rights of these people which need to be addressed.

Safeguarding Society against Infection

There is growing concern about the danger of wilful transmission and negligence that can lead to transmission. As indicated in Chapter One, HIV can be transmitted to an infant during pregnancy, labour and delivery, or breastfeeding. Cutting down on this risk will require that mothers are provided with adequate knowledge and also treatment, alternatives to natural birth and to breastfeeding where possible. Indeed these options account for drastic reductions in mother-to-child-transmission (MTCT) in the developed world.

A three-fold strategy is needed to prevent babies acquiring HIV from infected mothers. These are

- prevention of women and girls of child-bearing age from becoming infected with HIV;
- avoidance of unwanted pregnancies among HIV-positive women; and
- provision of voluntary counselling and testing (VCT), antiretroviral therapy (ART), safe delivery practices, and breast milk substitutes as a means of preventing the transmission of HIV from mothers to their infants during pregnancy, labour, delivery, and breastfeeding.

Protecting the rights and dignity of PLWHAs brings up the question of protecting other members of the community from infection. To some extent, effective protection of the interest of PLWHAs is one way of protecting other persons from infection. Clearly, a high level of self-confidence of PLWHAs and their increased participation in voluntary testing will slow down the silent spread of the disease.

There should be intensive education on voluntary counselling and testing for people to know their HIV/AIDS status early enough to inform their future actions. In addition, public disclosure of sero-status by HIV-positive people makes their communities aware of who can become infected with HIV and helps dispel many myths surrounding transmission. Seeing healthy people leading productive lives, and speaking out about living with HIV has been an important message of hope for PLWHAs. Speaking out is also said to be rewarded by enormous feelings of relief, and of lifting the burden of

secrecy that a person has carried since diagnosis. Many PLWHAs lead a double life from the time of diagnosis, so that being able to discuss their status openly has a positive impact on their health and spirits.

Getting the right balance in protecting all sides has proved to be difficult in dealing with HIV. In some instances, protecting the interests of PLWHAs through the ethics of confidentiality of medical records has exposed sex partners and relations to the virus, whereas they could have avoided infection if the positive status of their infected relations had been disclosed to them. It would be dangerous, however, to underrate the complexity of partner disclosure. For instance, where men are deemed more influential than their spouses, women are at greater risk of being thrown out of the home if they are the first to disclose that they have the infection.

In rare cases, infected persons may decide to knowingly infect others out of fear of disclosure or bitterness. (See Box 3.7) Meeting the challenge of protecting society against HIV infection therefore implies putting in place measures to enable PLWHAs to be open and honest about their status without fear or shame. The high cost of disclosure should therefore be compensated with adequate support, from state and non-state organisations, and security of employment, etc.

One other major means of meeting the challenge of protecting society against HIV infection is to continue to make available and accessible to the general public information about self-protection. This is particularly important for those who are taking care of PLWHAs in health facilities and in homes so that they will know how to protect themselves. Other policy measures include safe blood transfusion.

In the campaign against HIV/AIDS, the responsibility of disclosure has been largely linked to people infected. However, all sexually active Ghanaians also owe it a duty to disclose their status when appropriate, whether or not they are infected. Hence, the need for voluntary counselling and testing. (See Chapter Five).

The policy is that don't force people to get tested. But if you go to the constitution, citizens have the duty to prevent harm or refrain from causing harm to others. If we can't force people to be tested, then we should let them know they have a responsibility not to infect others. But you see the problem with Ghana is that people don't think HIV/AIDS is a problem.

- Ms Ester Amoako, Executive Director, AIDS Alert Ghana (NGO for Legal Challenges of HIV/AIDS)

BOX 3.7: STATEMENTS ON DELIBERATE TRANSMISSION OF HIV

1. "There was a lady, when I told her she had the virus, she stood up and said if I am positive then the only thing I will do is to spread it."
   - HIV/AIDS Counsellor
2. "I still have not told my partner. He talks too much. Even when we quarrel he will tell every body. He will do the same if I tell him."
   - PLWHAs
3. "It is good to be secretive because HIV is a taboo, it is disgraceful and nobody would like anybody to know of it"
   - Community leader

Source: Appiah and Afranie (2000); FHI (2002)

3.6 FROM AWARENESS AND KNOWLEDGE TO BEHAVIOUR CHANGE

The HIV/AIDS awareness and knowledge campaign is said to have been a great success in Ghana. The Ghana Demographic and Health Survey 2003 showed that awareness levels of men and women in both urban and rural areas were around 98%, and knowledge about ways of avoiding infection almost 96%. It must be acknowledged that with the current prevalence rate of HIV/AIDS infections in the country standing at 3.6% from an initial rate of 2.9% twenty years ago, Ghana has made remarkable progress in combating the pandemic. Within the two decades, only 0.7% new infections had been recorded nationwide. This is significant achievement, considering the astronomically high prevalence rates in other African countries.[33] While one is tempted to think that behaviour change is taking place after all, there are indications that it is too early to raise the victory flag.

The HIV Sentinel Report for 2003 suggests that the pace of infection may be quickening. For example, the national prevalence rate rose from 3.4% in 2002 to 3.6 % in 2003. In addition, some important changes are taking place in the pattern of infections which are worth noting. The rate among the youth group (15-24 year group) dropped from 3.4% to 3.0% between 2002 and 2003, but that for the older group (45-49 years) shot up within the year.

A Behaviour Change Survey by FHI (2002) reported further that less than a quarter of the male youth and less than 20% of the female youth regularly used condoms in sex with non-regular partners. Less than 10% opted for voluntary testing for HIV/AIDS. This is worrying against the background that the survey put more than 80% of the male youth and 75% of the female youth as being sexually active. In the case of the CSWs it was found that besides their customers some of them (Obuasi 40% and Accra 8%) were living with permanent sex partners at the same time, or they had other non-paying sex partners. In Accra, CSWs said they regularly used condoms on the job, compared to less than half of those in Obuasi.

From the survey it was obvious that most people were not prepared to relax their attitudes towards PLWHAs. Less than 25% of those interviewed indicated that they would show a positive attitude towards PLWHAs. Two things were confirmed by the FHI study: attitudes towards multiple-sex were not changing fast enough. Secondly, PLWHAs are still regarded as outcasts and the compassion campaign has a long way to go.

A recent study across Ghana to find out people's familiarity with HIV/AIDS revealed that many Ghanaians held misconceptions about the mode of transmission of the disease which was bound to interfere with their interaction with HIV-positive people.[34] For example, some believed that eating food prepared by a PLWHA, or eating with the person or indeed sharing space with the person exposed one to possible infection. (see Annex B)

Summary

What emerges from the discussion on social and ethical challenges of HIV/AIDS is a mixed picture of high levels of awareness about the condition and threat associated with HIV/AIDS, yet there is unwillingness to adopt behaviour change practices that would speed up the control of the disease. One can only conclude that current strategies to change individual behaviour are having only limited success, and that society will continue to stigmatise PLWHAs unless something dramatic is done to change the mindset of people. The aim

[33]It is not surprising that the United States of America did not include Ghana in the Emergency Plan for AIDS Relief package, which involved a 15-billion dollars over the next five years to fight the HIV/AIDS pandemic worldwide with special focus on Africa.

[34]Bortei-Doku Aryeetey, E.; Agyei, J and Addoquaye Tagoe, C, 2004. Familiarity with HIV/AIDS Sickness and Death, Draft Report. ISSER, Accra.

should be nothing less than a comprehensive cultural, social, economic, political, psychological and gender reorientation of people in their perception of PLWHAs. The shift in the focus of the Ghana AIDS Commission from awareness creation about the disease and its mode of transmission to care and support for PLWHAs with the hope of more disclosure of status to reduce spread is timely.

CHAPTER FOUR

ECONOMIC CHALLENGES POSED BY HIV/AIDS IN GHANA

CHAPTER FOUR: ECONOMIC CHALLENGES POSED BY HIV/AIDS IN GHANA

4.0 INTRODUCTION

The HIV/AIDS pandemic has claimed countless lives and taken a heavy social and economic toll over the past two decades, deepening inequality in welfare and well-being wherever it has struck. As a threat to humankind, the pandemic has united people around the world and prompted many governments, policymakers and other stakeholders to establish structures and processes for containing it. Yet, as noted earlier, while much has been said and done in respect of the clinical effects of the disease and the importance of changing individual lifestyles, until recently, the economic challenges posed by HIV/AIDS have not received adequate attention from analysts, policymakers and the larger civil society.

To help fill this gap, this chapter addresses the economic challenges posed by HIV/AIDS through its impact on human capital, production, trade, service delivery and their overall impact on macroeconomic stability and growth. As little has been documented in Ghana to enable a comprehensive discussion of the economic challenges of the disease, the discussion will draw on analogies from other African countries where there is much more information on the subject. This will enable us to make projections and draw attention to implications, before the disease reaches a crisis point in Ghana.

Whatever the unit of analysis, the demographic, social, cultural and economic impacts of HIV/AIDS have and will continue to involved huge expenditure outlays both directly and indirectly. However, it is reasonable to assume that any expenditure made in supporting PLWHAs to enable them contribute positively to the economy would be worthwhile.

- Dr. Victor Bampoe, Advisor on HIV/AIDS, DfID Ghana.

4.1 IMPACT OF HIV/AIDS ON HUMAN CAPITAL

The most obvious effects of HIV/AIDS are its effect on health and survival. While good health benefits the individual, to the degree that it also increases the potential for productivity, economic growth and well-being, it also contributes to the quality of human capital. Unfortunately, health indicators in Ghana are not very impressive. While life expectancy at birth is about 57 years, disability-adjusted life expectancy (the WHO's summary measure of health status, taking into account lost years due to morbidity) is about 47 years for the average Ghanaian. (WHO, 2003) Improving health status has therefore, become an integral component of recent growth and development strategies in Ghana, as elsewhere in Africa. Reducing maternal and child mortality, for example, is a major objective of the Ghana Poverty Reduction Strategy (GPRS). In this respect, Ghana is seeking to fulfil the Millennium Development Goals.

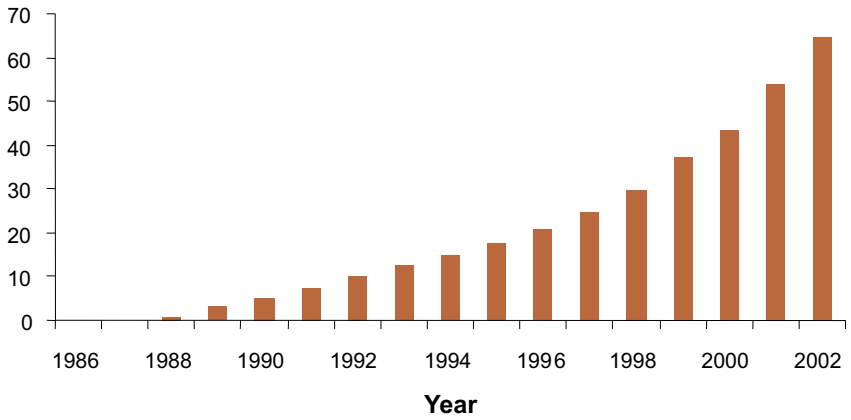
The threat of HIV/AIDS to any such development strategy has been amply demonstrated in earlier chapters of this Report. The health sector, particularly the public health system, is the first to feel the impact of HIV/AIDS, as it is the first point of call for most AIDS patients. The sector is thus, vital to the containment of the disease: providing and monitoring data on the pandemic, designing, implementing and evaluating intervention programmes, providing care and support, as well as helping to mitigate the socio-economic impact of the disease. (Barnett and Whiteside, 2000) HIV/AIDS thus puts an additional burden on the already stretched health budget through the increases in government health expenditure, especially with the recent introduction of subsidized antiretroviral treatment. (see Chapter Five). Nonetheless, to the extent that such expenditures result in reduced levels of the mortality and morbidity associated with the disease, the additional investment would be more than made up by increases in social productivity and well-being.

Increasing Demand and Rising Cost of Health Care

In addition to the extra burden on the health budget, the projected increase of AIDS patients will lead to increases in other social transfers as well. A study in Tanzania indicates that before dying, a typical AIDS patient suffers at least two episodes of persistent diarrhoea, ten episodes of oral thrush and about three skin infections. In addition, about 50% of the adult AIDS patients contract pneumonia and/or septicaemia, and 15%-25% suffer from tuberculosis, severe headache and/or neurological diseases. This brings the number of episodes of illness to 17 per adult AIDS patient over the one- to two-year period prior to death. Notionally, these periods of sickness would require 280 days of care, including home care, and if wholly treated in the health system would cost about $290 in drug, nursing and institutional expenditures. (WB, 1992) In Ghana, a study of 265 AIDS patients from the Atua and Saint Martin's hospitals showed that about 60 of the patients had attained stages I and II of the WHO clinical staging system, the rest being in stages III and IV. (Torpey et al. 2004a) The cost of care is quite significant. For clinical stages I and II, it is estimated at $23 per year and $32.5 per year, respectively, while for stages III and IV the estimates are about $660 per year. (Torpey et. al 2004b)

Figure 4.1 shows the cumulative number of reported cases of AIDS from 1986 to 2002. Many of these were in-patients competing with other patients for the limited number of hospital beds available in the public health facilities. A study by the Ministry of Health (MoH) estimated that bed occupancy due to AIDS was 50% in 2000, expected to increase to about 90% in 2010. (Asamoah-Odei et. al, 1995) This implies that additional facilities would have to be provided to meet the increasing demands from AIDS patients, if other patients are not to be displaced. Again, the NACP estimates that the cost of treating TB in 50% of all AIDS patients would increase annually from 59 billion in 1999 to about 169 billion in 2014.

Figure 4.1: Cumulative Repot AIDS cases in Ghana 1986 - 2002 ('000)



Cost of Maintaining Health Care Professionals

The national health care system suffers from a severe shortage of personnel, resulting from difficulties in recruiting and retaining an effective, well-motivated and appropriately skilled workforce. This, in turn, stems from problems such as low pay and morale, poor conditions of work and inadequate management. The situation is exacerbated by migration to the private sector or other countries and HIV/AIDS-related attrition. The "brain drain" of medical and health professionals to the developed countries is overwhelming, and a major contributing factor to the low health worker-to-population ratios. Data from the Ministry of Health (MoH) indicate that between 1995 and 2002, the nursing training and medical colleges, on average, turned out 895 nurses and 88 doctors per

annum. During the same period, an average of 61 doctors and 199 nurses left the country each year. The low turnout rates and mass exodus of health personnel, coupled with the increasing demand for health care that results from AIDS, will put the health system under intolerable stress.
Already average population/doctor and population/nurse ratios of about 35,909 and 1,511 to 1, respectively, give cause for concern. The economy is affected not only in terms of the cost of health care provision for both HIV/AIDS and non-HIV/AIDS patients, but also downstream pressure on all other sectors of the economy since good health, as previously noted, is a prerequisite for economic development and growth.

With the cost of training a doctor at $60,000 and a professional nurse at $3,600, and training periods of 6 and 3 years respectively, it is going to be difficult for the health system to maintain the level of service currently provided. Further, even if lost staff could be replaced, the loss of experience and extra cost of training would burden the state even further.

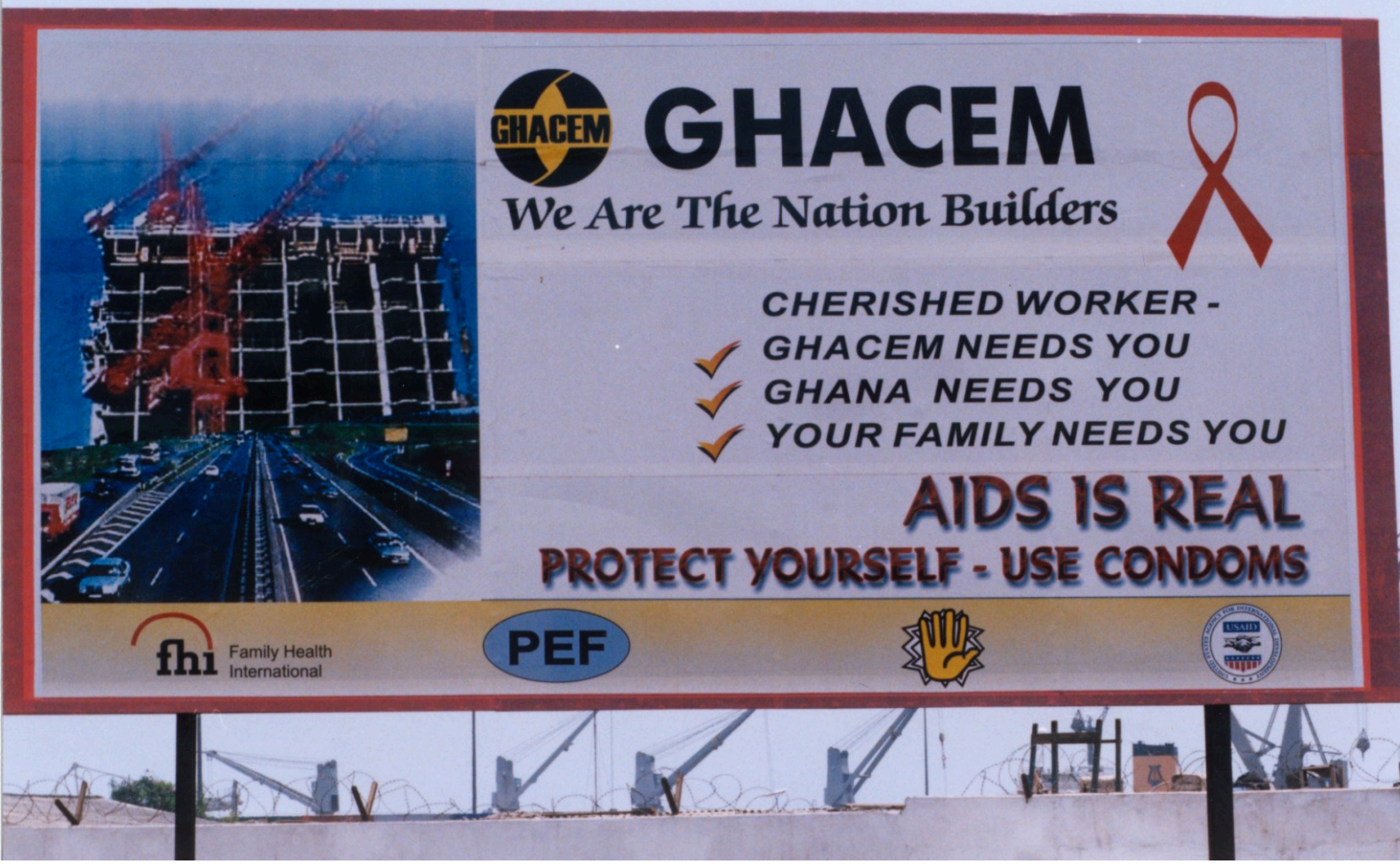
Impact on Education

An efficient education system could raise AIDS awareness, reduce the problem of stigmatisation in communities and help with the development of skills for out-of-school youth so they do not fall prey to the disease. As has been shown in many parts of the world, improvements in education have a positive relation with both economic growth and health outcomes. While the state of education is thus crucial, the picture in Ghana is, however, mixed. On the one hand, there have been increases both in access and in expenditure on education as a proportion of GDP. On the other hand, the quality of education has suffered, with students crammed into classrooms and residential facilities, a generally poor learning environment, and increased susceptibility to infectious diseases as a result of overcrowding. Yet those who do not gain access are in far worse shape, on almost any count.

Impact on Labour, Enrolment and Quality of Teaching

The education sector could be one of the areas most affected by the disease because it is made up of sexually active students and teachers, most of them falling in the peak age group of the disease. Posting teachers to places away from their homes and without their families and with inadequate supervision by experienced circuit officers might make teachers and other education workers more susceptible. There is a gender dimension to this problem. Male teachers using their power and status, are in a position to bargain for sex with female workers and students, while low salaries of female teachers in the primary and secondary schools could tempt some to yield to sexual pressure from their male counterparts. A study of 10 out of the 41 teacher training colleges in the country established that many teacher trainees did not practice consistent prevention methods and admitted to being at risk. Many of them admitted knowing of students who were sleeping with teachers. Stigmatisation was also very high among teacher trainees, inhibiting the use of VCT facilities. (Claypoole and Nazzar, 2004)

Attrition of teachers and educational workers because of AIDS would lead to increased teacher and supervisor losses, increases in medical cost for the teaching sector, additional demands on teachers to provide support and counseling, reduction in the quality of teaching and learning and a withdrawal of children from school. A study in Zambia shows that HIV/AIDS has led to nervousness and depression in teachers, absenteeism, deteriorated attitude towards work, low performance and a loss in the



average number of teaching hours per week. (Kalikiti and Mukuka, 1995)

4.2 EXPECTED IMPACT OF HIV/AIDS ON PRODUCTION

Impact on Agricultural Production, Farming Systems and Livelihoods

Agriculture in Ghana depends mainly on natural factors such as climate and soil. There are two farming seasons, corresponding to the two rainy seasons - the peak season (March-June) and the minor season (July-September). Demand for labour for land preparation, sowing, weeding and harvesting is therefore concentrated in these short periods. As the number of PLWHAs increases, the engagement of the healthy in care and domestic work takes precedence over farm work. Where this leads to a reduction in farm labour supply during the relatively short peak farming season, the impact on rural life is disastrous. A study in Uganda established that the majority (about 77%) of households had experienced a reduction in agricultural production in the last 10 years, with about 66 % attributing the reduction to the shortage in labour. (Barnett and Blaike, 1992)

Apart from reductions in farm production, the nature of farming itself could be affected. The production of cash crops such as cocoa is labour-intensive, depending on seasonal migrant labour. Thus reductions in labour supply and mobility could lead to

In the rural (agrarian) communities HIV/AIDS is very visible. In parts of the Brong Ahafo region for instance, neighbours can easily identify members of households who are PLWHAs or have died from AIDS….Their savings or loans to be used to purchase chemicals, quality seeds, tools or hired hands are partly spent on drugs, treatment and funerals.

WIAD (MOFA) Director.

a shift from cash crop production to production of subsistence food crops, basically for immediate consumption.

Subsistence agriculture is also labour-intensive and, therefore, liable to be heavily affected by an increase in HIV/AIDS infection. The impact of HIV/AIDS on the agricultural sector could be felt particularly at the household level through reduced labour for farming, an increase in the dependency ratio as death occurs disproportionately among the able-bodied, and a gradual decrease in agricultural production. Given the importance of agriculture to livelihoods and the economy as a whole, AIDS would, thus, have very dire effects on national development.

A change in farming patterns in Ghana has been noted in some places due to loss of labour. A change in production from commercial farming to purely subsistence production is reported to have occurred in the Yilo and Manya Krobo Districts of Ghana because HIV/AIDS has decimated the active labour force. (Woode and Acquah, 2004) The consequent decrease in crop production is disastrous for both the individual and the economy.

This brings to the fore, the need to mainstream HIV/AIDS education into agricultural extension services, a point appreciated by the Ministry of Food and Agriculture (MOFA). (See Box 4.1) Forward planning for shortage of skilled and professional labour as well as advancing credit for pesticides and fertilizer with the view to increasing productivity will also help farm families already struggling with the economic and other costs of AIDS.

BOX 4.1: MEASURES BY MOFA TO COMBAT HIV/AIDS

The MOFA acknowledges HIV/AIDS as a problem that affects all sectors of the economy. With support from the Ghana AIDS Response Fund (GARFUND), a survey has been undertaken to assess perception of risk among extension officers and farmers and their susceptibility to HIV/AIDS. The survey indicated that majority of the officers and farmers are aware of the disease and the adverse impact it can have on agricultural production. Motivation to have sex outside regular relationships was quite low between the two groups and about 50% of both groups believe they are not at risk, even though 23% of extension agents and 55.7% of farmers had never used a condom.

The Ministry in collaboration with Ministries, Departments and Agencies (MDAs) and UNAIDS is implementing programmes that will integrate HIV/AIDS within the guidelines of a national HIV/AIDS Strategic Framework. Desks have been created and capacities built to deal with HIV/AIDS issues. Achievements made in capacity building include producing trainers in skills for advocacy for sexual behavioural change and teaching regional MOFA trainers on how to support infected farmers through food security measures. Others are the training of 3,200 extension agents and supervisors to integrate HIV/AIDS into extension services and sensitisation of 32 Regional and District Directors of Agriculture on HIV/AIDS issues to gain their leadership support.

MOFA is collaborating with other NGOs poised on raising awareness and mitigating the effects of HIV/AIDS on the agricultural sector while anti-AIDS programmes and activities are also being targeted on fishing and farming communities and workplace programmes are being put in place for staff of the Ministry. The Ministry is also making efforts to establish baseline data for monitoring and tracking the effect of HIV/AIDS programmes on the sector.

Source: Personal Communication with Mrs Beatrice Duncan, Director, WIAD, MOFA

Changing Structure of Industrial Workforce

Industry will be affected by HIV/AIDS, directly through reduced labour supply and increased cost of production, and indirectly through reduced demand for products and services, as consumers' expenditure tilts towards health care expenditures. The specific impact will depend on factors like the numbers infected, the ease of replacement, the cost of managing the disease and, in particular, the category of job posts affected. With more than 80% of PLWHAs in Ghana in the 15-49 age group, there will be substantial changes in workforce profile as the most active and most experienced professionals, managers, foremen, etc. become persistently ill or die away.

Opportunities for multiple sexual networking by these categories of workers are great due to their relatively high income and position, placing them and their spouses at a high risk of HIV infection.[35]

Reduced Profitability of Firms

If HIV/AIDS prevalence continues to rise at the projected rates, the loss of the most experienced and well-trained and the most knowledgeable workers is bound to lead to production inefficiencies and declining productivity, thereby undermining the profitability of firms. This will result from losses in labour time due to ill health or death, rapid staff turnover, changes in work schedules at short notice, increase work load of other employees resulting in a disgruntled workforce, loss of a sense of continuity and stability at the work place, and even strikes. Welfare costs will rise as firms pay medical, death and survivor benefits for increasing numbers. All this will increase the cost of doing business,[36] disrupt operations, reduce productivity and profitability, and compromise the international competitiveness of national industry.

Box 4.2 summarizes studies on the economic impact of HIV/AIDS on some selected firms in Ghana.

BOX 4.2: ECONOMIC IMPACT OF HIV/AIDS ON SOME SELECTED BUSINESSES

A study was conducted on three organizations in banking, manufacturing and cargo handling, with an estimated workforce of 8,500 by Nabila et. al. (2001). One organization claimed to have had only one person known to have died of AIDS, another had 201 of the 615 employees testing HIV positive between 1996-2000, while the third reported 10 people had died of AIDS out of 29 reported AIDS cases between 1990-2000. It was evident that management was concerned about the growing AIDS situation in the country, though not all had workplace programmes on HIV/AIDS for their staff. Relatively low incidence of HIV/AIDS observed at the workplace showed a modest economic impact on companies.

Financing of HIV/AIDS programmes was relatively low, but was expected to increase significantly with the rise in HIV/AIDS cases. It costs one of the companies between $5 and $54.3 per episode of illness for employees who are sick and an average expenditure for medical problems was estimated at $10 per employee per year. It was also established that low demand for STI management and prevention from employees in all three organizations was worrisome since STI management and prevention is one of the main pillars for HIV prevention.

In a report prepared for the Ministry of Employment and Social Welfare (MESW) on a wood processing firm and a tobacco-processing firm (MESW, 1997), management reported that HIV/AIDS does not pose much danger or threat to their establishments. About 33.0 % and 11% of management knew of employees with HIV/AIDS and AIDS deaths respectively. Management reported that AIDS was not affecting their medical expenditure and operations, however, they were all aware that it could affect them in the future.

Sources: Nabila et al (2001) and (MESW, 1997)

[35] A study on HIV prevalence rates in a Kinshasa textiles mill showed that prevalence was high among executives (5.3%) followed by foremen (4.6%) and workers (2.8%) (Over, 1992), while one on the economic impact of HIV/AIDS on 14 firms in Benin showed that about 50% of workers living with AIDS held positions considered critical to the firm (Bollinger et. al., 1999).

[36] A study of the impact of HIV/AIDS on a textile, food processing and a packaging industry in Cote d'Ivoire established that the average annual cost of AIDS as a percentage of the wage bill was 0.8 percent, 1.3% and 3.2%, respectively (Aventin and Huard, 1997).

Workplace Policy

Despite the gravity and widespread awareness of HIV/AIDS, not many establishments have HIV/AIDS workplace programmes, and those that have, tend to emphasise prevention rather than care and support of PLWHAs.[37] The problem of PLWHAs being discriminated against or stigmatised persists at the workplace. Interestingly, workers in a South African firm were reported to worry more about stigma from co-workers than from discrimination within the workplace. Here in Ghana, workers are reported to have been slow to patronize the Coca Cola bottling company's confidential VCT programmes for fear of being stigmatised by colleagues. (See Box 4.3)

Although implementing credible health policies to take care of PLWHAs involves significant costs, it is clear that it reduces absenteeism as well as cost of hiring and training new staff, which may well be equally more costly to the firm in the long run. To ensure the success of workplace interventions, proprietors and managers need to show commitment to ensuring that PLWHAs are not victimised in any way.

Beyond economic considerations, such policies give firms a good social image, boost employee morale, narrow hierarchical gaps, strengthen cohesion among employees and facilitate the transfer of tacit knowledge.

BOX 4.3: INCORPORATING HIV/AIDS PROGRAMMES IN BUSINESS DECISION-MAKING

The Coca-Cola Bottling Company of Ghana acknowledges that HIV/AIDS could have devastating impact on employees, their families and its business by reducing skills, experience, productivity and earnings. Armed with this information, the company formulated an HIV/AIDS policy in 2000 aimed at preventing the spread of HIV/AIDS amongst workers and their families, provide protection against discrimination and stigmatisation and provide treatment, care, support and counselling for employees with the virus.

The strategies being used to address the problem include effective and comprehensive workplace programs, partnerships with, and involvement of the community. To improve the quality of life for HIV/AIDS employees, the company ensures reasonable accommodation, subsidized ARV treatments for workers infected by the disease and their families, and offer appropriate workloads. The programme also places emphasis on discouraging stigmatisation and discrimination against such employees. Confidentiality of HIV/AIDS status is strictly adhered to. Pre- and post-employment medical examinations exclude mandatory HIV/AIDS testing, while employees regardless of level or status, are continuously informed and educated about adopting non-risky behaviour. The company as part of its good corporate social responsibility has initiated community programmes, which include awareness creation in schools and sponsorship of PLWHAs at Saint Dominic Hospital. Major challenges faced by the company are the low participation in VCT due to the fear, stigma, discrimination and cost of care.

According to management, impact assessments by the company have shown that the organisation is better off putting in place HIV/AIDS intervention programs than doing nothing at all.

Source: The Coca Cola Bottling Company of Ghana Limited Workplace Policy 2003

[37] Out of 30 industries studied by Addo et al. (2004), only one third (all in the private sector) had a workplace programme and policy.

Providing more employees with all-round skills, increasing flexible work shifts, regular medical screening of employees, and helping PLWHAs to access medical care, are some strategies that firms can adopt to combat absenteeism and high turnover.

The incidence of AIDS in Ghana has not yet reached levels at which its impact on firms and industries becomes clearly visible. A study of firms in Ghana concludes that, "the relatively low incidence of HIV/AIDS at the workplace means that there is little demonstrable economic impact on companies". (Nabila et al, 2001) This makes it difficult to persuade firms of the urgency of investing in preventive policies and measures. It is, therefore, vital to step up the educational campaign and get firms moving before the adverse effects emerge, by which time it will be too late!

4.3 EXPECTED IMPACTS ON UNIFORMED SECURITY SERVICES

The mobile nature of the work of uniformed service personnel[38] renders them susceptible to the disease. Many young and (more sexually) active personnel are often sent on duty away from home (and spouses) for a period of time. The tendency to contract infections is higher for these personnel should they succumb to indiscriminate sex, especially in high prevalence zones.

Uniformed services rely heavily on highly trained professionals; investments made in training are significant. HIV/AIDS could reduce the total force strength. Considering the military for instance, though the hazards of the work may claim lives, the probability can be greater for HIV/AIDS to deplete human resources from the Force. PLWHAs are not recruited, or are soon discharged from the service. Higher prevalence could result in much strain on the fewer human resources in the near future. Security service delivery would be weakened, resulting in loss of continuity at the command level and within ranks. This diminishes promptness of security services to adjust to any eventualities. In the extreme case, a breakdown of law and order is possible.

The need for effective management of HIV/AIDS in the uniformed services has long been recognised in Ghana. Intervention programmes have been targeted to sections of the services since 1998 when Family Health International's donor-funded IMPACT project (see Box 4.4) was initiated.

Some outcomes observed for the Police Service, for instance, indicate the effectiveness of such programmes: increased condom use from 50% in 1999 to 85% and 100% in 2000 and 2002 respectively. In a recent interview, at the Police Hospital it came out that an average of two AIDS-related deaths of Police personnel were being recorded previously; the situation has apparently improved.[39]

4.4 IMPACT ON SOCIAL SECURITY AND POVERTY

A family's social security is traditionally embedded in the extended family system in Ghana. The major formal social security scheme in Ghana apart from a few organizations that administer some forms of annuity, health and death benefits for their employees, is the Social Security and National Insurance Trust (SSNIT). Unfortunately, the SSNIT scheme provides no health or unemployment benefits to contributors, while death benefits that may accrue to survivors are conditioned upon the years and volume of contributions. In effect, the scheme offers little or no relief to PLWHAs.

[38] Members of the uniformed security services comprise the regular military and paramilitary organizations like the Ghana Armed Forces, Customs Excise and Preventive Services, Ghana Immigration Service, Prisons Service, Ghana Fire Service, Ghana Police Service and other private security agencies whose services are crucial to the individual and state safety and security.

[39] HIV/AIDS/STI programmes of the Ghana Police Service

BOX 4.4: GHANA UNIFORMED SERVICES HIV/AIDS PROGRAMME

The Family Health International under its USAID funded IMPACT Project initiated a project in 1998 to support The Ghana National AIDS/STI Control Programme (NACP), the National Public Health Laboratory and the Ghana Police Service to establish advocacy programmes at the 37 Military Hospital and Police Hospital respectively, as well as build AIDS laboratories and train technicians in AIDS and STIs testing. An expansion of the Project in 2001 increased the number of participating uniformed service agencies to six, namely: the Ghana Armed Forces (GAF), Ghana Police Service (GPoS), Ghana Prisons Service (GPrS), Ghana National Fire Service (GNFS), Customs Excise and Prevention Service (CEPS) and the Ghana Immigration Service (GIS). Findings from qualitative studies under the programme confirmed that all six service agencies viewed HIV/AIDS and malaria as major health concerns within their organisations.

The main programme areas included: advocacy sessions; formative research; capacity building for programme sustainability; peer education training; behaviour change communication (BCC), materials development and use (e.g. condom wallets); development of training curriculum and monitoring of activities. The programme also included support for a TB programme.

Several categories of employees received various skills training under the Programme, including: 100 civilian employees; 18 religious leaders (priests and imams); 144 mess boys and 'table top' ladies; 5 laboratory technicians; 83 health providers; 7 doctors and 5 medical assistants; 70 prison reception officers and social workers; 53 choir-music bandsmen; 178 members of Wives' Associations; 29 VCT counsellors; 35 commanding officers.

An evaluation of programme activities led to several recommendations for strengthening the programme, a few of which are listed below:

- Need to sustain advocacy for behaviour change and use of VCT/STI clinics;
- Need to expand Behaviour Change Communication interventions to target drug abuse, alcohol and its role in HIV/AIDS/STI, and stigma reduction activities;
- Need to organise trips to PLWHA associations to encourage staff of uniformed services to patronise VCT and STI clinics; and
- Need to develop an M&E plan and to train an M&E officer to undertake regular monitoring of programmes in each agency.

Under the Project, two rounds of behaviour surveillance surveys (BSS) have been conducted, and the findings show important improvements in the knowledge and attitudes of services personnel on certain key issues, e.g.: in round II more personnel knew about mother-to-child transmission and associated factors (11% 44%); more personnel had correct information about preventive methods (46% 66%); more personnel had voluntarily taken the HIV test (5% 14%); more personnel acknowledged that they knew people who had died of AIDS (19% 31%).

Source: FHI Ghana (2003). Working with Uniformed Services: Issues and Recommendations. Programme Supported by USAID Ghana. Accra.

Apart from the limited coverage of SSNIT benefits, its coverage of the population is also limited. Only about 10% of Ghana's labour force contributes to the SSNIT scheme, almost all in formal employment. As the scheme does not cover the large proportion of the labour force in informal employment or business arrangements, the vast majority of the population, mostly the

poor, has no access to formal social security. This coupled with unstable livelihoods dispose many people in the informal sector to risk-taking for survival. The illegal and often underground nature of some activities (e.g., galamsey, smuggling, and commercial sex) makes it difficult to plan and monitor interventions in the sector. This makes management of the disease in the sector particularly challenging.

For most Ghanaians, the benevolence of family and society become the main source of support when sick or no longer productive.[40] It is therefore worrying that the demand for support is increasing alongside the steady collapse of the extended family system.

4.5 IMPLICATIONS FOR MACROECONOMIC STABILITY

HIV/AIDS poses a challenge to the macro economy, as previously argued. At the demographic level, rapid attrition resulting from AIDS threatens to decrease the average fertility rate and the future growth of Ghana's population, especially, those in the most productive age. The ILO projects that up to 10% of the world's labour force will be lost to HIV/AIDS by 2020. Given the profile of the lost segment, as detailed above, the impact on productivity could be quite high, unless the technological and capital components of production are improved and antiretroviral treatment programmes are expanded.

Employment data from the Labour Department reveals that the number of placements is always less than the number of vacancies in the face of substantial unemployment, 10% in the 2000 population census. This indicates that there is a persistent mismatch between labour demand and supply, and that training and upgrading of the labour force to close the gap is already a problem. This problem of the labour supply/demand mismatch would be compounded if, as a result of AIDS deaths and morbidity, replacement becomes increasingly cyclical, with newly recruited staff trained only to die and be replaced by new staff. The passing on of acquired knowledge and technical skills from worker to worker and between generations, which has been a major factor in the growth of labour productivity, would go on at a reduced pace, resulting in increases in the cost of doing business as well as providing services in both the public and the private sectors.

A further macroeconomic effect of HIV/AIDS will be a reduction in the level of net savings, with grim consequences for the rate of investment and economic growth. The annual cost of scaling up HIV programmes alone to meet current needs is estimated to be 1.26% of GDP. The implications are that increased portions of the savings of households, firms and the nation as a whole will be directed towards the containment of the disease, reducing the amounts left for productive activities and investment. Further reductions in domestic savings will result from the fall in incomes and an increase in consumption expenditure, particularly additional domestic expenditure on AIDS. Unfortunately, such expenditure would not necessarily go to increase welfare, since it acts as defensive expenditure. As the capacity to produce and export, and increases in production costs shift the balance of payment position of the country in a negative direction, competitiveness on the international market will be further jeopardised. Increased borrowing to close the gap will only aggravate the already increasing debt situation of the country and exert negative downstream impacts on all other sectors.

[40] In a study by Anarfi (1995) about 33% of households reported receiving assistance from the extended family or borrowing to pay for medical costs.

Summary

In a nutshell, HIV/AIDS will affect all sectors of the economy through the reduction of the quantity and quality of the labour force, and degrade economic growth prospects through a decrease in savings and investments.

It has been suggested that even the narrow definition of the economic cost of AIDS (health cost plus forgone output due to early mortality), the returns to investments in the prevention of HIV transmission and care could far exceed that on conventional capital investments. Ghana, with a low HIV prevalence rate, should act seriously and urgently with effective policies in order to avoid the full economic and social costs associated with AIDS. Policy interventions should focus at the level of the household and the firm where policies on behavioural change are most likely to be effective and where most of the AIDS costs will occur.

CHAPTER FIVE

HEALTH CARE RESPONSE TO THE HIV/AIDS PANDEMIC

CHAPTER FIVE: HEALTH CARE RESPONSE TO THE HIV/AIDS PANDEMIC

5.0 INTRODUCTION

Until recently, care and support for people living with HIV/AIDS (PLWHAs), their families, and their communities did not feature highly in HIV/AIDS programmes in resource-poor settings. Many governments and donor agencies focused only on preventing the spread of HIV, believing that prevention would obviate the need for care and support and the high costs associated with them. We now know that access to appropriate diagnostic services, treatment of opportunistic infections and provision of antiretroviral therapy (ART) are as important to preventing HIV transmission as they are to the caring for HIV-infected individuals. (Lamptey, P. R. and Gayle, H. D (eds.) 2001)

Prospects for expanded access to care in poor countries have greatly improved as a result of global and national efforts to reduce the cost of antiretroviral (ARV) drugs and the growing availability of cheaper generics. In addition, there is now increasing financing available from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), as well as corporate initiatives, government budgetary resources and multilateral and bilateral donors. (Kasper et al. 2003; Fleck F, 2004; Loewenson (2004); Stevens et al. (2004)

In place of the scattered programmes and projects, what is required is a comprehensive approach that embeds treatment within an accessible health system. It is important, therefore, to review the comprehensiveness of the current health care delivery service and its capacity to provide access to the estimated 350,000 Ghanaians who are infected with HIV and require care.

5.1 THE RESPONSE TO THE PANDEMIC TO DATE

AIDS has spread relatively slowly and steadily in Ghana over the past two decades. Today, the national prevalence rate is estimated at 3.6%. Over the past two decades several stakeholders have been involved in HIV prevention efforts. First and foremost, the Government of Ghana through the Ministry of Health spearheaded the response. To increase the effectiveness of the national response through a multi sector approach, the Government of Ghana has established a multi-sector national commission known as the Ghana AIDS Commission to coordinate all activities in the country.

The National HIV/AIDS/STI Policy (2004) aims at protecting persons living with HIV/AIDS and addressing issues affecting them. The policy, introduces measures for combating the further spread of the disease and reducing the current prevalence rate of 3.6% to the barest minimum. The policy aims at addressing issues such as behavioural change communication, blood screening and testing, home self-testing, treatment, mother to child transmission, young people and HIV/AIDS, gender and AIDS, and legal and ethical issues. Also captured in the policy are wilful and negligent transmission, the use of traditional medicine, HIV/AIDS education in schools, human rights, treatment, care and research. Other areas include the creation of a conducive environment to ensure sustained political commitment and support for effective action against HIV/AIDS and STIs. The policy also encourages employers and the society generally to adopt a positive attitude towards people living with the disease and keep them in productive employment for as long as possible.

In the area of research, the Noguchi Memorial Institute for Medical Research (NMIMR) has recently embarked on studies to support the Ministry of Health's programme of treatment with nevirapine for the prevention of MTCT of HIV and the treatment of AIDS with approved cocktails of antiretroviral drugs. Additionally, the NMIMR has agreed to work with Dr. Davis and Grace Eureka and Bio Medical Research to confirm his claim that injecting viruses into a goat will result in the production of anti-serum against HIV.

5.2 PREVENTION OF HIV INFECTION

The overall strategy of the prevention programme as noted in Chapter One, has been to limit the sexual transmission of HIV. The objectives include, among other things, promoting abstinence and faithfulness; delayed sexual activity among adolescents; promoting the correct use and consistent availability of condoms, including female condoms; and improving programmes for the control of sexually transmitted infections.

National awareness of the spread of HIV/AIDS dates back to the mid-1980s. The initial Information, Education and Communication (IEC) messages gave basic information about the aetiology and mode of transmission of the disease. Subsequent messages were geared towards achieving behavioural change, and dispelling false rumours and misconceptions about the disease. These educational efforts were primarily for the general public. In addition, there were targeted interventions for groups with the highest levels of infection, such as commercial sex workers and long distance truck drivers. Commercial sex workers were targeted for specific interventions such as treatment of sexually transmitted infections and education on safer sex, including condom promotion. The current focus, as noted in Chapter 3, is on care and support for people living with HIV/AIDS (PLWHAs).

Capacity to Manage HIV/AIDS

An expanded response to the HIV/AIDS epidemic should combine primary prevention, prevention of mother-to-child transmission linked to voluntary and confidential counselling and testing (VCT). It should also focus on treatment of STIs, improved blood supply, treatment of opportunistic infections and care and support for people living with HIV/AIDS.

As pointed out in Chapter 4, the national health sector is facing a crisis in human resources. This is a major constraint to upscaling, affecting its capacity to absorb new resources, provide quality ART and meet cumulative demand for chronic care.

Although "brain drain" emigration is not a new phenomenon, the growing numbers of health workers leaving sub-Saharan African countries, as well as those leaving the health sector altogether exacerbate the shortage of health care personnel. The Ghana Health Service describes the situation in the following terms:

"The human resources management has been a major challenge, with problems of poor staff retention in relation to health needs, especially in the northern regions and remote areas all over the country. Employees within the sector are poorly motivated and thus their output is not optimal. There is high rate of attrition of professional staff and this poses a great threat to quality of service delivery and ability to improve on geographical access to health care".
(MOH, 2002 p5)

BOX 5.1: HEALTH WORKERS HIV/AIDS STATUS IN ASHANTI REGION

A team of doctors from The Kumasi Centre for Collaborative Research into Tropical Medicine (KCCR) undertook a study of health workers drawn from six districts in Ashanti Region. One of the objectives of the study was to find out the level of sero-prevalence of HIV among health workers in Ashanti Region. A simple random sample was used to select six out of 18 districts in the region. From public health facilities in these districts, a purposive sample of 478 health workers was selected. The health workers included medical officers (5%), nurses (53%) and paramedical staff (37%) with the rest drawn from among pharmacists, drivers, labourers, etc. The data collection tools included qualitative and quantitative interview schedules, observation and blood tests (using three different laboratory test methods for HIV/AIDS sero-prevalence). On the whole, there was a high level of willingness to undergo testing among the workers. Nearly all the workers were found to be HIV/AIDS free, but they appeared to have inadequate knowledge about the disease, as the summary below shows:

- 304 (63%) out of the 478 health workers that were studied submitted to the HIV test.
- 0.7% of the 304 health workers were found to be positive, indicating that 99.3% were negative.
- 81% of the workers displayed poor knowledge of the major and minor signs of the disease.
- 78% of the workers had no idea of the prevalence rate at the time of the study.
- 7.4% made an accurate estimate of the range within which the prevalence rate fell.

Source: Owusu-Dabo, E; Ohene, A; Kruppa, T; Enimil, A; Berberich, C. 2004. Awareness and Seroprevalence of HIV/AIDS among Health Workers, Ashanti. Implications for Voluntary Counselling and Testing Policy, KNUST, SMS and KCCR. Kumasi

Apart from shortage arising from dissatisfaction, health workers face special problems. They are probably more susceptible to HIV/AIDS and its opportunistic infections than the general populace, as not all health professionals strictly observe the universal precautions in the sector. A study in South Africa established that between 1991 and 1998, TB among health staff increased five times, and about 86% of those tested were HIV positive. While the situation in Ghana does not appear to be alarming, the risks are clear. A case study of health workers in the Ashanti Region confirmed the notion that health workers are presently not unduly exposed. However, the study suggested that there may be a lack of basic information about HIV/AIDS among health workers in Ghana. (See Box 5.1)

Stress and trauma resulting from the fear of contracting the disease, stigma associated with working with PLWHAs, especially when the affected person is a friend or relative, could also be very high. Ethical issues posed by HIV, such as keeping the HIV status of patients confidential, even though such patients might be putting others at risk, as well as seeing the discharge of ill patients into an unsuspecting society could increase the levels of stress on health workers. In addition, health personnel may migrate to less affected areas, resulting in unequal distribution of health personnel. Given the skill-intensity of the medical profession and the requirement that newly-trained doctors work under experienced ones for a lengthy period, the downstream impact of the loss of experienced personnel on health care delivery is likely to be all the more serious.

A review of the human resource requirement for the effective implementation of the Ghana Health Service (GHS) programmes reveals shortages in all categories of personnel. (See Table 5.1) Unless a concerted effort is made to produce and retain health care workers, the quality of health care will deteriorate further. (Ministry

TABLE 5.1: PROJECTED TOTAL NUMBERS OF HEALTH PROFESSIONALS NEEDED BY 2006

CATEGORY	CURRENT NUMBERS	NUMBER 2006	DESIRED NUMBERS	SHORTFALL
Doctors	1600	2,334	4,200	1,866
P/Nurses	11,876	14,297	21,000	6,703
Pharmacists	1,136	661	2,100	1,439
Midwives	3,690	3,859	10,500	6,641
CHN	2,280	3,285	10,500	7,215
Med. Lab	62	91	210	119
ENV. Health	2,172	2,716	6,300	3,584
Physiotherapists	13	59	320	261
Radiographers	96	91	420	329

Source - Ministry of Health: Human Resource Policies and Strategies for the Health Sector 2002-2006

Increasing training capacity for this purpose may be difficult and will take time, owing to many constraints in the education sector. But it must be planned for and invested in. The health system must be willing to create a new cadre of health care workers appropriate to the actual working conditions, for example, HIV specialists to work at the district level. For this, it is imperative to improve the pay and conditions of public sector health workers.

Traditional donor reluctance to fund recurrent costs and to support only short in-service training has distorted incentives and undermined the capacity of the health sector to reproduce itself. Managing internal migration and deployment between the public and private sectors is very critical. There is a real danger that the growth in funding for new services in the non-governmental sector will undermine staffing in the public system and delivery of essential services to the public as a whole in Ghana.

Apart from human resources, comprehensive care and support need adequate infrastructure. Also needed are monitoring, to assess the progress of patients receiving ART, as well as good quality laboratories with well-trained staff to conduct CD4[41] count tests and basic safety tests for side effects. All these are currently in very short supply. Again, the issue of whether non-health work staff can be trained to do some of these components of the campaign should be seriously considered.

Improving the Safety of Blood Transfusions

It has been difficult to make blood and blood products completely risk free. Therefore, reducing transfusions is desirable for several reasons.

In some countries, commercial blood donation acts to amplify the spread of transfusion-transmitted HIV infection both to the recipients of blood as well as to donors who may become infected through exposure to unsterilised equipment. (Lamptey, & Gayle (eds.) 2001) Women and children are especially at risk of transfusion-transmitted HIV infection. Women of

[41]CD4- Cluster of differentiation 4, a protein embedded in the surface of some T-cells and certain outer cells. HIV invades cells by attaching to their CD4 receptacle.

childbearing age are at high risk because of the high incidence of anaemia and haemorrhage associated with pregnancy, and children because of anaemia resulting from malaria.

Major steps have been taken to control blood-borne HIV transmission in Ghana. These include donor selection and exclusion, testing of donor blood, and reducing unnecessary transfusions. Despite these measures, the risk of transmission of HIV and other blood pathogens remains.

A review of blood transfusion practice in the country shows that about half of all blood transfused in Korle Bu Teaching hospital is to women and children. In the other regions, blood usage for women and children is even higher, between 60-80%. The National Blood Transfusion Service estimates that the service needs 100,000 units of blood annually. Currently, the Service is able to collect between 60,000-70,000 units, relying mostly on replacement donation instead of voluntary donors. It is estimated that prevalence of HIV infection among blood donors is just over 3% in 1999 (Table 5.2.) and hepatitis B about 10.3%.

Even though blood transfusions are becoming safer as more screening tests for viruses are introduced, it is necessary to reduce the requirement for blood transfusions. Measures for doing this include educating staff and patients about the pros and cons of blood transfusion, and the development and evaluation of transfusion protocols and guidelines. Other measures for improving the safety and availability of blood are to encourage the public to donate and to continue donating in order to increase the supply of blood from low risk volunteer blood donors.

The most effective and inexpensive way to reduce anaemia associated mortality and exposure to the risks of blood transfusion is to prevent severe anaemia. Again, better nutrition, sanitation, the use of bed nets and early treatment of malaria would greatly help to reduce anaemia.

TABLE 5.2: HIV PREVALENCE AMONG BLOOD DONORS FOR 1994 -1999

CENTRE	1994	1995	1996	1997	1998	1999
Accra	1.42	2.28	2.50	2.85	3.12	3.6
Eastern	1.98	2.41	2.48	2.50	2.48	3.13
Western	1.49	2.00	2.70	2.50	2.62	2.75
Ashanti	1.45	2.01	2.15	2.25	2.40	2.62
Northern	1.16	2.10	2.42	2.27	2.39	3.28
Total	**1.50**	**2.16**	**2.45**	**2.48**	**2.60**	**3.12**

Source: Annual Report, Ghana National Blood Transfusion Service, 2000

5.3 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

Prevention of mother-to-child transmission (PMTCT) is one of the most effective interventions for preventing HIV in children. As already stated in Chapter 3, whereas paediatric HIV-infection is on the verge of being eliminated in the developed countries, in sub-Saharan Africa it has become a major cause of admission to hospital and a major contributor to child mortality. HIV infection is, therefore, threatening the advances that have been made on child survival in many sub-Saharan African countries. The fear of disclosure of HIV positive status, stigma attached to being HIV-positive, lack of cooperation from husbands or male partners, and lack of follow up resources and low PMTCT services have been documented elsewhere in this report.

The Ghana PMTCT programme was piloted in two hospitals in the Manya Krobo District in 2002, and later expanded to other health facilities. (Box 5.2) It is expected that NACP with assistance from the Global Fund will increase the number of sites from 19 in 2003 to 240 by the end of 2005. It is quite clear that the success of PMTCT is not just dependent on treatment but also on breast-feeding practices as is discussed later.

BOX 5.2: PREVENTION-OF-MOTHER-TO-CHILD-TRANSMISSION SITES CURRENTLY IN GHANA

The lessons learnt from the Pilot programmes in Atua Government Hospital and St. Martin de Porres' Hospital in Agomanya have enabled the programme to be expanded to 19 additional sites in the country with the support of Family Health International (FHI) and the Global Fund. The list below shows the PMTCT sites in Ghana:

Greater Accra Region:
La Polyclinic
Maamobi Polyclinic
Ashiaman
Mamprobi Polyclinic
Tema General Hospital
Korle Bu Teaching Hospital

Eastern Region:
Atua Government Hospital
New Juaben Municipal Hospital
Nsawam Hospital
St. Martin de Porres Hospital
Akim Oda Government Hospital

Ashanti Region:
Komfo Anokye Teaching Hospital
Suntreso Hospital
Offinso St. Patrick's Hospital
Obuasi Government Hospital
Kumasi South Hospital
Obuasi (AGC) Hospital

Upper East Region:
Bawku East Hospital
Bolgatanga Central Hospital

The NACP expects to increase the number of PMTCT sites to 240 health facilities by the end of 2005 with support from the Global Fund.

Source: NACP, Accra

TABLE 5.3: SHOWING PMTCT ACCEPTANCE RATE AT ATUA GOVERNMENT HOSPITAL

Month	Total ANC Attendance	New ANC Registrants	No. of pregnant women accepting VCT	Acceptance rate (%)	No. of pregnant women HIV-positive	% of pregnant women HIV-positive
October 2002	300	122	66	54.1	8	10.6
November	210	161	22	13.7	2	9.0
December	288	144	39	27.0	3	7.6
January 2003	250	171	96	56.1	6	6.2
February	346	129	73	62.8	11	13.6
March	216	139	34	24.4	1	2.9
April	271	131	39	29.8	5	12.8
May	405	163	23	14.1	4	17.4
June	302	85	7	8.2	1	14.2
July	308	128	38	29.7	6	15.8
August	254	123	20	16.2	1	5
Sept.	256	81	12	14.8	3	25
TOTAL	3406	1577	469	29.7	51	10.9

Source: Annual Report: Prevention of Mother-To-Child Transmission Programme, Atua Government Hospital, 2004

At the Atua Government Hospital, the acceptance rate of this intervention was 29.7%. (See Table 5.3)

A number of studies have shown that the protective effect of the various drug regimes is diminished when babies continue to be exposed to HIV through breast feeding. Thus, breast feeding can greatly erode the short-term benefit of drugs to prevent MTCT of HIV.

HIV-positive mothers should be counselled on the risks and benefits of different infant feeding options and should be helped to select the most suitable option for their situation. For some, the use of infant formula may be neither feasible nor safe. Dependence on infant formula deprives the baby of special vitamins, nutrients and protective agents found in breast milk. And the cost of infant formula often puts it beyond the reach of poor families in poor countries, even when the products are widely available.

A major challenge faced by this programme is non-disclosure of HIV status to partners; only a few of the women have brought their partners to be tested. Another concern has been the physical violence against women who disclose their HIV status. Lack of male involvement and stigma has also affected the infant feeding options for lactating mothers. Most of the mothers have opted to breastfeed even though they are aware of the risk of transmission through breastfeeding, because they are unable to purchase infant formula feed.

Similar findings have been reported in settings where PMTCT have been provided. For instance, in Kenya, only 27 percent of 340 women in Nairobi found to be HIV infected communicated their test results to their partners. In a small study from the Western Cape in South Africa, less than 50

percent of sero-positive women were able to disclose their HIV- status to anyone, and only a minority of these discussed it with their partner. In the MTCT programme in Botswana disclosure to partners is also reported to be low and very few men are either tested together with their wives/partners or agree to test at a later date.

It has been suggested that involving men in the prevention of MTCT, by encouraging them to undergo VCT or couple counselling, will enable them and their partners to make informed decisions about MTCT prevention interventions. The current programme in Ghana has to incorporate this in the proposed expansion programme.

Even though increasing PMTCT sites to 240 could contribute to the reduction of perinatal transmission, caution is necessary. The evidence is that while the uptake of VCT by pregnant women in the antenatal clinic has often been high in PMTCT pilot and research projects, it has sometimes been much lower where scaling up of projects has occurred or in national-level programmes. Thus, for successful scaling up, there must be a strengthening of communication on MTCT and men must be brought into VCT and MTCT prevention activities. Where partner testing is logistically difficult to implement, and for men who are not willing to be tested in Maternal and Child Health (MCH) centres, alternative sites away from the MCH services may be more acceptable.

5.4 VOLUNTARY COUNSELLING AND TESTING (VCT)

The vast majority of HIV infected people do not know their HIV status. Voluntary Counselling and Testing (VCT) services have not been widely available in many sub-Saharan countries until recently, and many people who wish to know their HIV status attend blood donation sites. In promoting VCT, a major challenge will be partner disclosure. In Zimbabwe, informing marital partners was found to be a major problem for most people with HIV. The main reasons were that people felt in perfect health and emotionally stable; or were afraid of rejection; or had limited knowledge and belief in strategies of "living positively with HIV". Other reasons included women's economic dependency and lack of power in sexual relations, as well as refusal of men to accept condom use and other safe sex practices.

In Ghana, where an expanded, comprehensive care and support programme has been adopted as the national response to the epidemic, VCT is seen as the entry point for care, support and treatment. VCT is a new intervention with facilities available in only 26 sites in the last couple of years. It is, therefore, not surprising that the preliminary report from

BOX 5.3: VOLUNTARY COUNSELLING AND TESTING SITES IN GHANA

Currently VCT services are available in the following health facilities in Ghana:

Greater Accra Region:

La Polyclinic
Tema General Hospital
Ashiaman Health Centre
Anyidado Fie Salvation Army
Police Hospital
Vital Health Foundation
Family Health Foundation
Community Home Care
Mamprobi Polyclinic
PPAG
Korle Bu Teaching Hospital
Tema Polyclinic
Adabraka Polyclinic
CENCOSAD
West African AIDS Foundation (WAAF)

Eastern Region:

Atua Government Hospital
New Juaben Municipal Hospital
St. Martin de Porres Hospital
Akim Oda Government Hospital

Ashanti Region:

Komfo Anokye Teaching Hospital
Suntreso Hospital
Kumasi South Hospital
Obuasi Government Hospital

Brong Ahafo Region:

Sunyani Regional Hospital
Dormaa Ahenkro Presby Hospital

Source: NACP, Accra

the Ghana Demographic Health Survey indicated that only 7% of the population knew their HIV status, even though general awareness of AIDS is near-universal for both men and women (99.2% and 98.4%, respectively). Box 5.3 shows some of the current VCT sites in Ghana.

Given the high level of awareness, with proper education and the promotion of services, the uptake of VCT should increase in spite of the difficulties enumerated above. The NACP plans to provide 240 sites by 2005. This calls for massive resources - both human and infrastructure. NACP is optimistic that this can be achieved despite reductions in the number of health staff. The assumption is that non-health care workers can be brought in to take on non-clinical as well as administrative tasks. The NACP decision to expand VCT sites is backed by evidence from the pilot sites in the Eastern region, which suggest that if introduced, community members will avail themselves of the services, as indeed is evident in Table 5.4.

HIV/AIDS is a family disease which makes treating patients who do not disclose their status difficult. This is why making voluntary counselling and testing widely available in the country will help to improve access to testing, decrease HIV stigmatisation and eventually help with issues related to disclosure.

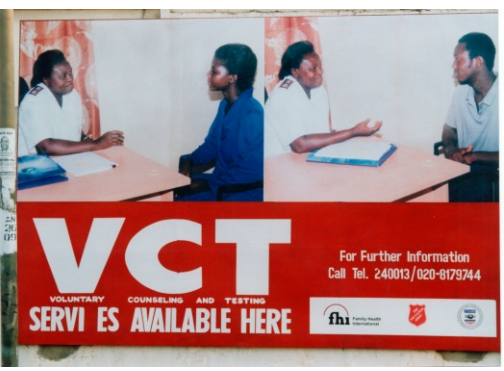
- Dr. Peter Lamptey, President, Family Health International

TABLE 5.4 : VCT UPTAKE AT THE ATUA GOVERNMENT HOSPITAL

Month	No. of clients counselled	No. of clients tested	Male	Female	No. of clients who received Post test counselling	HIV-positive males	HIV-positive females	Total number of HIV positive clients
October 2002	101	100	42	59	100	11	29	40
November	86	84	32	54	84	14	28	42
December	74	74	30	44	74	6	21	27
January 2004	73	71	25	48	71	13	27	40
February	81	81	39	42	81	16	19	35
March	83	83	36	47	83	10	23	33
April	68	67	42	26	67	7	20	27
May	91	89	29	62	89	9	23	32
June	73	70	23	50	70	8	24	32
July	72	69	33	36	69	12	14	26
August	35	35	15	20	20	1	14	15
Sept	43	43	13	30	43	2	17	19
Total	880	866	359	518	851	109	259	368

Source: Annual Report of the Voluntary Counselling and Testing Programme, Atua Government Hospital, 2004

The availability of treatment has been shown in other parts of the world to increase the demand for counselling and testing. This is because those who test positive can expect to avail themselves of clinical care to improve their quality of life. The uptake of voluntary counselling and testing in a rural clinic in Haiti is reported to have increased by 300% after the introduction of antiretroviral drugs. One expects similar results in this country and through public health care since ARVs are now available.



Even though one expects VCT sites will be patronised, studies have shown that the centre itself could be stigmatised, making it difficult for people to use it. Some of the worrying issues are the misconceptions that anyone who visited the VCT centre had AIDS and that anyone who went for the VCT test might have been immoral which would result in insults on him/her and the family. Another major drawback to the programme is that, even if the clients are willing to patronise the centres, there are very few counsellors trained to provide VCT.

In the circumstances, there is need for widespread educational programmes at the community as well as national levels, using all available media, to discuss the benefits of VCT. Secondly, at the initial stages, NACP would need to train a large number of counsellors.

5.5 COST OF TREATING HIV/AIDS

In industrialized countries, the development of highly active antiretroviral therapy (HAART) has had a dramatic effect on the long-term survival of people with HIV. In Europe and the United States, the death rate from HIV has fallen significantly as a result of the availability of HAART. The positive impact of HAART on HIV/AIDS-related mortality and morbidity has also been reported in poorer countries. These studies have shown that antiretroviral therapy (ART) can be used safely and effectively in poor countries and by poor people. Demands for the introduction of antiretroviral therapy in Africa have, therefore, been growing over the past few years. The situation in Ghana is spelt out in Box 5.4.

At present, the only public source of ARVs in Ghana is through two hospitals in Manya Krobo in the Eastern Region and the two teaching hospitals, Komfo Anokye in Kumasi and Korle Bu in Accra. There are also three private fee-charging health institutions-Akai Clinic, Nyaho Medical Centre and Trinity Medical Centre-providing ART. The current cost of ART from the private sector is between $200 and $300 a month - the daily minimum wage is just over a dollar in Ghana. Uptake of ART, which has been lower than anticipated in some high prevalence settings, is influenced by financial, organizational, physical and social factors. Indeed, affordability has been found to be a major barrier to accessing treatment in contexts where patients are expected to pay for all or some of the costs of treatment.

The National AIDS Control Programme (NACP) intends to integrate treatment within the health services. This implies strengthening the personnel needed to implement programmes, the managerial skills needed to procure and manage antiretroviral drugs, and the clinical skills required to diagnose and treat opportunistic infections. It is also important to strengthen the skills of individuals who provide community education and mobilization, and support NGOs and CBOs who work at the community level.

It is worth noting that Ghana has begun supplying free antiretroviral drugs to some PLWHAs, and is considering producing the life-prolonging medicines locally. A UN Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has provided $15 million to partially pay for the drugs, refurbishment of hospitals and laboratory facilities, and to cover the cost of counselling and testing for the next two years. The Fund support is expected to cover 2,000 people a year while the Government will be responsible for a further 4,000 patients. Meanwhile, the World Health Organisation (WHO) has indicated that Ghana needs to put 29,000 Ghanaians living with AIDS on antiretroviral therapy by 2005 under its global three by five initiative.[42] All this amounts to 50% coverage of people currently living with HIV/AIDS. Meanwhile, as a further boost to make ARVs accessible to the majority of those who require it, the Ministry of Health has directed that patients be charged only 50,000 monthly for ARV medication. This represents 10% of the total monthly cost of care.

Experience to date has been very positive and many people living with HIV/AIDS, who currently benefit from this initiative, appreciate the government's efforts to provide ART. So far the over 600 HIV/AIDS patients currently receiving government subsidized ARV drugs at the Korle Bu Teaching Hospital are reportedly responding well to the treatment, as many who were admitted ill and weak eventually leave the clinics feeling much better and able to go about their normal duties. This is confirmed by one PLWHA:

[42] WHO's "three by five" initiative aims at scaling up the response of individual countries to AIDS so that three million people can be put on life-sustaining but expensive antiretroviral drugs by 2005

BOX 5.4: DIRECTIVE ON ANTIRETROVIRAL THERAPY IN GHANA

The Ministry of Health from December 2003 introduced the Highly Active Antiretroviral Therapy (HAART) in Ghana for the care of PLWHA. It is anticipated that 2000 people will benefit in 2004. The programme initially started with the two teaching hospitals, Korle Bu and Komfo Anokye in addition to the two pilot institutions of St. Martin De Porres Hospital and Atua Government Hospital, both in the Eastern Region. With the cost of service, the Government of Ghana will subsidise the cost of the Antiretroviral drugs and other services related to the programme namely Voluntary Counselling and Testing, Clinical Management and Prevention of-Mother-to-Child Transmission at the following rates:

Voluntary Counselling and Testing	-	5,000
Clinical Management*	-	50,000
Prevention of Mother-to-Child Transmission#	-	Free

*Clinical Management comprises:

- Provision of one month's consignment of ART according to the National Guidelines
- Prophylaxis/treatment for Opportunistic Infections for one month
- CD4 count up to four (4) times per year
- Basic laboratory Investigations up to four (4) times per year including full blood count, blood uea and electrolytes, liver function test and fasting blood sugar.

#Prevention-of-Mother-to-Child Transmission services are free and include VCT, delivery, administration of nevirapine to Mother and baby and follow-up counselling.

Source: NACP Bulletin, Quarterly Technical Bulletin on HIV/AIDS/STIs in Ghana NACP/GHS. Vol. 1 No. 2, December 2003

"Since I started the treatment, I have been feeling better and better. Taking my medications twice a day and going to hospital once a month is not a constraint because I know this treatment is saving my life". (Grace, a person living with HIV/AIDS in Greater Accra Region.)

In order to achieve WHO's target of providing ARV to about 29,000 HIV/AIDS patients, we need, once again and with emphasis, to break the prevailing secrecy about AIDS that still persists even in the face of sickness and death. The visible causes of illness in persons living with HIV/AIDS are often diseases such as tuberculosis and pneumonia, which are also common in HIV-negative individuals. Because of this unusual feature of AIDS, the silence that surrounds the epidemic persists even when AIDS patients are ill and dying.

Another effort at providing comprehensive care and support for PLWHAs comes under the Treatment Acceleration Project (Box 5.5)

Mention should also be made of the positive correlation between good nutrition and prolonging the health status of PLWHAs.

Concerns about medication toxicities and side effects run high in the HIV community. Multiple medications are being prescribed not just for HIV infection, but also for prevention or treatment of other infections, high cholesterol and fat accumulation, diabetes, heart, liver, kidney, and digestive

Box 5.5: Treatment Acceleration Project (TAP)

Ghana is one of three African countries implementing the Regional HIV/AIDS Treatment Acceleration Project (TAP) with funding support of $14.9 million from the WHO and UNECA. The primary goal of the TAP is to plot strategies for strengthening the country's capacity to scale up comprehensive programmes providing care and treatment. The programme will plot treatment systems which are effective, affordable and equitable and will ensure that PLWHAs and their immediate families benefit from care and treatment which has been demonstrated to:

- Enable infected persons to live longer, healthier and more productive lives and to care for their dependants;
- Be effective in preventing mother-to-child HIV transmission and in decreasing the risk of sexual transmission; and
- Diminish the stigma of HIV/AIDS

The TAP covers areas like VCT, PMTCT, Home-based Care, ARV and Opportunistic Infections as well as strengthening national institutional capacity among others.

Source: NACP, 2004

diseases, cancer, hormonal deficiencies, pain syndromes, and mental health concerns. Nutritional risk factors, such as poor quality diet, weight loss, mild to moderate nutrient and hormonal deficiencies, dehydration, and substance abuse aggravate these conditions and worsen toxicities. Research suggests that aggressive nutrition support boosts the immune system and detoxification, improves digestion, and produces positive health outcomes. It is therefore necessary for PLWHAs to be put on appropriate diets to boost their immune system against opportunistic infections. This calls for maximum cooperation between the family and the health authorities. Relatively, high levels of poverty in many Ghanaian households therefore pose a danger to PLWHAs.

5.6 HOME-BASED CARE FOR PEOPLE LIVING WITH HIV/AIDS

Home-based care includes the provision of basic medical, nursing and psychological and sometimes spiritual care by health workers at the home of the patient. Usually the volunteers, families and people with HIV also receive education and training and in some cases, material and financial support. The choice of home-based care for people living with HIV/AIDS is made for different reasons. Hospital care is not always available or accessible for people. Home based-care programmes can reduce the pressure on the hospitals, which are not able to deal with the growing numbers of AIDS patients.

Not only is hospital care more expensive than home-based health care, but it is often not needed by terminally ill people. Many HIV-related infections such as diarrhoea and fever can be treated at home just as effectively, with home visits by health workers. Moreover, when patients are cared for in the home they are less isolated and the family can be involved in the care.

Indeed, home-based care projects are built upon the coping and caring capacity of families.

In Ghana, home-based care for persons living with HIV/AIDS has been provided by the Christian Health Association of Ghana (CHAG) as an extension of hospital services since the early 1990's. Of major concern are issues of confidentiality and the safety of the persons living with HIV/AIDS. This is compounded by the stigma and discrimination that persist, despite all the efforts at public education. (Price & Navele 2002) Paradoxically, education about HIV/AIDS has sometimes been partly responsible for the stigma and discrimination. Some messages used in the past, such as "Avoid sex before marriage", "Stay faithful to your partner", "Avoid promiscuity, to avoid AIDS" tended to worsen stigma. By emphasising what must be avoided instead of promoting safer behaviour, these negative messages stigmatise behaviour, infer guilt and blame, and consequently induce shame and secrecy. Even though home care staff and volunteers recognised the need for confidentiality, they were concerned that it facilitated long periods of denial by some PLWHAs.

Concealing the hospital diagnosis of HIV infection from others is a common coping strategy among people with HIV/AIDS. Some PLWHAs engaged in self-isolation for fear of being pointed or jeered at. Some complained that their friends had ceased to visit once their diagnosis had been made known to them. Many have come to the conclusion that they would gain nothing from being open about their sickness: it would rather harm them. In order to overcome this situation, some health workers and volunteers have resorted to identifying themselves as "Friends of the sick", and going around visiting all the sick in the communities where they operate. This obviously adds to their workload.

It is important to note that successful AIDS care projects such as the well-publicised Uganda TASO (The AIDS Support Organisation) started when some courageous individuals decided to break the silence surrounding the disease. The "Reach out, Show Compassion Campaign" launched in 2002 aimed at working with religious leaders both Christian and Moslem to reduce the stigma surrounding HIV/AIDS.

The other major issues are the absence of community ownership and management, vital for the success of the home-based care programme, and the sporadic nature of funding for the essential activities. The reasons for weak home-based care lie partly in the origins of most of the programmes as extensions of care from the hospital to the community because of the unwillingness of some health staff to admit terminally-ill AIDS patients. To remedy the situation, some of the money provided by the Ghana AIDS Commission to community-based organisations and non-governmental organisations for AIDS awareness programmes in the community should be specifically earmarked for community education on the benefits of home-based care and for soliciting community involvement. The Department of Community Development, which has expertise in community mobilization, could spearhead the drive for community involvement at the grass roots level. Finally, the home-based care programme should feature as part of the District Response Initiative (DRI) so that funding could be provided for it through the District Assembly.

5.7 HERBAL TREATMENT AND HIV

Traditional healers have claimed success for the use of herbal remedies to help HIV

patients with ailments that biomedicine had failed to treat. The Ministry of Health has been working with the Centre for Research into Plant Medicine to investigate some of these claims. The work done to date, suggests that some of the local herbal preparations ameliorate a number of opportunistic infections, particularly diarrhoea, and counteract the loss of body mass. However, further research is needed to confirm whether these medications improve the CD4 count and lower the viral load as well.

The NMIMR is also establishing a laboratory for testing the safety, efficacy and potency of herbal preparations claimed as cures for HIV/AIDS. The $100,000 project would be carried out with support from the Ghana AIDS Commission (GAC). This should help settle once and for all the contestations around claims by traditional practitioners that their preparations could cure HIV/AIDS. As is generally known, part of the difficulty with the claims of herbalists has to do with the context within which they express their claims. Very often the identification, preparation and application of the medication are tied up with magical ritual and secrecy about the core components of the preparation. This is quite different from the approach of modern science, a difference that defines the conflict between modern science and indigenous knowledge practices, as was discussed in the 2000 GHDR. (UNDP/ISSER 2001) The Institute proposes to work with traditional healers and other stakeholders in developing guidelines that will facilitate the investigation of such claims. The issue of intellectual property rights needs to be addressed in this context also.

Even so, some of the claims are so compelling that they have attracted partnerships with medical scientists. The story of Evangelist Kweku Owusu is one such. (See Box 5.6) The Evangelist was invited to the African Development Forum 2000 on "HIV/AIDS, the Greatest Challenge" through the Akwatia Project which is supported by UNAIDS.

This work needs pursuing, as preliminary evaluation of herbal preparations used for the management of HIV/AIDS in other African countries has shown encouraging results. For instance, a herbal preparation developed by a local pharmaceutical firm in South Africa is used as a tonic for diseases associated with significant loss of body mass. The information available is that about half of the patients on this preparation experience a cessation of diarrhoea, weight gain and a lift in their morale. In Uganda some of the patients on herbal preparations have seen improvement in opportunistic infections such as herpes zoster, and a general improvement in their quality of life. On the evidence so far, herbal preparations for treating HIV/AIDS may yet prove to be affordable local alternatives for many AIDS patients. Government must therefore intensify its support for exploring these alternative remedies by providing the necessary funding for research and trials, and establishing an appropriate intellectual property rights regime to protect traditional knowledge forms from what may be described as "bio-piracy".

5.8 GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV/AIDS

One of the shortcomings of many approaches to the response to the pandemic is the failure to involve persons living with HIV/AIDS actively in campaigns. At the social level, the public involvement of PLWHAs helps reduce stigma and discrimination, and sends a powerful signal to society regarding acceptance and recognition of the importance of PLWHAs.

BOX 5.6: EFFORTS AT HERBAL CURE FOR HIV/AIDS IN GHANA

This account was narrated by myself, Evangelist Robert Kwaku Owusu. Eight members of the Bible Research and Gospel Propaganda Church in Kumasi and I were asked by our spiritual leader, to pray for the revelation of a cure for the AIDS disease. Many plants were revealed to us in our prayers but we waited upon God for the necessary combination of the plants for curative purposes. I got the revelation for the formula for the cure for AIDS which thus made me the leader of the AIDS Team. The Team included 3 junior herbalists and 6 apprentices. We lived in Kumasi and obtained our herbs from Brong Ahafo and Northern Regions. We first went to Atebubu to try the preparation on patients but were rejected by the people.

The team, upon recommendation, went to Sunyani hospital to examine and treat AIDS patients and had to sign an undertaking for responsibility for the patients (6/1/94). We were given 5 patients (women with opportunistic infections, rashes, diarrhoea, boils and discharges) from the Sunyani Hospital. After a period of two weeks, these patients (except one) whose families had neglected them were examined and it was realised that their health had improved. One patient took the medicine for only one week, but died later. The others continued, and are still alive but no longer on medication, and they then claimed it was not HIV/AIDS.

An AIDS Researcher who had heard of the team's work in Sunyani invited me to Akwatia where he was doing research on pregnant women with infections. St. Dominic Hospital first experimented with 35 patients. Thirty of them improved after one week. All symptoms had different herbal formulas.

Since the team's first experience at St. Dominic Hospital, we have had several patients who had tested HIV positive. Some of these patients have died but more than 80% have usually overcome their symptoms, ranging from diarrhoea, weight loss, prolonged fever, persistent cough, disorder, amenorrhoea, oliogomenorrhoea, genital ulceration etc. Currently, the team has 1510 patients from across the length and breath of the country. The team has since 1999 been giving free treatment to patients at the Fevers Unit Korle Bu. The team's services and drugs are provided for free. I collect the herbs myself from the Brong Ahafo and Northern regions and prepare them, whilst the ministry finances my trips.

Personal Communication - African Development Forum, AIDS, The Greatest Challenge, 3-7 December 2000, Addis Ababa Ethiopia.

PLWHAs have an essential role to play in AIDS care and support, and a few have spoken out strongly to present their perspectives on living with HIV. They can be powerful advocates for change, provided they are trained and given appropriate support. Again, seeing them as people

Leading productive lives and speaking out about living with HIV has been an important message of hope for other PLWHAs. It is only when we are able to give the pandemic a human face by more public involvement of persons living with HIV/AIDS, that we can successfully break the chain of HIV/AIDS.

PART THREE
THE WAY FORWARD

CHAPTER SIX
CONFRONTING THE HIV/AIDS CHALLENGE IN GHANA:
RECLAIMING THE FUTURE

CHAPTER SEVEN
CONCLUSION AND POLICY IMPLICATIONS

CHAPTER SIX: CONFRONTING THE HIV/AIDS CHALLENGE IN GHANA: RECLAIMING THE FUTURE

6.0 INTRODUCTION

From the outset, the national response to HIV/AIDS was formulated in collaboration with civil society, community-based groups, non-government organisations and the international community. More recently, religious organisations and traditional authorities have been included. In addition, local authority agencies form part of the overall national response through what is known as the District Response Initiative (DRI). One of the major challenges is how to implement HIV/AIDS campaigns, policies, programmes and strategies to enable Ghana to avoid reaching the crisis point.

Managers of the HIV/AIDS campaign are anxious to see their multi-pronged approach to fighting the disease yield fruit at different levels. For instance, it is hoped that the general trend in sexual networking will tilt towards more conservative precautionary practices, with people consciously reducing numbers of sex partners; more people practicing safe sex and seeking voluntary counselling and testing; and people being more tolerant and sympathetic towards those infected with the disease and those affected by it. Above all, the empowerment of women and girls to enable them protect themselves is critical.

The national response accepts that behavioural change, both at the personal and societal levels, will have to go hand in hand with medical intervention to demonstrate that there is life after infection. But realism is important here, especially the need to drive home the message that in a country that can ill-afford to divert its very limited health budget to the treatment of HIV/AIDS, prevention is smarter than the struggle for a cure!

This chapter examines Ghana's response to HIV/AIDS in relation to the guiding principles, policies, the institutional framework and the strategies and initiatives adopted to date to address the pandemic. The chapter has the following sections:

The National Response Framework

Civil society and private/public sector participation in the national response to HIV/AIDS in Ghana

Partnership with multinational and bilateral agencies

Moving forward the campaign agenda.

SECTION A: THE NATIONAL RESPONSE FRAMEWORK

6.1 POLITICAL SUPPORT AND THE NATIONAL RESPONSE

Government responded promptly to the HIV/AIDS emergency by setting up the National Advisory Committee on AIDS (NACA) in 1985, even before the first official case was recorded in Ghana in 1986. This was followed by a series of initiatives all geared to bringing the spread of the disease under control, as is shown in Box 6.1. This included the preparation of guidelines for sectoral plans, on the basis of which sixteen MDAs have developed strategic plans.

The successful implementation of strategic plans in combating the pandemic depends on massive political support. This is

BOX 6.1: POLICY INITIATIVES AND OTHER SUPPORT FOR THE FIGHT AGAINST HIV/AIDS IN GHANA

EVENTS	DATE
• National Advisory Committee on AIDS (NACA)	1985
• National AIDS Control Programme	1987
• HIV/AIDS/STI Sentinel Systems	1990
• The Constitution of Ghana	1992
• Revised National Population Policy	1994
• Ghana AIDS Commission	2000
• Compassion Campaign	2000
• National HIV/AIDS Strategic Framework	2001-5
• Regional Response Initiative	
• District Response Initiative	
• Sector Plans	
• National Monitoring and Evaluation Plan for HIV/AIDS	2001-5
• Ghana Poverty Reduction Strategy	2002-5
• STI Guidelines for Management	2002
• Guidelines for the Management of Opportunistic Infections and Other Related HIV Diseases	2002
• Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)	2002
• National Guidelines for the Development and Implementation of HIV Voluntary Counselling and Testing	2003
• Promotion of Antiretroviral Therapy	2003
• Revised National Reproductive Health Service Policy and Standards	2004
• National HIV/AIDS/STI Policy	2004

symbolised by the President of the Republic being the Chairman of the Ghana AIDS Commission.

In all respects the state has been the prime mover in developing an enabling context for fighting the HIV/AIDS pandemic. Many see this as the more effective approach to ensure harmonisation of initiatives and maximum use of scarce resources. But this predominance of the state has potential costs. For example, it raises the possibility that non-state actors will feel inhibited from making "controversial" proposals that they suspect will not attract state support. This may deprive the campaign of some of the more innovative ways of dealing with HIV/AIDS. At the moment, associations of PLWHAs have emerged in all regions of Ghana, and several NGOs are working in the area of voluntary counselling and testing, behaviour change and prevention etc., as is discussed later in this chapter. These fora are essential processes to evoking a formidable HIV/AIDS lobby outside the state.

In 1987, the Ministry of Health established the National AIDS/STD Control Programme (NACP) to facilitate programmes geared at the prevention, management and control of the disease (see Box 6.2).

In response to the steady increase in the prevalence rates, and as a further demonstration of political support and commitment, Government established the Ghana AIDS Commission to lead the coordination of the national response to the disease.

BOX 6.2: THE NATIONAL AIDS/STD CONTROL PROGRAMME (NACP)

The National AIDS/STD Control Programme was established in 1987 within the Ministry of Health to implement and coordinate the AIDS response. This was an important acknowledgement by the state that HIV/AIDS was a public health problem. NACP launched a public education programme through the mass media and workshops, to inform the public about the need for safe sex with and without condoms. It is currently part of the Ghana Health Service and is primarily responsible for monitoring care and support as well as prevalence through HIV sentinel surveillance and behavioural surveys.

The HIV Sentinel Surveillance Survey started in 1990 and has been on an annual basis since 1994. The overall objective is to provide HIV prevalence data for planning, monitoring and evaluation of HIV/AIDS prevention and care activities. The system is based on an annual HIV sero-prevalence Survey of selected sentinel sites using an unlinked anonymous method and pregnant women accessing antenatal services as the sentinel population. The prevalence of HIV among pregnant women is said to be a good indicator of the spread of the epidemic in the general population, as the level of HIV infection among pregnant women is similar to that in the general population of men and women aged 15-49 years.

Source: NACP Bulletin, Quarterly Technical Bulletin on HIV/AIDS-STIs in Ghana NACP/GHS. Vol. 1 No. 2, December 2003

Ghana AIDS Commission

The Ghana AIDS Commission (GAC) was inaugurated in September 2000, and was placed directly under the Presidency, to demonstrate the political commitment of the Government and emphasize the importance attached to the disease. The 46-member Commission is made up of the President, the Vice-President, 16 representatives (either the Minister or Deputy Minister) from various Ministries, with the other members representing civil society organizations, faith-based organizations (FBOs), academia, the private sector and the Director General of the Ghana AIDS Commission.

The Commission, as the highest policy-making body on HIV/AIDS, has the mandate to provide leadership in the co-ordination of programmes and activities of stakeholders, with the specific functions of:

- formulating comprehensive national policies and strategies, and establishing programme priorities relating to HIV/AIDS;
- providing high-level advocacy for HIV/AIDS prevention, control care and support;
- providing effective leadership in national planning and co-ordination of support services;
- expanding and co-ordinating the total national response to HIV/AIDS;
- mobilizing and managing resources and monitoring their allocation and utilization;
- fostering linkages among all stakeholders;

  promoting research, information and documentation on HIV/AIDS;
- monitoring and evaluating on-going HIV/AIDS activities for the eventual elimination of the disease.

Additionally, seven Technical Advisory

Committees of the Commission have been constituted. They include the following:

- Steering Committee
- Project Review and Appraisal Committee
- Legal and Ethical Committee
- Prevention and Advocacy Committee
- Care and Support Committee (Incorporating Orphans and Vulnerable Children Committee)
- Resource Mobilization Committee
- Research, Monitoring and Evaluation Committee

The Commission has adopted a multi-sectoral approach and works with relevant ministries, departments and agencies, donor organisations, private sector, CBOs, civil society organisations, academia, etc., to carry out its functions. Under its research programme the Commission has supported studies on orphans and vulnerable children; governance and HIV/AIDS; PLWHA associations and support networks; and home-based care.

6.2 POLICY FRAMEWORK IN GHANA

All parties have come to accept that the fight against HIV/AIDS is a fight for survival and a development challenge. Consequently,

6.3: THE NATIONAL HIV/AIDS STRATEGIC FRAMEWORK (NSF)

The Strategic Framework (2001-2005) provides broad guidelines for sector Ministries, Departments, Agencies, District Assemblies, the Private Sector, Non-Governmental Organisations and Civil Society to evolve specific HIV/AIDS strategic plans and activities to suit their peculiar interests and skills.

The goal of the Strategic Framework is to prevent and mitigate the socio-economic impact of HIV/AIDS on individuals, communities and the nation and has the following objectives:

- To reduce new HIV infections among the 15-49 age-group and other vulnerable groups especially the youth
- To improve service delivery and mitigate the impact of HIV/AIDS on individuals, the family and the communities by the year 2005.
- To reduce individual and societal vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the implementation of the national response.
- To establish a well-managed multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programmes in the country.

The five key intervention areas as embodied within the NSF are:

- Prevention of New Transmission of HIV
- Care and Support for PLWHA
- Creating an Enabling Environment for National Response
- Decentralised implementation Institutional Arrangements
- Research, Monitoring and Evaluation

And the planned outcomes are:

- Incidence of new HIV Infections among the youth and other vulnerable groups reduced by 30 percent by the year 2005
- Condom-use rate of casual sex increased to 60 percent
- Thirty percent (30%) of communities and health facilities with adequate arrangements to care for PLWHA attained by the year 2005
- Necessary laws enacted and enforced on HIV/AIDS
- Necessary institutions established at national, regional, district and community levels

Source: Ghana AIDS Commission, Accra.

the policies that have evolved to deal with the situation have focused on the potential danger of a runaway infection rate, rather than what may seem like the low level of threat facing Ghana at the moment.

As indicated in earlier chapters and in Box 6.1, various policies have been put in place to help reduce the serious threat to national development posed by the slow but steady rises in prevalence rates. Guidelines are continuously being developed and a national HIV/AIDS Strategic Framework is in place (see Box 6.3) to address this problem. For example, by 2004 the tone of the policies shifted more towards care and support and later compassion, compared to earlier initiatives on advocacy and awareness creation.

Decentralised Arrangements for the National Response to HIV/AIDS

While there is a perception that the HIV/AIDS Campaign has been a largely urban-based programme, the spread and level of awareness are evidence that the message has transcended urban boundaries. Efforts have been made to establish a structure for promoting the campaign and for implementing the care and support programmes at the sub-national level through the District Response Initiative. The Ghana AIDS Commission, in consultation with the Ministry of Local Government and Rural Development, has established a multi-sectoral and multi-disciplinary institutional framework (see Figure 6.1) for managing HIV/AIDS at the national, regional and district levels.

Fig.6.1 illustrates the decentralised monitoring and evaluation framework for the national response, which is being coordinated by the Ghana AIDS Commission. At each level, some agencies have been more active than others at implementing their plans due to human capacity and other resource problems.

Ministries/Departments and Agencies

Many MDAs have developed and are implementing sector-specific plans. These include the Ministries of Food and Agriculture; Defence; Interior (Prisons and Police); Education, Youth and Sports; Justice; Communication and Technology; Women and Children's Affairs; Manpower Development and Employment; Local Government and Rural Development; Health; Tourism and Modernisation of the Capital City; Roads and Transport; The Ghana Employers' Association; Trades Union Congress; and the Office of the Head of Civil Service (OHCS). In addition, selected agencies have set up areas of responsibility for HIV/AIDS. These include the National Development Planning Commission; the National Population Council; Ministry of Health and Ghana Health Service; and the National Council on Women and Development.

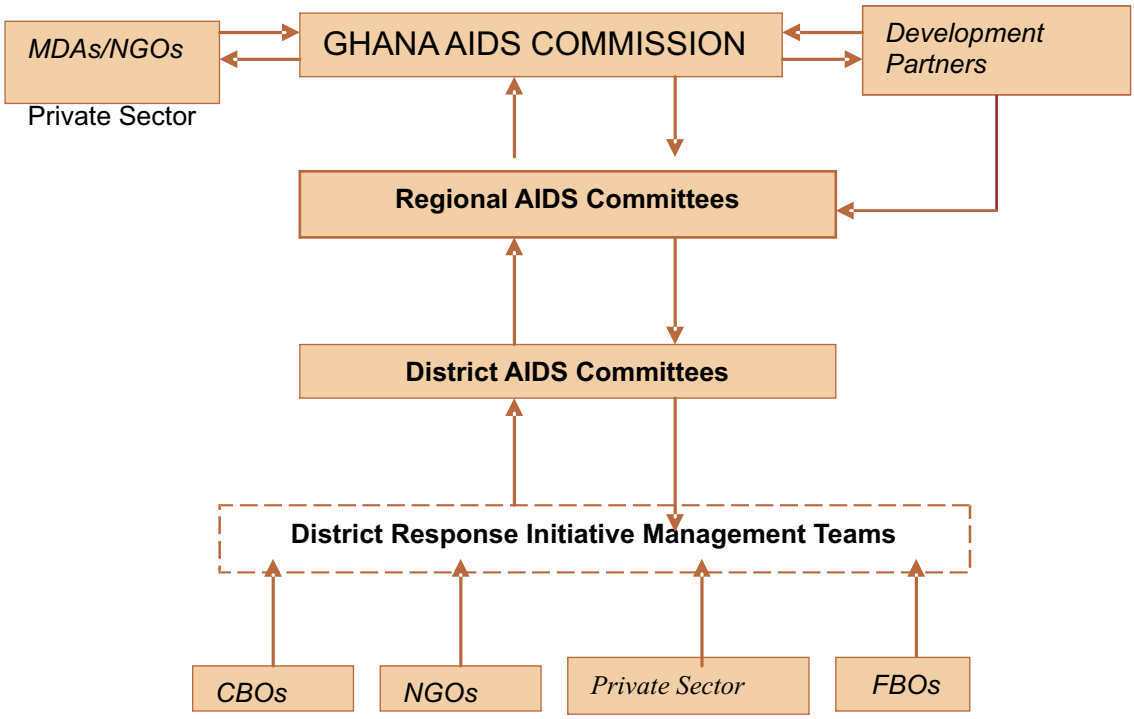
Regional AIDS Committees

Regional AIDS Committees (RACs) exist in each of the 10 regions under the auspices of the Regional Coordinating Councils (RCCs). The committees are chaired by the various Regional Ministers and include key members of the RCC and other stakeholders, including representatives of civil society groups and traditional leaders. Among several assignments, the Regional AIDS Committees are charged with maintaining oversight over local level responses to the epidemic, including district capacity development. Each RAC has a Monitoring and Evaluation focal person, who reports on district activities in relation to the campaign, training, VCT centres, and partner agencies.

District AIDS Committees (DAC); District Response Management Team (DRMT)

District AIDS Committees (DAC) have been formed in 110 districts, and are chaired by the respective

Figure 6.1: Decentralised Monitoring And Evaluation Framework



Source: Ghana AIDS Commission 2002, Annual Report 2002.

Metropolitan/Municipal/District Chief Executives. The Membership includes ministries, departments and agencies, NGOs, FBOs, traditional authorities, youth and women's associations, and people living with HIV/AIDS (PLWHAs). The District AIDS Committees are expected to provide technical assistance and support for local stakeholders, as well as financial and human resources towards the development of HIV/AIDS activities in the community. There is also a monitoring and evaluation focal person in each district. Together with other stakeholders in the district, they review NGO/CBO proposals submitted to the district assembly, prepare monitoring and evaluation plans for HIV/AIDS activities within the district through the selection of appropriate indicators, and monitor and evaluate activities of NGOs, CBOs, FBO, and institutions working on HIV/AIDS related activities in the district. GAC is one of the major funders of HIV/AIDS campaign activities at the district level.

Among the challenges to the effective implementation of District Responses is the attrition rate of monitoring and evaluation focal persons working in the regions and districts. Also, district level budgetary allocations for HIV/AIDS interventions are inadequate. It is necessary to strengthen partnerships at the district level, especially between District AIDS Committees and private sector groups, as well as between District Health Management Teams and Monitoring and Evaluation Focal Persons.

6.3 FUNDING FOR THE GHANA CAMPAIGN

To carry out activities effectively, the Ghana AIDS Commission established the Ghana AIDS Response Fund (GARFUND) with a World Bank/IDA credit facility of US$25 million. The Fund became operational on 8th May 2002. Funds from this are disbursed to MDAs, NGOs, District Assemblies, Regional Co-ordinating Councils and CBOs for HIV/AIDS activities. This has been boosted by a Department for International Development (DfID) grant of 20 million to support GARFUND operations. As at the end of July 2002, a total of $8,650,376.25 had been approved and disbursed to MDAs, NGOs and CBOs for HIV/AIDS projects (GAC, 2003). Budget lines are also provided for all sector Ministries. In addition to this, Parliamentarians are provided with funds to enable them undertake advocacy on HIV/AIDS issues, particularly within their constituencies.

SECTION B: CIVIL SOCIETY AND PRIVATE /PUBLIC SECTOR PARTICIPATION IN HIV/AIDS INITIATIVES

6.4 CIVIL SOCIETY PARTICIPATION

The wide range of non-state interest groups that have joined the campaign has already been acknowledged earlier in this chapter. Besides the NGOs, CBOs, FBOs and traditional authorities, the media has also been an indispensable partner in the campaign. These agencies are active in all the regions in both urban and rural areas, providing services for prevention, care and support, as well as monitoring and evaluation. Table 6.1 summarises some of the main findings of a Rapid Situational Appraisal conducted by GAC on the nature of participation of associations and support networks (ASNs).

The findings of the Rapid Situational Appraisal study corroborate observations of a Beneficiary Assessment study commissioned by GAC to track beneficiaries of its advocacy grants. (GAC, 2004) This shows the lop-sided nature of the Ghana Response in favour of IEC activities. Current efforts to broaden this scope need to be considerably increased to have the necessary impact.

Capacity Building for HIV/AIDS Implementers

Despite their enthusiasm to contribute to the fight to limit the spread of HIV/AIDS, it is evident that many civil society groups do not have the requisite skills to work effectively in this area. The Ghana AIDS Commission has therefore, been engaged in capacity development for over 800 NGOs and CBOs involved in HIV/AIDS related activities. They are taught how to put together proposals to enable them attract funding to support their work. In addition, training has also focused on organisational skills enhancement and information dissemination. This has been done with assistance from the Support for International Partnership against AIDS in Africa (SIPAA) financed by DfID. NGOs specialized in capacity building have been sub-contracted to carry out this task.

The Mass Media Campaign

Mass media (print, television and radio) play a central role in the fight against HIV/AIDS in Ghana. In recent years, campaigning through the mass media has been intensified remarkably, which has contributed to the achievement of the high level of knowledge and awareness on HIV/AIDS. With most of the over 30 radio stations, 4 TV stations and more than 20 newspaper houses countrywide involved in HIV/AIDS education, the mass media have provided hope in the fight against HIV/AIDS. The media has also increased

Table 6.1: Summary Characteristics Of Associations And Support Networks (ASNs)

AREAS OF STUDY	FINDINGS	REMARKS
Location and Representation	All regions have ASNs, but 35% were in Greater Accra (ATMA) Representation of ASNs: International level -22% National level – 46% Regional level – 37% District level – 38% Community level – 31%	Organisations tend to locate near the capital. None of the ASNs had representation at all levels as one structure.
Activities	Activities tended to be area specific Information, Education and Communication (IEC) formed the main activities of ASNs.	Very few ASNs focused on care and support, and mother-to-child-transmission.
Resources	40% of ASNs relied on donors 36% relied on internally generated funds 10% relied on government sources	ASNs are expected to raise most of their sponsorship from private sources.
Target Groups	Main Beneficiaries: 42% youth	Only 7% identified PLWHAs as direct beneficiaries.
Collaboration	51% collaborated with other organisations 49% did not collaborate with any organisation	GAC and local authorities are not always kept informed about activities of ASNs to *reduce the potential for coordination*.
Reporting Mechanism	4% of ASNs confirmed that they submitted reports on their work to supervising authorities or collaborating partners	Collaboration and coordination is greatly hampered by the lack of reporting by the majority of ASNs.
Publications	Types of Publication: 9% prepare Quarterly or Annual Report 8% prepare research reports	Apparent lack of regular publication on activities is bound to retard sharing of experiences on best practices and failed interventions
Achievements	Main Areas of Success: Awareness campaign	The scope of achievement is quite limited to IEC activities.
Constraints	Main Constraints: Lack of funds	

Source: GAC, 2004. Ghana AIDS Commission Annual Report 2002, Accra. Appendix 7, pp 50-51

compassion for people living with the virus, and emphasized the need to adopt non risky lifestyles.

Through radio, ordinary Ghanaians have had the opportunity to raise questions and discuss their own views and beliefs associated with stigma and compassion in radio talk shows. In February 2000, a mass media HIV/AIDS awareness campaign was launched as a result of the initiative led by the Ghana Social Marketing Foundation (GSMF), in partnership with Johns Hopkins University, Ghana AIDS Commission, the Ministry of Information and other stakeholders. The second phase of the campaign started in May 2002 with emphasis on compassion, care and support for PLWHAs. This campaign has no doubt contributed in diverse ways by increasing risk perception, social support and compassion for PLWHAs. It is important to note that there is a clear rural-urban divide in the coverage of media messages, due to the generally low accessibility to media channels in rural areas.

The broad approaches being used by communication channels to augment prevention efforts in the HIV/AIDS campaign include the following:

Radio: Radio talk shows, debates and interviews, as well as drama in English, Hausa, Dagbani, Twi, and Ga have been developed, and these form the backbone of the mass media campaign. The spots are 30-60 seconds in duration. Radio is particularly important in this process as it enjoys the highest patronage of all the media forms in Ghana. Over 70% of Ghanaians listen to the radio at least once a week. It is therefore worrying that patronage of radio is below average in the three northern regions, and among women generally (GSS, 2003).

Television: Next to radio, TV is the most popular form of information dissemination; at least 40% of Ghanaians watch TV once a week, though there are exceptions in the northern regions and in many rural areas (GSS, 2003). Drama skits such as 'Cantata'; music videos such as, Don't Do It, Stop AIDS Love Life, Show Compassion, It Pays To Wait, Say No to Casual Sex; infomercials such as ' Protect yourselves' (for the hearing impaired) and films such as The Scare, the Joris Wartenberg series, Angels etc., are also shown on TV. Discussion programmes such as Talking Point and Adult Education in 5 major local languages on GTV, Agenda, have also been used to reach the literate urban population as well as community and national leaders. Various NGOs are using "Theatre for Development" to reach out to rural communities.

Print Media: Articles and full-page insertions are used occasionally in the various newspapers to reinforce the messages heard or seen on TV. Additionally, billboards, posters and fliers, magazines and newsletters have been used to augment messages. Newspapers do not appear to be central to the HIV/AIDS campaign due to the very low readership that has been observed. Only about 12% of women and 28% of men in the country read a newspaper at least once a week (GSS, 2003).

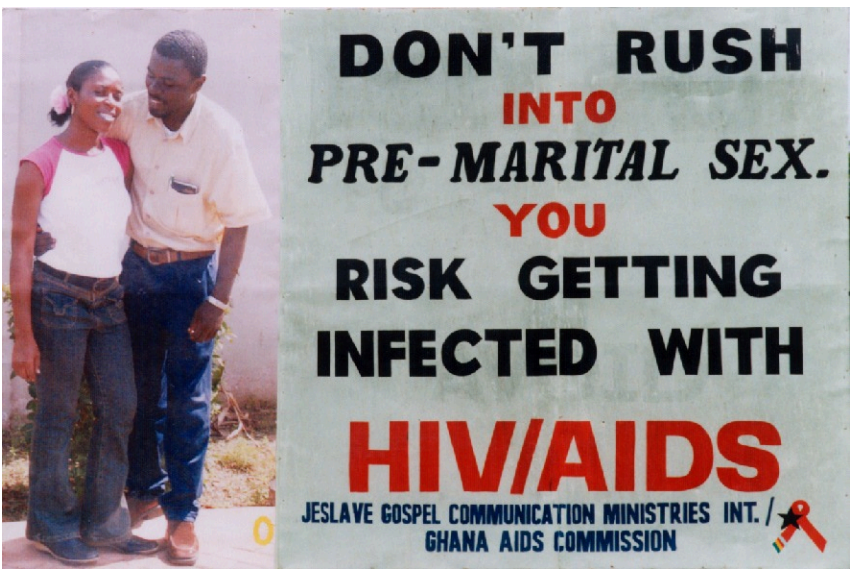
Whilst the mass media have been instrumental in creating very high HIV/AIDS awareness levels, the challenge remains that of getting the desired behaviour change that would bring down infection rates. There is an urgent need for the mass media to re-package and refocus their campaign, and to develop a *sustained* approach to delivering messages on HIV/AIDS. As a large number of media inputs are sponsored, there is a risk of

stoppage when sponsorship packages cease. However, this effect could be less if media houses would, from their own resources commit themselves to providing some specific period of free airtime to support the HIV/AIDS campaign. Increased use of local languages in media messages, especially on radio and TV would greatly enhance the reach of the campaign.

One significant area of challenge is the difficulty in getting people to believe that healthy looking persons could be carriers of the virus. This is the result of early campaign efforts that overemphasised the symptoms of AIDS rather than the worrisome non-symptomatic nature of HIV. This has hindered appreciation of risk taking behaviours and has kept infection rates growing. The challenge now calls for an effective media campaign that would get people to review their thinking on the nature of the disease.

Religious Bodies and Faith-Based Organisations Initiatives

Religious bodies and faith-based organisations are beginning to play a major role in helping society to change negative attitudes towards PLWHAs. Ordinarily, FBOs would be expected to champion the cause to win compassion for PLWHAs. Religious bodies have good structures for effective education because they are easy to mobilize, their leaders elicit high compliance to directives and they have the capacity to sustain activities.



However, opposition to condom use created conflicts over morality which until recently held back many FBOs from fully endorsing the compassion campaign. The dilemma is that even though religious authorities would concede that not all their members could be leading "holy lives", they still have difficulty endorsing the use of condoms. Box 6.4 below exemplifies the condom challenge.

Today, however, religious leaders are increasingly embracing Ghana's national response. They have integrated HIV/AIDS campaigning into their mainstream activities and have begun to provide effective guidance and counselling to PLWHAs. Some have even established HIV/AIDS Committees to promote their work. Since 1992, the Planned Parenthood Association of Ghana (PPAG) has sought to build the capacity of religious bodies and faith-based organisations towards HIV/AIDS related educational campaigns and support services at national and lower downstream levels of government. Sermons and out-reach programmes that include supportive HIV/AIDS messages are apparently becoming more common. Religious authorities, however, have reservations about a national response to HIV/AIDS that encourages a compassion campaign but restrains faith-based organisations from emphasising moral uprightness in the fight.

BOX 6.4: SOME RELIGIOUS LEADERS' VIEWS ON CONDOM USE

"How can I ask my members to use condoms? For what activities would I be asking them to use the condoms? Is it not sex outside marriage, which we strongly speak against? If we ask them to use condoms, are we not invariably giving encouragement and approval to the behaviour for which the condom is to be used? Knowing that some of our members engage in illicit sex is one problem, asking them to use condom is another."

- ***Recorded from a conversation with a Religious Leader***

"It is our duty to say that there are better means than the condom to protect oneself against AIDS conjugal fidelity, that fact of having only one partner, to respect him/her, the fact of learning to be capable of expressing true love. We are in favour of the means that respect human dignity and honour the society. We therefore refuse, given our mission, to enter that logic according to which, the immediate answer to the dramatic question about AIDS is the condom."

- ***Catholic Bishops of Chad, 2002***

PLWHA Associations

In an effort to ensure group solidarity and support, and also to have a common mouthpiece on matters that affect their interest, PLWHAs have formed associations. A total of thirty-one PLWHA associations and support networks have been identified nationwide; most of them were established by NGOs and faith-based organisations. Over 80% of them are located in urban centres. It appears members generally conceal their membership in order to avoid stigmatisation. Consequently, very few community members are aware of the existence of the associations in their communities.[43] Among the best-known is the Wisdom Association, formed in 1997 and located at the Fevers Unit of the Korle Bu Teaching Hospital, Accra. Recently, the Women United Against AIDS in Ghana (WUAAG) has also been formed in Accra. Both Associations are promoting the formation of branches in other regions of Ghana.

The Wisdom Association (WA), with a membership of 600 (350 active) has been quite active in educational campaign efforts in collaboration with the Ghana AIDS Commission and several other organisations. Their contribution has been to present real life situations that hopefully could stimulate behaviour change. The Association has trained 60 members who participate, on request, in church, school and community advocacy and education programmes. Other key activities have been the provision of care and support through payment of medical bills and provision of food ration for members. The Wisdom Association has also been involved in income-generating activities such as batik and bead-making and poultry rearing to raise funds for its activities and to offer employment to some members. Another major activity of the Association has been an internal programme named "positive living", in which members are sensitised

[43] JSA Consultants. Paper presented at National AIDS Research Conference, La Palm Royal Beach Hotel, Accra. 11-13 February 2004.

and prepared to accept their condition and to live with it.

The activities of WUAAG and WA have been supported with funding from the Ghana AIDS Commission. The Wisdom Association has also received support from an NGO - World Education - for capacity building and technical assistance for the acquisition of computers and photocopying machines and other IT accessories.

PLWHA associations face significant problems. First, they seem to depend on handouts of drugs and food, the periodic absence of which creates disinterest and threatens their survival. Second, despite good efforts aimed at forging positive living, several members are reported to be living lives of despair, reinforced by the deep-seated feeling of stigmatisation they experience. Due to stigma, members still wish to operate in anonymity and frequently participate in advocacy programmes in regions other than where they live.

6.5 SEX AND HIV/AIDS: A MORAL QUESTION?

As clearly spelt out in Chapter Three, HIV/AIDS does not affect only the physical condition; it also affects the social being and relations between people, and invariably, puts people in a condition of socially defined impurity. One major reason for this is the perception that HIV/AIDS is acquired through promiscuous sexual behaviour, marking persons living with it as morally bankrupt. The disease, therefore, carries with it many of the stigmatising and negative moral associations of a sexually transmitted disease.

Following from this discriminatory social environment against PLWHAs everywhere in the world, HIV/AIDS tends to weaken social relationships and interaction between PLWHAs and even members of their families and communities. Indeed, some people withdraw physically or emotionally from relations who are infected, because they do not want to be associated with the shame brought by a supposedly immoral relative.

The often assumed strong African traditions of kinship and good neighbourliness do not seem to hold under the force of perceived immorality associated with HIV/AIDS infected persons. In some parts of the country, PLWHAs have been removed from public view so as not to endanger the chances of other members of the family getting marriage suitors. Cases of abandonment of PLWHAs in hospitals by members of their families, once their sero-positive status became known, have also been reported. Anecdotal evidence suggests that those who have been kept at home have been isolated from the rest of the family and been given separate drinking cups, plates and bedding. At a general level, nearly 70% of Ghanaians say that they are willing to care for PLWHAs at home, but only about 9% of women and 15% of men expressed an accepting attitude towards PLWHAs on all the four variables studied in the GDHS 2003. (GSS, 2003) Box 6.5 reports views and concerns as expressed by the community and PLWHAs.

The perceptions and attitudes expressed in Box 6.5 permeate the entire Ghanaian society and are so strong that persons who contract the disease dare not disclose their status. A study in Ghana showed that out of 101 persons living with HIV/AIDS who were surveyed; only 9% had made their status known to others. (Appiah and Afranie (2000)

The strong association that the general public makes between HIV transmission and sex makes it difficult to get in the message that there are non-sexual modes

of transmission. This is not surprising, given that 80% of transmission in Ghana is through heterosexual sex. But the campaign managers fear that this over focusing on sexual transmission may lead people to be negligent about transmission through blood products. Then there are those who contracted the disease in spite of leading apparently chaste lives. For instance, an unfaithful married partner who can contract the disease outside marriage can infect his/her faithful partner. Infection

BOX 6.5: VIEWS AND CONCERNS AS EXPRESSED BY THE COMMUNITY AND PLWHAs

HIV/AIDS Aetiology in Akan with Literal translation

"Adwamanmmo Yadee"	-	Disease that is contracted through Promiscuity
"Animguasesee/Feree/ Aniwuo Yadee"	-	Disgraceful/Shameful Disease
"Yare Bone" or "koankro"	-	Bad Disease, deadly and incurable
"Mogya mu yadee"	-	Blood related disease
"Panin Bone/Panin dwamanfo"	-	Elderly person who contracts HIV/AIDS: Bad Adult/Promiscuous adult

Some Concerns expressed by PLWHAs

- My brothers spend a lot on me anytime I fall sick and this happens often. If they should know that I have the disease, they will never spend on me again.
- I have a particular aunt. If she hears that I have the disease, I believe she will even poison me.
- All my relatives are worried that I fall sick often and they all try to help. But if they realize that I have the disease, their empathy will turn to scorn.
- My mother is sitting right behind this window. She is the one who is supporting me at this hospital whilst I am on admission. As at now she does not know that I have tested positive. Please tone down your voice because if she hears someone interviewing me, she would become suspicious and start questioning me. The moment she hears I have the disease she would abandon me.

(Appiah and Afranie 2000)

Community Perceptions and Attitudes towards PLWHAs

- Persons who get the disease are immoral, promiscuous and a disgrace to their families and communities.
- The sex of the person who contracts AIDS does not matter, they are all unacceptable they all get it through sexual immorality.
- Anyone who gets AIDS becomes dangerous and must be feared.
- People who have AIDS are living but dead

Community views on why PLWHAs would not want to disclose their sero-positive Status

- PLWHAs are afraid they would be tagged immoral.
- AIDS is a shameful and bad disease to disclose.
- PLWHAs know they will be socially isolated if they disclose their status.

(Appiah and Afranie, 2002)

could also have occurred before marriage, so that there is no act of marital infidelity on either side. The statement below shows a vivid example of passive infection:

"I never had sex and stayed a virgin until I married. I married someone I knew very well in my church an energetic, handsome and up and doing man. Unknown to both of us, he had the virus and ended up infecting me after we were married. He died two years after our marriage and one year after I gave birth. My child too has tested positive".
(A PLWHA's account of how she got infected: Appiah and Afranie, 2000)

In all the circumstances, the challenge thrown to religion is not just about admonition, but also about promotion of positive change. A return to religious sexual codes of conduct has become the theme of some of the civil society groups that are trying to save the youth from infection. In Ghana, Virgin Clubs are springing up in various places to encourage young people to remain chaste until marriage. This initiative has however been quite lop-sided in targeting. Most of the members of Virgin Clubs are girls rather than a mixture of boys and girls.

SECTION C: PARTNERSHIP WITH MULTINATIONAL AND BILATERAL AGENCIES

Ghana has actively participated in the global debate about HIV/AIDS and has been directly influenced by the policies that have evolved from this process. As a result, HIV/AIDS activities in Ghana have benefited considerably from international technical co-operation and funding. As noted in section 6.3, Ghana has benefited from the GARFUND. A collaborative project with ACTIONAID on Support to the International Partnership against AIDS in Africa (SIPAA) is being executed with the technical collaboration of UNAIDS and is funded by DfID with the sum of 2 million.

In 2002, the UNDP sponsored the recruitment of consultants to assist in the country's resource mobilisation exercise. Internally, funding, technical and co-operative assistance has come from Barclays Bank Ghana Ltd., Coca Cola AIDS Foundation, Coca Cola Bottling Plant Ghana Ltd., DANIDA, GTZ, USAID and DfID. Through collaboration between GAC and MOH, $15million was accessed from the Global Fund to fight AIDS, Tuberculosis and Malaria control programmes, part of which was used to purchase antiretroviral drugs for 2000 patients and to upscale voluntary counselling and testing.

SECTION D: MOVING FORWARD THE CAMPAIGN AGENDA

Leadership

The point has been made several times and at various stock-taking gatherings that the only way to galvanise a nation into action about HIV/AIDS is to have in place a strong broad-based leadership strategy. Ghana subscribes to this view and has endeavoured to follow some of the best practices in Africa and elsewhere. To this end, comprehensive institutional arrangements for implementation, coordination, monitoring and evaluation of activities in the country have been established, as indicated earlier in this chapter. In addition, a clearly laid out policy environment that provides a framework for specific HIV/AIDS policies and implementation of activities by various stakeholders has been created. Enthusiasm for all these initiatives seems very high among stakeholders and this provides the impetus for further activities. NGOs, CBOs, public and private sectors, FBOs and several civil society organisations as well as donors have demonstrated their readiness to join in the fight against the spread of the disease. Such willingness has translated into capacity

We need to appreciate though that we cannot run away from foreign support for quite a while. Indeed the national recurrent budget itself is deeply supported by donors. Secondly the world is together in the fight against the disease and countries need to support each other.

- Prof. F. T Sai, Presidential Advisor on HIV/AIDS

building and massive initiatives in key intervention areas in virtually all parts of the country. Despite all these efforts and the obvious high awareness levels, however, behaviour change has been relatively limited.

Leaders of the campaign are caught in a debate about the missing pieces. Taking into account the experience of those countries that have successfully held off an epidemic, perhaps where the national strategy falls short is in the area of mass leadership - in families, communities and at workplaces - to assure people of support and that it is alright to undergo VCT, to practice safe sex, and to seek treatment when infected. Openness about HIV/AIDS that rests on strong supportive leadership can create an appropriate platform from which activism for behaviour change can be intensified.

In another sense there is a leadership vacuum in Ghana that must be addressed. This is in relation to the pursuit of global goods and services to deal with the looming epidemic in Ghana. Unlike other developing countries, Ghana has been relatively silent in the activist struggles with transnational pharmaceutical companies for the right to produce generic drugs to combat the disease.

Streamlining the Campaign Agenda

The Ghana campaign, like others across the globe, has identified as its priority areas prevention, care, reduction of stigma, and decentralised HIV/AIDS management, coordination and treatment. While everyone is more or less aware of these intentions, it is perhaps not so clear to the various interest groups what difference they could each make to the process, or indeed how essential it is that they contribute to it. The compassion campaign is generally founded on this theme, but probably does not go far enough to establish how, as individuals, groups and agencies, they can contribute to the success of the total programme. At this stage in the Ghana Response, linkages between different priorities should be unfolding more clearly. This can be achieved by designing messages that are tailored to achieve this purpose. For example, a lot of the effort that is going on is ultimately expected to affect vulnerabilities of people infected with and those affected by HIV/AIDS, as well as the vulnerability of the general public. It is time to direct some more effort to the specific issue of HIV/AIDS and vulnerability, with particular reference to gender, age, the role of concealment of status and stigma in the spread of the disease, etc.

There are also concerns about the balance between prevention and treatment, bearing in mind that the state, which is currently sponsoring subsidised treatment, is not in a position to extend this to all those who need it - it is suggested that, owing to scarcity of resources, less than 10% of those who need subsidised treatment will get it. In this context, it is fair to argue that Ghanaians cannot relent on the prevention effort because of treatment possibilities. On the question of treatment, medical treatment (specifically the use of ARVs) is being upscaled alongside other key treatment enhancing activities such as psychosocial support, herbal treatment, STIs and TB prevention and cure; and nutrition information and support for PLWHAs.

Capacity Development for Management and Activism

Considerable training has been going on in Ghana to increase the capacity of various professionals in public and private institutions to do HIV/AIDS work. Through awareness campaigns ordinary Ghanaians are acquiring greater capacity for coping with the disease as a result of additional knowledge about the limits on sexual activity imposed by HIV/AIDS. But Chapter

Five makes it quite clear that Ghana simply does not have all the medical, paramedical and other professionals required to mount a comprehensive onslaught on HIV/AIDS. In addition, Ghana's response initiatives are characterised by a number of challenges. For instance, information gathering, documentation and dissemination are still inadequate, such that meaningful assessment and evaluation of progress is difficult. For example, coordination and monitoring of the activities of CBOs, NGOs, DAs and other initiatives are weak, making difficult the critical evaluation of activities, especially those funded under the GARFUND.

The Ghana AIDS Commission seems understaffed, which is likely to hamper its efforts at coordination. Furthermore, the District Assemblies that are at the heart of the decentralised arrangements for HIV/AIDS activities do not have the requisite staff. Programme implementation, monitoring and evaluation and report preparation have, therefore, been affected. Ministries, Departments and Agencies (MDAs) are required to provide 5% mandatory counterpart funding for HIV/AIDS activities under the GARFUND arrangements. Implementation of workplace HIV/AIDS programmes have delayed as a result of failure of many MDAs to raise the 5% required.

Although the HIV/AIDS epidemic has not reached its high proportions experienced in Southern Africa, with the current prevalence rate, Ghanaians cannot be complacent. Reports that the number of surveillance sites with prevalence rates above 5% has increased to eight give little comfort. HIV/AIDS activities have been largely funded through external donor support. How to generate sufficient internal funding for activities provides a remarkable challenge. There are various ways in which the country can lose the momentum in the pursuit of this agenda, for example, by failing to mobilise adequate resources to continue the education, VCT and treatment campaign; shying away from the controversies surrounding condom use, or by failing to scale-up initiatives to popularise VCT and treatment. Social action in support of treatment for PLWHAs, as well as the mainstreaming of policy instruments to protect the rights of such people are all waiting for more vigorous prosecution.

Stigmatisation of HIV/AIDS and persons living with it does not permit infected persons to disclose their status. Worse still, anonymity of PLWHAs poses a serious threat to efforts to control the spread of the disease.

CHAPTER SEVEN: CONCLUSION AND POLICY IMPLICATIONS

CONCLUSION

Ghana has sustained her interest in creating an enabling environment to promote development, both by supporting growth-related initiatives and by promoting social justice. In this, she is in tune with major global initiatives to achieve equity-based development, while recognizing and supporting the private sector. The 1992 Constitution lays a firm foundation for a development agenda that is sensitive to the ideals of human development, expanding people's choices to live meaningful and rewarding lives as individuals and groups. Ghana's Human Development Index has improved from 0.556 in 2000 to 0.568 in 2004, even as her ranking has declined from HDI 129 in 2000 to 131in 2004. A further negative sign is the downward revision of the estimated life expectancy from 60.4 to 57.8 between 2003 and 2004.

The Ghana Human Development Report 2004 has analysed the implications of HIV/AIDS for progress and survival in Ghana. It is acknowledged that HIV/AIDS poses a unique threat to the country as it does to the whole of humanity. The Report characterises this challenge as one of bondage - a state of being held in chains. To overcome it therefore, involves breaking the chains.

Chapter One lays a brief sketch of the global as well as local crises of the HIV/AIDS pandemic. The peculiar situation facing Ghanaians is that while prevalence rates (3.6%) are relatively low by international standards, they are close enough to the breaking point (5%) in the spread of the disease to cause serious concern. Particularly worrying is the realisation that a growing number of places in Ghana already have prevalence rates exceeding 5%. Relatively low average rates appear to breed complacency and hold back acceptance of the looming threat among a large segment of the population.

Areas of development activity that have been recognized as key to achieving expanded development, namely education, health and livelihoods have continued to be the focus of much attention since the 2000 Ghana Human Development Report was launched. In collaboration with development partners, including development-oriented non-government organizations and other civil society groups, several new initiatives have been pursued to improve people's capacities in these areas, particularly among the poor. Some of these programmes are discussed in Chapter Two in addition to a section on the profile of HIV/AIDS in Ghana.

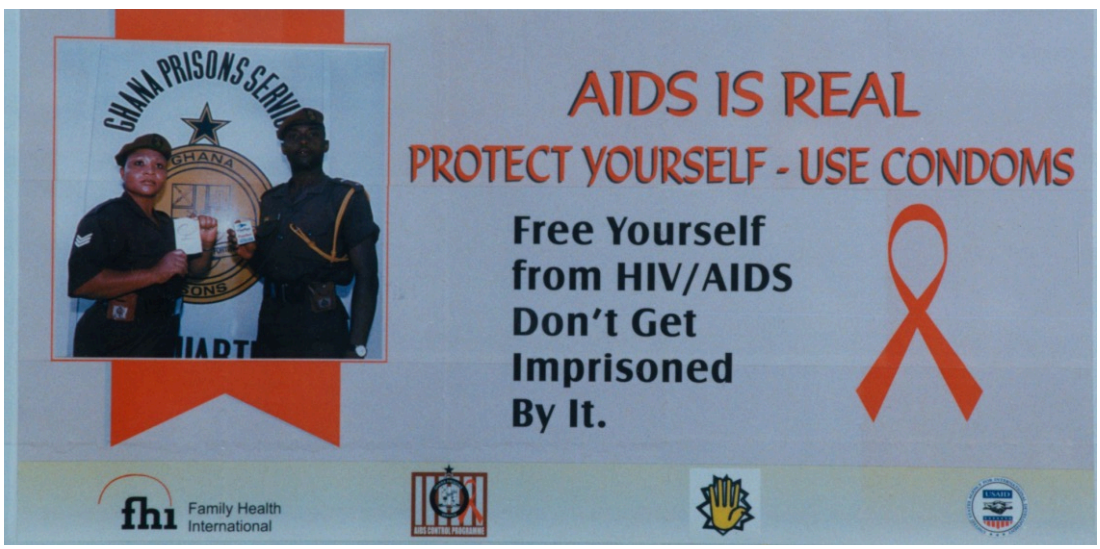
Many pilot projects have been launched in the education sector for a variety of objectives, though the main focus is on quality improvement. The record shows that the outcomes of education, particularly in the public sector, have been well below expectation, except in the rehabilitation and provision of new infrastructure, areas in which Government has traditionally been strong. Such fundamental capacity development constraints cast doubts about the overall goal of transforming the national economy into a knowledge-based economy of middle-income status in the short to medium term. At this rate, Ghana is unlikely to meet the key MDGs. Another feature that stands out is the apparent lack of replication of pilot projects, even where it is demonstrated that they offer superior methods and systems, compared to existing ones.

With specific reference to HIV/AIDS, the formal education system offers opportunities for sensitising young people to adopt protective sexual behaviour habits. The School Health Education Programme (SHEP) and similar initiatives have already provided entry points for introducing pupils and older students to HIV/AIDS. Lack of material and other support for these types of programmes, however, is bound to limit their effectiveness as channels of sex education.

Health infrastructure has benefited from increased support over the past four years. Yet chronic problems of poor equipment and generally poor working conditions persist. From all indications, the health status of Ghanaians has largely stagnated or in certain respects declined somewhat since 2000. This is based on the simple fact that health conditions of children under five years has not improved appreciably, with nearly 30% of children suffering from stunting or being underweight. In addition, all the evidence suggests that the consumption of micronutrients is relatively inadequate, and anaemia is prevalent among women and children. Poor nutritional status holds grave implications for fighting HIV/AIDS, posing major problems for PLWHAs, as they lose their means of livelihoods and support. In addition, links between nutrition and learning outcomes are not being adequately addressed.

Without doubt the biggest challenge facing the campaign against HIV/AIDS is how to overcome it in a way that leaves intact the rights of those infected and those affected as well as the society at large. The compassion campaign has helped to draw attention to the rights of PLWHAs. More concretely, the challenge is about what strategies to adopt to accelerate the pace of behaviour change.

A level of tension can be observed in the direction that the AIDS Campaign has taken in recent times. To a certain extent the need to achieve acceptance of PLWHAs now seems to overshadow the drive to make people adopt precautionary behaviour. The



ideal situation would be one in which people are challenged by the information they receive from the media and other places, to be concerned about both self-preservation and the harm they may cause to others by their behaviour.

Though some categories of behaviour are characterized as high risk, experience shows that it would be highly dangerous to limit the risk factor to only selected social groups. This is because of the risk-prone lifestyles found generally in the population, e.g. early start to sex and multiple sexual networking. The social challenges actually go beyond lifestyles. It is also linked to poverty and gender which worsen the plight of PLWHAs and their families, and also aggravates the vulnerability of women and children as discussed in Chapter Three.

On the issue of workplace programmes for addressing the potential work-related aspects of HIV/AIDS, Chapter Four indicates that most firms are yet to start or have only just begun to look at the potential impact of the disease on their operations. Employers and workers both have a major hurdle to overcome in accepting PLWHAs as co-workers. It is also necessary to resolve ethical conflicts over whether to spend the firm's resources to extend the contributions of PLWHAs to the organisation, and in the process prolong their lives.

The decision of the Government of Ghana to introduce highly subsidized antiretroviral drugs is a major step forward. However, even with the best intentions, this and other programmes for PLWHAs, and others interested in voluntary counselling and testing (VCT) cannot be given wide coverage for a number of reasons, including: human capacity limitations within the health service and allied services (counsellors); serious funding and infrastructure shortfalls. Of particular importance is the need for innovative schemes to stem the brain drain of medical personnel. Chapter Five highlights the difficulty of popularising voluntary counselling and testing (VCT) among the general population. The obvious danger here is that, without knowing their status people will not be able to protect themselves and others. Every means must be found to increase the rate of VCT as a matter of urgency. Steps should be taken to correct the view point that disclosure of HIV status is the responsibility of those infected alone rather than an obligation on everyone.

It is gratifying to note the relatively high level of cooperation in addressing HIV/AIDS in Ghana as shown in chapter 6. Unlike the situation about ten years ago, it is clear that all the major stakeholders are now involved in the awareness and compassion campaign, which explains the near 100% awareness in the country. The international community has made important contributions in this process; besides funding there has also been technical assistance to augment local expertise in dealing with the situation. There are, however, areas in which more private efforts could make a big difference. Instances include the provision of support for PLWHAs, orphans and civil society groups, as well as intervention in VCT and treatment programmes.

POLICY IMPLICATIONS

The major issue emerging from the analysis of socio-economic impacts of HIV/AIDS on human development in Ghana remains how to meet the threat - how to break the chain. Research and experience suggest a number of ways in which the campaign should generally be modified in order to

extend its benefits. While these observations are not necessarily new, their importance lies in the call for an intensification of ongoing strategies. They may be summarized as follows:

- Given that all institutions and activities in the country are bound to suffer from the human capacity loss associated with HIV/AIDS, the campaign should become more mainstreamed into all aspects of human development in Ghana
- The scope of the campaign should be multi-faceted to ensure that all aspects of dealing with the management of the disease are tackled simultaneously
- The agencies in charge of managing the campaign should seek more home-grown solutions to achieve behaviour change
- Decentralized agencies should be given greater technical and material support to be able to develop and sustain more regular campaigns and monitoring at the grass roots
- District assemblies should be required to devote more of the health budget from the District Assemblies Common Fund (DACF) to fighting the spread of
- the disease.
  Effort should be devoted to empowering foot soldiers for the campaign to make the community-based efforts more
- effective
  With the flight of health workers at a critical time such as now, donors should rethink their reluctance to fund
- recurrent costs (e.g. salary top ups)!
  More GAC funds should be allocated to NGOs committed to community-based care to increase family and community ownership of this initiative.

Following are specific issues linked to the various sub-themes addressed in this 2004 Report.

Human Development should be given more intense support.

- Support to girls, with such measures as scholarships and food rations should be expanded on a wider scale around the country, as this has been shown to improve enrolment and retention in school. Boys in selected troubled spots should be given similar assistance.
- Urgent attention should be given to best practices from pilot project in basic education such as QUIPS which have demonstrated that it is possible to improve quality significantly in the public school system by applying new and more rigorous management techniques to the school environment.
- Improving nutritional levels of children must be addressed as part of a strategy to improve not only their physical well-being, but also their learning ability and their future capabilities.

Dealing with the Social and Ethical Challenges

- The HIV/AIDS campaign has to devise more persuasive messages to encourage people to make far-sighted decisions about safe sex, especially as it moves to address younger children seen to be the window of hope.
- To counteract the deepening complacency, issues of prevention, care and compassion should be pursued simultaneously at all times.
- The general public should be made aware of the existence of high prevalence rates in particular parts of the country to help dispel the notion that Ghana is safe from the pandemic.
- It is important to emphasise to the public that awareness by itself is no protection against infection unless behaviour change occurs.

Economic Challenges

For Ghanaian society to safeguard its labour force, it is imperative that the government maintains an active interest in the provision of care and treatment to PLWHAs, and that business organisations prepare support mechanisms to help PLWHAs get treatment so that they may continue to contribute to their organizations.

New schemes will have to be designed to accommodate alternative employment arrangements such as time-share to enable skilled labour work reduced hours when incapacitated by HIV/AIDS, while at the same time, making it possible for such people to contribute to the families.

The Health Care Response

Given the shortage of medical and paramedical personnel, more attention should be devoted to training non-health personnel to perform some of the psychosocial services that will have to be expanded as the demand for counselling and testing increases.

Public health education about associated illnesses, including opportunistic infections such as TB, should be intensified.

A hygiene and sanitation campaign should be incorporated in the HIV/AIDS campaign to counteract the spread of TB and other opportunistic infections.

Reclaiming The Future

By all indications, the success of the HIV/AIDS Campaign can only be won through cooperation and collaboration between stakeholders from all sides of the table. Certain basic features of such a state of affairs may be described as follows:

- All public agencies should share a common understanding and adoption of common goals for directing the HIV/AIDS Campaign to reduce tension, conflict and waste.
- Greater efforts should be made to arrive at shared goals with non-state agencies that may be bound by their own philosophies to move the Campaign in directions that may conflict with the general GAC-sponsored framework.
- There should be support for innovativeness and experimentation within the broad framework to allow people to pursue alternative strategies for managing the disease.
- Religious organisations and activist groups should be encouraged not only to counsel the public about reaching out and compassion, but also to open up debates about lifestyle, self-preservation and obligation which obviously play a role in the spread of the disease.
- District Assemblies should work more closely with Parliamentarians and assembly members as well as civil society groups to deepen local HIV/AIDS initiatives.
- Accelerating growth is essential to changing the pace of human development. This is directly linked to getting the human fundamentals right - direct intervention in basic education and basic health (nutrition and morbidity) resulting in wellness to boost productivity. Uncontrolled HIV/AIDS makes these aspirations all seem the more difficult to achieve.
- Finally, to fully articulate the way forward and reclaim the future, a strong case is made for volunteerism in Ghana. The UN Volunteers Programme (UNV) in Ghana has a good pedigree in grassroots and community interventions. At short notice, the Programme can draw from its enormous experienced but cost-effective human resource base to assist in the areas of advocacy, monitoring, evaluation and reporting on the pandemic. Providing care and support to PLWHAs at community level will

require extensive hands-on field Interventions. The UN Volunteers come in handy to complement the activities of both state and non-state actors.

UPDATE FROM THE 2004 HIV SENTINEL SURVEY IN GHANA

The HIV/AIDS epidemic has not only been a public health challenge but also a major challenge to the socio-economic development of many countries, including Ghana which had a median prevalence rate of 3.6% in 2003. This translates into 392,000 HIV/AIDS infected persons as at the end of 2003.

As at the time of printing of this report, the Ghana Health Service which is responsible for providing strategic information for monitoring the trends of the HIV/AIDS epidemic and for planning and monitoring the national response had released the 2004 HIV Sentinel Survey Report - the 13th round to be conducted in the country since 1990. Highlights of this report are given below:

Sentinel sites have been established in all regions and presently each region has a minimum of three sites with at least one rural site. A total of 35 sites were involved in the 2004 survey and the HIV sentinel survey was successfully conducted in all but the Dangme East (rural) antenatal clinic site and the STI Clinic site in Kumasi. (2004 Report)

The results show HIV site prevalence ranging from 0.4 percent to 7.4 percent with a median prevalence of 3.1 percent down from 3.6% in 2003. The reduction in overall median prevalence was achieved on the basis of reduction in prevalence in 14 sentinel sites including Agormanya, Eikwe, Cape Coast and Kumasi. One site, Nadowli (rural) maintained its prevalence for last year while other 14 sites recorded increases over last year's prevalence. Six sites had prevalence of 5% or more. Among these was one rural site (Fanteakwa, 6.8%) The number of sites with HIV prevalence above 5% reduced from 8 in 2003 to 6 in 2004 survey.

The 3.1% prevalence results recorded for 2004 does not necessarily represent an overall decline of HIV infection in the country although it may be the earliest sign of an epidemic slow down. Although most sites recorded either a decline or a lower level of increase compared to 2003, the mean prevalence of all sites in the last 5 years (2000 to 2004) is 3.5%.

Mean regional HIV prevalence ranged from 1.7% in the Upper West region to 6.5% in the Eastern Region. (See Annex A Table 8) HIV prevalence for the rural and urban sentinel sites were median (2.8% and 3.6%) and mean (3.4% and 3.7%) respectively.

Comparing the results of the HIV sentinel surveys done over the previous years, that of the 2004 survey points to a slowing epidemic with challenges in specific age groups and geographical locations. It is worth noting however that on the average for the last five years, no site recorded prevalence below 1%. The 5-year average prevalence also indicate that only 4 sites have had prevalence above 5% while 13 sites had prevalence between 3% to 3.9%. In 2003, there were 8 sentinel sites, where HIV prevalence was more than 5% whilst in 2004 these sites reduced to 6 out of which one was a rural site. The slight upward movement of prevalence in the 15 to 19 and 25 to 29 years age group should be an issue of concern as it may indicate very little impact has been made in those two age groups. Since 2001 when the UNGASS declared the 15 to 24 years age group for special consideration, Ghana has seen a consecutive decline in this age group in three years which gives some hope.

The decrease in HIV prevalence in 14 sites most likely is responsible for the overall decline in prevalence. There is the need to increase the number of rural sites to have a fair balance of rural-urban sites for improved analysis. The need for behavioural surveillance at this stage of monitoring the HIV epidemic cannot be over emphasized. Key target groups should include the youth, sex workers and adults living around the sentinel sites.

HIV/AIDS analysts suggest that a consistent decline in prevalence over a three-year period is required before one can convincingly say that a decline is taking place. The decline in the HIV prevalence observed this year should be seen as an opportunity to intensify interventions within appropriate age groups and geographical locations. If Ghana can find the resources and commitment to implement the policy recommendations of the Ghana Human Development Report 2004, it would be moving in the right direction in attaining this goal.

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ANNEXES

GHANA HUMAN DEVELOPMENT REPORT, 2004

The Ghana Human Development Report (2004) has three annexes including, Annex A, which presents information on the statistics of human development indicators; Annex B, which presents the findings of a survey by ISSER on people's knowledge and familiarity with HIV/AIDS sickness and death and Annex C, which presents annotated bibliography of HIV/AIDS-related research in Ghana.

A: STATISTICAL INFORMATION ON HUMAN DEVELOPMENT IN GHANA

B: FAMILIARITY WITH HIV/AIDS SICKNESS AND DEATH

C: ANNOTATED BIBLIOGRAPHY ON HIV/AIDS-RELATED RESEARCH IN GHANA

ANNEX A

STATISTICAL INFORMATION ON HUMAN DEVELOPMENT IN GHANA

Annex A is divided into 8 sections labelled A to H and presents information on human development indicators, from the global perspective as well as country-specific statistics, where available. All the data presented in this Annex are from secondary sources, mainly from international and multinational agencies like the United Nations, UNICEF, World Bank and World Health Organisation as well as from national establishments like the Ghana Statistical Service, Ministry of Finance, National Development Planning Commission, National ICT Policy & Plan Development Committee, Women and Juvenile Unit of the Ghana Police Service, Ghana Road Safety Commission and the Ghana Health Services. Internet search enquiries were also widely used. All sources of information are duly acknowledged under the various tables in the Report.

The statistical information has been grouped as follows:

A: Selected Welfare Indicators	-	Table 1
B: Education	-	Table 2-5
C: Incidence of Poverty	-	Table 6
D: HIV/AIDS Statistics	-	Table 7-11
E: Human Safety and Security	-	Table 12-14
F: Good Governance	-	Table 15-16
G: Gender and Empowerment	-	Table 17
H: Computer and Internet Usage	-	Table 18

Summary of Sections

Section A: Selected Welfare Indicators - specifies selected welfare indicators and makes a two-year comparison (1997 and 2003) on access to utilities (water, electricity and sanitation), education and health across the 10 regions of Ghana. The information was obtained from the Ghana Statistical Service reports on the Core Welfare Indicator Questionnaires (CWIQ) for 1997 and 2003. The first edition of the CWIQ was published in 1997. It was supposed to be a yearly publication but so far it is only the 1997 report and the preliminary results of the 2003 that are available.

Section B: Education - presents data on education at the tertiary level in Ghana, and makes a five-year comparison of students' intake and output from the country's public and private higher education institutions. Tertiary education is a requisite for knowledge-based national development as this nurtures a nation's human resources for socio-economic development.

Section C: Human Poverty Index - Whereas the human development index (HDI) measures average achievement of a country, the human poverty index measures deprivations in the three basic dimensions of human development captured in the HDI (UNDP Human Development Report 2003). The three key dimensions of human development used in computing the Ghana Human Poverty Index (G-HPI) for the 10 regions include:[44]

(i) A long and healthy life vulnerability to death at a relatively early age, as measured by the probability at birth of not surviving to 1 year (infant mortality). However, in the absence of data on infant mortality, lack of access to health was used.[45]

(ii) Knowledge exclusion from the world of reading and communications, as measured by adult illiteracy rate

(iii) A decent standard of living lack of access to overall economic provisioning, as measured by the unweighted average of two indicators, the percentage of the population without sustainable access to an improved water source and the percentage of children underweight for age.

Calculating HPI-1

The formula for the HPI[46] is

$$HPI\text{-}1 = [1/3(P_1^{\beta} + P_2^{\beta} + P_3^{\beta})]^{1/\beta}$$

Where:

P_1 = Probability at birth of not surviving to age 40 (times 100). Due to lack of data on infant mortality, lack of access to health was used for the computation.
P_2 = Adult illiteracy rate
P_3 = Unweighted average of population without sustainable access to an improved water source and children underweight for age
$\beta = 3$: The value of β has an important impact on the value of the HPI. If $\beta = 1$, the HPI is the average of its dimensions. As β increases, greater weight is given to the dimensions in which there is the most deprivation.

Unweighted average = 0.5 (population without sustainable access to an improved water source) + 0.5 (children underweight for age)

The HPI-1 for the ten regions of Ghana for two data periods (1997/98 and 2002/2003) are listed in the text as Table 2.1 or Table 6 under Section C.

Section D: HIV/AIDS Statistics - presents HIV/AIDS statistics, first, giving an African scenario of people living with and who have died of the disease. In terms of numbers, Ghana ranks 14th in Sub-Saharan Africa. The section presents data from Ghana on the prevalence of the disease by geographical belt, age grouping and sentinel sites and years. Also, the educational status of HIV/AIDS orphans and vulnerable children in Ghana is presented in this section. Data was

[44] These were adapted from the UNDP Human Development Report 2003, pp 342
[45] The GDHS 2003 was officially released after these estimates were calculated.
[46] There are two measures of deprivation, namely, HPI-1 and HPI-2. HPI-2 measures deprivation in the same dimension as the HPI-1 and also captures social exclusion (rate of long-term unemployment 12 months or more)

obtained mainly from the Ghana Health Service HIV/AIDS Sentinel Survey 2002 and 2004 Reports.

Section E: Human Safety and Security - presents data on human safety and security as elements of human development. Data on different types of crimes committed in a five-year period (1999-2003) are presented. Also, data on offences committed in 2003 by prisoners in custody in the various prisons across the country are presented. A bane to human safety and security is road accidents, with its attendant casualties and fatalities. Road traffic accidents have effects on children, adults and the nation: breadwinners are lost, poverty cycle expands, industries collapse, a pool of orphans is created and dependency load increases. There is also the financial cost to individuals and the nation. Inter-year data on such fatalities are presented in this segment. According to the World Disaster Report, 1998, road crashes would move to third place in the world league table for death and disability by the year 2020. In Ghana, road transport caters for 96 per cent of national freight tonnage and 97 per cent of passenger traffic. On a yearly average, over 10,000 vehicles are involved in accidents, over 10,000 people get injured through accidents and at least 6 people are killed in road accidents daily. Also, about 70% of the dead or injured are males, and in 2001, the country was rated the second highest road traffic accident-prone among six West African countries.

Section F: Good Governance Indicators - presents indicators of good governance. Recently the terms "governance" and "good governance" are being increasingly used in development literature. Major donors and international financial institutions are increasingly basing their aid and loans on the condition that reforms that ensure "good governance" are undertaken. This section focuses on global corruption indicators and the performance of Ghana's Commission on Human Rights and Administrative Justice (CHRAJ) in the disposal of cases. Data on remand prisoners with expired warrants is also presented.

Section G: Gender Empowerment - presents a table on women in public life in Ghana as well as a list of Women's Associations in the country.

Section H: Computer and Internet Usage Technology is a powerful tool for human development and poverty reduction. Today, new technologies such as ICT and biotechnology are leading to healthier lives, greater social freedoms, improved knowledge and more productive livelihoods. No country, at any level of development, can afford not to participate in these networks (HDR, 2001). Internet usage in Ghana has taken off in an unprecedented way with individuals and companies rushing to get access to the Internet. This section presents data on Internet usage in selected African countries as well as usage in government ministries in Ghana.

A: SELECTED WELFARE INDICATORS

TABLE 1: CHANGES IN WELFARE INDICATORS, IN PERCENTAGE BY REGION

VARIABLE	WR	CR	GAR	VR	ER	AS	BAR	NR	UER	UWR	TOTAL
Basic Household Needs											
Access to water											
2003	96.7	96.6	97.1	88.8	95.3	98.4	91.5	80.2	90	87.7	94
1997	89	89.4	93.7	77.2	76.5	86.3	74.7	64.6	80.9	85.4	82.1
Safe water source											
2003	71.2	80.9	81.9	52.1	71.2	84.9	70.3	54.4	79.4	90	74.1
1997	54	80.1	94.3	35.3	45.1	75.5	68.4	44	78.9	84.7	65.2
Safe sanitation											
2003	52.8	56.5	82.7	37.5	60.3	65.6	47.1	23.5	10.7	23.3	55
Has electricity											
2003	50.6	49.4	83.1	36	42.1	59	43.2	28.8	14.7	18	50.6
Improved waste disposal											
2003	71.4	73.4	79.5	44.9	64	89.2	76.1	18.4	8.7	19.6	65.8
Non-wood fuel for cooking											
2003	34.7	36.9	92.8	26.8	28.7	49.4	22.4	18.2	45	19.8	43.4
Education											
Primary School											
2003											
Access to school	85.3	90.9	90.2	83.9	88.4	92.7	83.7	80.1	61.9	67.1	85.4
Primary enrolment	74.9	72.6	80.9	64.7	75.6	78.9	69.3	49.9	56	51	69.9
Male	75.2	73	80.4	65	74.9	78.9	68.7	52.2	55.3	47.3	69.9
Female	74.5	72.2	81.4	64.3	76.4	78.9	70	47.6	56.9	55.4	70
Satisfaction	68	75.7	88.3	55.7	65.4	79	70.3	45.3	47.6	49.8	69.1
1997											
Access to school	86.1	83	92.8	88	78.5	89.9	84.2	70.1	45.7	56.8	81.2
Primary enrolment	74.6	72	70.4	70.2	78.1	72.2	72.4	40	45.1	36	67
Male	76.3	71.9	73.6	70.3	80.1	71.3	72	43.4	48.7	32.9	67.9
Female	72.8	72	67.3	70.1	76.1	73.2	72.8	36	41	39.5	66
Satisfaction	23.2	45.4	76.9	19.5	38.3	50.1	34.3	34.5	35.9	35.2	40.4
Secondary school											
2003											
Access to school	35.1	52.1	63.4	39.4	47.1	56.1	34.2	21.5	7.9	17.2	43.4
Secondary enrolment	39.5	40.9	54.6	33.8	40.3	44.9	33.3	16.2	19.5	21.4	38
Male	41.3	40.6	54.7	34.3	40.2	45.1	34.7	16.9	18.6	21.9	37.8
Female	37.5	41.3	54.5	33.3	40.3	44.7	31.9	15.3	20.8	20.7	38.3
Satisfaction	73.4	76.1	89.7	61.5	71.4	79.2	77	59.5	53.7	56.7	75.8

Male	41.3	40.6	54.7	34.3	40.2	45.1	34.7	16.9	18.6	21.9	37.8
Female	37.5	41.3	54.5	33.3	40.3	44.7	31.9	15.3	20.8	20.7	38.3
Satisfaction	73.4	76.1	89.7	61.5	71.4	79.2	77	59.5	53.7	56.7	75.8
1997											
Access to school	86.1	83	92.8	88	78.5	89.9	84.2	70.1	45.7	56.8	81.2
Secondary enrolment	74.6	72	70.4	70.2	78.1	72.2	72.4	40	45.1	36	67
Male	76.3	71.9	73.6	70.3	80.1	71.3	72	43.4	48.7	32.9	67.9
Female	72.8	72	67.3	70.1	76.1	73.2	72.8	36	41	39.5	66
Satisfaction	23.2	45.4	76.9	19.5	38.3	50.1	34.3	34.5	35.9	35.2	40.4
Medical services											
Health access 2003	46.9	67.2	80.9	49.5	60.1	69	53.8	35	26.7	30.4	57.6
1997	28	35.9	77.6	41.7	32.8	43.2	31.9	18.4	8.2	19.8	37.2
Need 2003	19	21.2	14	22.1	20.8	18.3	17.6	15.9	19.4	14.7	18.3
1997	23.8	14.9	14.1	19.6	20.4	16.2	25.9	18.1	11.8	13.9	18.6
Use 2003	18.8	21.1	15.4	18	21.7	20.4	17	15.6	16.8	13.2	18.4
1997	20.1	20	17.8	25.6	26.5	17.1	33.6	20	11	10.9	21.6
Satisfaction 2003	79.8	79.9	76	78.4	73.7	85.6	82.3	73.7	66.7	70.4	78.6
1997	41.2	66.8	59.8	53.8	66.5	61.9	49.8	55.6	59.4	55.8	57
Pre-natal care 2003	92.7	89.7	86.3	86.7	92.5	93.9	93	84.5	92.5	91.1	90.2
Delivery by health professionals											
2003	46.5	51.1	85.9	41.9	49.4	67.4	56.1	16.3	23.7	31.2	51.1
Children's health											
Stunted 2003	41.7	31.9	31.5	32.8	30.7	33.9	32.2	40.3	35.2	27.5	34.3
1997	27.3	30.7	13.4	27.9	24.5	30.2	25.1	40.2	53.4	46.8	29.9
Wasted 2003	9.7	15.3	31.2	14.1	15.5	31.8	12	13.4	22.1	11.9	19.3
1997	4.7	4.7	8.4	50	4.4	5.3	5.7	10.5	11.4	10.4	6.5
Underweight 2003	36.9	31.5	40.4	30.1	32.9	46.8	26.1	33.9	32.6	24.8	35.8
1997	22.4	23.5	10.8	21.7	22.5	24.3	21	41.8	48.8	42.4	26

Source: Ghana Statistical Service, Core Welfare Indicator Questionnaire 1997 & 2003 (Draft Report)

B. EDUCATION

TABLE 2: ADMISSION AND GRADUATION IN PUBLIC UNIVERSITIES UNDERGRADUATE LEVEL (1997/98 TO 2001/2002)

INSTITUTION		YEAR				
		1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
University of Ghana	*Intake*	2578	2699	3919	4427	5327
	Output	1940	2189	2242	2521	2459
University of Cape Coast	*Intake*	2500	2607	2854	2914	3224
	Output	704	1445	1411	1885	2107
Kwame Nkrumah University of Science and Technology	*Intake*	2392	2156	2465	2631	3652
	Output	2326	942	1269	1602	1852
University College of Education	*Intake*	1508	2235	3340	3300	3155
	Output	1176	1980	2701	2580	-
University for Development Studies	*Intake*	158	180	167	163	402
	Output	37	85	31	62	116

Source: Data from the various universities through National ICT Policy & Plan Development Committee

TABLE 3: ADMISSION AND GRADUATION STATISTICS IN PUBLIC UNIVERSITIES POST-GRADUATE LEVEL (1997/98 TO 2001/2002)

INSTITUTION		YEAR				
		1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
University of Ghana	*Intake*	500	646	760	620	603
	Output	220	223	246	423	391
University of Cape Coast	*Intake*	70	90	50	116	130
	Output	57	50	67	52	-
Kwame Nkrumah University of Science and Technology	*Intake*	205	280	243	231	429
	Output	152	188	216	240	217

Source: Data from the various universities through National ICT Policy & Plan Development Committee

TABLE 4: ADMISSION AND GRADUATION STATISTICS PRIVATE UNIVERSITIES UNDERGRADUATE LEVEL (1997/98 TO 2001/2002)

Institution		Year				
		1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
Ashesi University	*Intake*	-	-	-	-	30
	Output	-	-	-	-	-
Central University College	*Intake*	-	271	543	435	456
	Output	-	-	-	-	-
Valley View Univ.	*Intake*	185	357	366	565	705
	Output	18	17	22	27	52
Methodist Univ. College	*Intake*	-	-	-	214	243
	Output	-	-	-	-	-

Source: Data from the various universities through National ICT Policy & Plan Development Committee

TABLE 5: ADMISSION AND GRADUATION STATISTICS IN POLYTECHNICS UNDERGRADUATE LEVEL (1997/98 TO 2001/2002)

INSTITUTION		YEAR				
		1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
Kumasi Polytechnic	*Intake*	1012	1122	1327	927	1247
	Output	428	574	637	759	-
Accra Polytechnic	*Intake*	1239	969	1006	1236	1528
	Output	473	752	596	916	889
Takoradi Polytechnic	*Intake*	973	944	866	980	1293
	Output	295	410	575	724	-
Sunyani Polytechnic	*Intake*	311	810	820	828	722
	Output	-	805	795	815	710
Ho Polytechnic	*Intake*	701	596	526	608	707
	Output	350	466	609	545	-
Cape Coast Polytechnic	*Intake*	267	659	1037	1177	1174
	Output	84	111	181	225	613
Koforidua Polytechnic	*Intake*	266	470	700	416	624
	Output	-	-	-	-	290
Tamale Polytechnic	*Intake*	203	379	735	1392	2000
	Output	287	317	400	450	340??

Source: Data from the various universities through National ICT Policy & Plan Development Committee http://www.ict.gov.gh/pdf/REPORT-Ghana%27s%20HRD&RD.pdf

C. HUMAN POVERTY INDEX (HPI)

TABLE 6: GHANA HUMAN POVERTY INDEX

REGION	HP1-1: 1997/1998	HP1-1: 2002/2003	DIFFERENCE
NATIONAL	51.7	41.0	-10.7
Western	55.1	44.7	-10.4
Central	52.0	37.9	-14.1
Greater ACCRA	21.7	24.3	+2.6
Volta	49.1	46.0	-3.1
Eastern	53.0	38.8	-14.2
Ashanti	49.3	34.3	-15.0
Brong Ahafo	55.3	45.9	-9.4
Northern	74.4	64.4	-10.0
Upper East	77.3	66.2	11.1
Upper West	69.5	63.7	-5.8

Data Used are mainly from CWIQ 1997/1998 & 2002/2003

D. HIV/AIDS STATISTICS

TABLE 7: ESTIMATED NUMBER OF PEOPLE IN AFRICA LIVING WITH HIV/AIDS

	ADULTS AND CHILDREN, END 2003		*ADULTS AND CHILDREN, END 2001*	
COUNTRY	**ESTIMATE**	***[LOW ESTIMATE - HIGH ESTIMATE]***	***ESTIMATE***	***[LOW ESTIMATE - HIGH ESTIMATE]***
Global Total	37,800,000	[34,600,000 - 42,300,000]	34,900,000	[32,000,000 - 39,000,000]
Sub-Saharan Africa	25,000,000	[23,100,000 - 27,900,000]	23,800,000	[22,000,000 - 26,600,000]
Angola	240,000	[97,000 - 600,000]	220,000	[86,000 - 550,000]
Benin	68,000	[38,000 - 120,000]	65,000	[36,000 - 110,000]
Botswana *	350,000	[330,000 - 380,000]	350,000	[330,000 - 380,000]
Burkina Faso *	300,000	[190,000 - 470,000]	280,000	[180,000 - 440,000]
Burundi	250,000	[170,000 - 370,000]	240,000	[160,000 - 360,000]
Cameroon *	560,000	[390,000 - 810,000]	530,000	[370,000 - 770,000]
Central African Republic	260,000	[160,000 - 410,000]	250,000	[150,000 - 400,000]
Chad	200,000	[130,000 - 300,000]	190,000	[120,000 - 290,000]
Comoros	…	…	…	…
Congo	90,000	[39,000 - 200,000]	90,000	[39,000 - 200,000]
Côte d'Ivoire	570,000	[390,000 - 820,000]	510,000	[350,000 - 740,000]
Dem. Republic of Congo **	1,100,000	[450,000 - 2,600,000]	1,100,000	[430,000 - 2,500,000]
Djibouti	9,100	[2,300 - 24,000]	8,100	[2,400 - 23,000]
Equatorial Guinea	…	…	…	…
Eritrea	60,000	[21,000 - 170,000]	61,000	[22,000 - 160,000]
Ethiopia	1,500,000	[950,000 - 2,300,000]	1,300,000	[820,000 - 2,000,000]
Gabon	48,000	[24,000 - 91,000]	39,000	[19,000 - 78,000]
Gambia	6,800	[1,800 - 24,000]	6,700	[1,800 - 24,000]
Ghana *	350,000	[210,000 - 560,000]	330,000	[200,000 - 540,000]
Guinea *	140,000	[51,000 - 360,000]	110,000	[40,000 - 310,000]
Guinea-Bissau	…	…	…	…
Kenya	1,200,000	[820,000 - 1,700,000]	1,300,000	[890,000 - 1,800,000]
Lesotho *	320,000	[290,000 - 360,000]	320,000	[290,000 - 360,000]
Liberia	100,000	[47,000 - 220,000]	86,000	[37,000 - 190,000]
Madagascar	140,000	[68,000 - 250,000]	100,000	[50,000 - 180,000]
Malawi *	900,000	[700,000 - 1,100,000]	850,000	[660,000 - 1,100,000]
Mali	140,000	[44,000 - 420,000]	130,000	[40,000 - 390,000]
Mauritania	9,500	[4,500 - 17,000]	6,300	[3,000 - 11,000]
Mauritius	…	…	…	…
Mozambique	1,300,000	[980,000 - 1,700,000]	1,200,000	[930,000 - 1,600,000]
Namibia	210,000	[180,000 - 250,000]	200,000	[170,000 - 230,000]
Niger	70,000	[36,000 - 130,000]	56,000	[28,000 - 110,000]
Nigeria	3,600,000	[2,400,000 - 5,400,000]	3,400,000	[2,200,000 - 5,000,000]
Rwanda *	250,000	[170,000 - 380,000]	240,000	[160,000 - 360,000]
Senegal *	44,000	[22,000 - 89,000]	40,000	[20,000 - 81,000]

Rwanda *	250,000	[170,000 - 380,000]	240,000	[160,000 - 360,000]
Senegal *	44,000	[22,000 - 89,000]	40,000	[20,000 - 81,000]
Sierra Leone	…	…	…	…
Somalia	…	…	…	…
South Africa *	5,300,000	[4,500,000 - 6,200,000]	5,000,000	[4,200,000 - 5,900,000]
Swaziland **	220,000	[210,000 - 230,000]	210,000	[190,000 - 220,000]
Togo	110,000	[67,000 - 170,000]	100,000	[65,000 - 160,000]
Uganda *	530,000	[350,000 - 880,000]	620,000	[420,000 - 980,000]
United Rep. of Tanzania *	1,600,000	[1,200,000 - 2,300,000]	1,600,000	[1,100,000 - 2,200,000]
Zambia	920,000	[730,000 - 1,100,000]	890,000	[710,000 - 1,100,000]
Zimbabwe	1,800,000	[1,500,000 - 2,000,000]	1,700,000	[1,500,000 - 2,000,000]

http://www.unaids.org/bangkok2004/GAR2004_pdf/GAR2004_table_countryestimates_en.pdf

TABLE 8: HIV/AIDS PREVALENCE IN GHANA BY REGIONAL DISTRIBUTION (2003 & 2004)

REGION	MEAN REGIONAL PREVALENCE		MEDIAN REGIONAL PREVALENCE	
	2003	2004	2003	2004
Ashanti	4.7%	3.0%	5.0%	3.0%
Brong Ahafo	3.7%	4.5%	3.6%	4.1%
Volta	2.8%	3.5%	2.0%	3.9%
Central	5.4%	3.5%	5.4%	4.0%
Eastern	6.1%	6.5%	6.6%	6.8%
Western	4.2%	4.6%	4.0%	4.6%
Greater Accra	4.3%	3.6%	4.2%	3.9%
Northern	2.1%	1.8%	2.1%	2.5%
Upper East	3.4%	3.1%	3.2%	3.2%
Upper West	2.1%	1.7%	1.8%	1.4%

Source: Ghana Health Service, National AIDS/STI Control Programme, 2003 & 2005

TABLE 9: HIV/AIDS PREVALENCE IN GHANA BY AGE GROUPING

	15 – 19	20 – 24	25 – 29	30 – 34	35 – 39	40 – 44	45 – 49	Total
Mean	1.9	3.5	4.4	4.7	4.5	3.3	6.0	3.9
Median	1.1	3.0	3.8	4.2	3.7	0.0	0.0	3.6

Source: Ghana Health Service, National AIDS/STI Control Programme, 2003

TABLE 10: HIV/AIDS PREVALENCE IN GHANA BY SENTINEL SITES (2003)

REGION	SITE	NO. TESTED	HIV1	HIV2	HIV 1&2	TOTAL HIV +	HIV PREVALENCE %
Ashanti	Kumasi	500	25	0	0	25	5.0
	Mampong	499	27	0	0	27	5.4
	Obuasi	460	16	0	1	17	3.7
Brong Ahafo	Asunafo	305	10	0	1	11	3.6
	Wenchi	500	20	0	7	27	5.4
	Sunyani	300	6	0	0	6	2.0
Volta	Hohoe	500	21	0	0	21	4.2
	Ho	498	10	0	0	10	2.0
	North Tongu	293	6	0	0	6	2.0
Central	Assin Fosu	497	16	0	0	16	3.2
	Cape Coast	498	31	0	7	38	7.6
Eastern	Agomanya	498	46	0	0	46	9.2
	Fanteakwa	334	20	0	2	22	6.6
	Koforidua	496	12	0	1	13	2.6
Greater Accra	Adabraka	498	24	1	1	26	5.2
	Korle Bu	499	21	0	0	21	4.2
	Maamobi	499	19	0	2	21	4.2
	Tema	498	17	0	0	17	3.4
Western	Eikwe	495	28	0	2	30	6.1
	Sefwi Asafo	464	7	2	2	11	2.4
	Takoradi	494	20	0	0	20	4.0
Northern	Nalerigu	499	3	0	0	3	0.6
	Tamale	500	18	0	0	18	3.6
Upper East	Bawku	498	16	0	0	16	3.2
	Bolgatanga	498	14	0	1	15	3.0
	Navrongo	499	22	0	0	22	4.4
Upper West	Jirapa	498	9	0	0	9	1.8
	Nadowli	310	4	0	0	4	1.3
	Wa	500	16	0	0	16	3.2
		13427	504	3	27	534	

Source: Ghana Health Services, National AIDS/STI Control Programme, 2003

TABLE 11: HIV/AIDS PREVALENCE IN GHANA BY SENTINEL SITE AND YEAR

Site	1992	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Adabraka	0.7	-	1.3	2.2	2.1	3.4	2.0	4.0	2.3	4.0	5.2
Agomanya	18.0	9.4	10.5	12.8	13.4	13.2	8.2	7.8	6.6	7.0	9.2
Amasaman	-	-	-	-	-	-	2.6	2.2	2.9	-	-
Assin Foso	-	2.5	1.2	1.6	1.2	3.6	2.0	2.4	2.6	2.6	3.2
Bawku	-	2.4	2.4	-	1.6	1.8	1.6	1.6	3.6	3.8	3.2
Bole		3.8	2.7	-	-	-	-	-	-	-	-
Bolgatanga	-	2.0	1.6	1.0	2.8	3.0	1.6	1.0	1.6	2.8	3.0
Cape Coast	-	3.5	2.4	2.6	0.8	3.4	3.2	3.0	3.6	2.6	7.6
Eikwe	-	3.0	-	5.7	5.8	5.8	4.8	3.2	5.8	6.0	6.1
Hamile	-	4.3	4.2	-	-	-	-	-	-	-	-
Ho	-	2.4	2.4	2.8	3.8	4.0	5.2	4.2	2.6	3.2	2.0
Hohoe	-	2.3	3.2	2.1	4.2	4.0	4.4	5.0	2.8	3.2	4.2
Jirapa	0.4	2.5	0.3	3.0	1.4	-	0.6	1.5	1.7	1.7	1.8
Koforidua	3.2	2.4	3.8	2.6	4.2	2.4	1.0	2.8	6.4	8.5	2.6
Korle-bu	-	-	-	-	2.0	2.2	2.2	2.2	4.8	2.2	4.2
Kumasi	4.6	2.4	3.2	3.8	5.5	6.8	4.9	3.8	3.4	4.2	5.0
Maamobi	-	-	-	-	-	-	-	-	-	4.2	4.2
Mampong	-	2.0	3.6	2.0	5.2	5.0	3.4	1.6	4.8	2.4	5.4
Nalerigu	-	1.0	1.0	0.4	0.2	-	0.6	1.4	1.7	1.6	0.6
Nandom	-	2.0	2.9	-	-	-	-	-	-	-	-
Navrongo	-	-	-	-	-	-	-	-	2.4	5.1	4.4
Obuasi	-	-	-	-	-	-	-	-	-	6.0	3.7
Sunyani	4.0	3.0	-	2.2	2.0	3.4	2.8	2.1	1.1	3.4	2.0
Sekondi-Takora di	-	1.8	-	4.2	3.8	3.0	4.0	3.0	4.0	4.1	4.0
Tamale	-	1.0	1.0	1.6	1.0	-	0.8	1.3	1.6	2.4	3.6
Tema	-	-	-	-	-	-	2.6	3.9	2.5	6.5	3.4
Wa	1.8	3.0	0.8	1.8	1.6	2.3	2.2	1.4	6.0	3.4	3.2
Wenchi	4.0	-	3.2	2.6	2.4	2.0	2.2	1.0	3.4	3.2	5.4
Median Prevalence	**3.6**	**2.4**	**2.4**	**2.4**	**2.3**	**3.4**	**2.4**	**2.9**	**2.9**	**3.4**	**3.6**
Mean Prevalence	**8.7**	**3.0**	**2.8**	**3.7**	**3.5**	**3.4**	**2.9**	**2.8**	**3.6**	**3.8**	**3.9**

Source: Ghana Health Service/National AIDS/STI Control Programme, 2003

E:HUMAN SAFETY AND SECURITY

TABLE 12: STATISTICS OF CRIME CASES REPORTED TO WOMEN AND JUVENILE UNIT (WAJU), FROM JAN. 1999 TO DECEMBER 2003

TYPE OF CASE	YEAR					TOTAL
	1999	2000	2001	2002	2003	
Rape	23	34	58	134	100	349
Defilement	154	181	204	533	509	1581
Assault	95	86	232	1456	1559	3428
Threatening	21	16	60	652	461	1210
Causing harm	4	6	7	40	28	85
Causing danger	6	3	6	60	43	118
Indecent assault	11	17	28	69	49	174
Incest	5	6	5	16	8	40
Offensive conduct	4	1	2	175	165	347
Unnatural canal knowledge	3	2	0	0	5	10
Failing to supply necessities	0	7	17	142	54	220
Abduction	3	5	9	80	79	176
Child trafficking	0	0	0	4	4	8
Child stealing	1	3	0	16	9	29
Stealing	20	7	12	130	106	275
Exposing child to harm	1	0	4	67	48	120
Abortion	1	1	0	5	4	11
Procuration	1	1	0	0	0	2
Fraud	6	5	3	1	0	15
Attempted defilement	0	0	1	1	0	2
Attempted rape	1	2	3	17	28	51
Attempted abortion	0	1	0	19	15	35
Non child maintenance	523	1383	1047	1899	3024	7876

Source: Accra WAJU 2003, Ghana Police Service (WAJU):
http://www.ghanapolice.org/waju/statistics.htm

TABLE 13: OFFENCES COMMITTED BY PRISONERS ACROSS THE COUNTRY IN 2003

OFFENCE	REGIONAL LOCATION OF PRISONERS										TOTAL
	GAR	ER	CR	WR	AR	VR	BAR	NR	UER	UWR	
Stealing	807	1,349	847	548	1,216	357	929	358	193	82	**6,686**
Assault	9	162	68	59	68	36	17	17	9	12	**457**
Murder	0	26	10	0	1	1	3	0	15	0	**56**
Robbery	0	24	0	0	10	0	5	0	3	0	**42**
Narcotics	1	75	15	9	0	12	0	100	5	0	**217**
Manslaughter	0	7	0	0	0	4	0	1	1	0	**13**
Fraud	21	145	58	27	74	11	4	18	12	6	**376**
Threat of death	14	14	24	23	10	0	4	0	1	4	**94**
Unlawful entry	29	315	150	107	297	113	5	104	15	24	**1,159**
Causing harm	28	143	65	39	49	43	18	64	15	13	**477**
Causing damage	4	44	70	41	21	1	10	0	22	14	**227**
Conspiracy	1	27	128	85	162	50	6	103	15	17	**594**
Rape	0	11	8	2	3	3	1	18	4	0	**50**
Defilement	37	160	24	40	43	43	13	80	2	5	**447**
Causing financial loss	0	3	0	0	0	0	0	0	0	0	**3**
Others	168	813	209	122	841	184	37	101	31	27	**2,533**
Total	**1,119**	**3,318**	**1676**	**1,102**	**2,795**	**858**	**1,052**	**964**	**343**	**204**	**13,431**

Source: Ghana Prison Service, 2004

TABLE 14: ROAD ACCIDENT RATES IN GHANA (1996 2001)

YEAR	NO. OF VEHICLES INVOLVED	ACCIDENT RATE USING 1996 AS BASE YEAR (%)	NUMBER OF PERSONS KILLED	ACCIDENT DEATH RATE USING 1996 AS BASE YEAR (%)	NUMBER OF PERSONS INJURED	PERSONS INJURED BY ACCIDENT USING 1996 AS BASE YEAR (%)
1996	15,252	100	987	100	8,372	100
1997	15,704	103	824	83	8,018	96
1998	18,034	118	1,646	167	11,083	132
1999	20,606	135	1,288	130	8,791	105
2000	21,152	139	1,159	117	10,518	126
2001	15,671	103	1,242	126	7,239	86
Total	**106,419**	**2,694**	**7,146**	**2,719**	**54,021**	**2,641**

Source: National Road Safety Commission, 2002

F. GOOD GOVERNANCE

TABLE 15: COMPARISON OF CORRUPTION PERCEPTIONS INDICES (2002 & 2003)

COUNTRY	COUNTRY RANK (2002)	COUNTRY RANK (2003)	CPI 2002 SCORE	CPI 2003 SCORE
Finland	1	1	9.7	9.7
United Kingdom	10	11	8.7	8.7
USA	16	18	7.7	7.5
Botswana	24	30	6.4	5.7
Malaysia	33	37	4.9	5.2
South Africa	36	48	4.8	4.4
Czech Republic	52	54	3.7	3.9
Jamaica	45	57	4.0	3.8
Ghana	50	70	3.9	3.3
Egypt	62	70	3.4	3.3
India	71	83	2.7	2.8
Vietnam	85	100	2.4	2.4
Uganda	93	113	2.1	2.2
Nigeria	101	132	1.6	1.4
Bangladesh	102	133	1.2	1.3

NB: The Corruption Perception Index (CPI) relates to perceptions of the degree of corruption as seen by business people, academics and risk analysts, and ranges between 10 (highly clean) and 0 (highly corrupt).
Sources: http://www.transparency.org/cpi/2003/cpi2003.en.html
http://www.transparency.org/pressreleases_archive/2002/2002.08.28.cpi.en.html
http://www.globalcorruptionreport.org/download/gcr2004/12_Corruption_research_I.pdf

TABLE 16: TYPE OF COMPLAINTS RECEIVED AT THE CHRAJ OFFICES FROM 1997-2000

TYPE OF COMPLAINT	COMPLAINTS RECEIVED IN 1997	COMPLAINTS RECEIVED IN 1998	COMPLAINTS RECEIVED IN 1999	COMPLAINTS RECEIVED IN 2000
Labor	1929	1518	2074	2023
Human Rights	1224	347	1512	975
Property	1343	1318	1392	1280
Family	910	984	2941	3749
Miscellaneous	470	702	973	1327
Total	**7873**	**6867**	**10891**	**11354**

Source: CHRAJ Annual Report, 2000

TABLE 17: WOMEN IN PUBLIC LIFE, 2003

POSITION	TOTAL NUMBER OF MINISTERS	NUMBER OF WOMEN
Women Cabinet Ministers	19	1
Non Cabinet Women Ministers	7	0
Women Ministers of State	6	2
Women Deputy Ministers	N/A	6
Women Parliamentarians	200	18
Women Regional Ministers	10	0
Women Deputy Regional Ministers	5	1
Women District Chief Executives	110	5

Source: http://ghanareview.com/review/

WOMEN-RELATED ASSOCIATIONS IN GHANA

- Abantu for Development
- Abokobi Rural Women's Development Association
- Ark Foundation
- Association for the Advancement of Women in Africa (ASAWA)
- Christian Mothers Association
- Federation of Ghana Business and Professional Women (FGBPW)
- Federation of Women Lawyers (FIDA)
- Forum for African Women Educationists (FAWE)
- Ghana Assembly of Women
- Ghana National Commission on Children (GNCC)
- Gender Centre
- Media and Health Coalition
- Ministry of Women and Children's Affairs (MOWAC)
- Mother and Child Foundation
- National Council on Women and Development (NCWD)
- Progressive Women's Credit Union
- Rural Women's Association
- Sungsim Women's Association
- Syanshiegu Women's Association
- Telania Women's Association
- 31st December Women's Movement
- Women and Juvenile Unit of Ghana Police Service (WAJU)
- Women in Management Resource Center
- Women in Progress
- Women's Development Agency
- Women's Studies Collection
- Women's World Banking
- Young Women's Christian Association

Source: http://www.euronet.nl/ fullmoon/womlist/countries/ghana.htmlhttp://www.euronet.nl/ fullmoon/womlist/countries/ghana.html)

TABLE 18: ICTS IN GOVERNMENT MINISTRIES AND PUBLIC SECTOR ORGANISATIONS

TYPE	ALL SECTORS	GOVERNMENT MINISTRIES	PUBLIC SECTOR ORGANIZATIONS
Level of involvement in e-commerce			
Organizations involved in E-commerce	6%	8%	4%
Organizations not involved in E-commerce	94%	92%	96%
The degree of Internet access			
Percentage with internet access	72%	54%	91%
Percentage without internet access	28%	46%	9%
Percentage of staff that uses computers			
0%(none)	0%	0%	0%
Below 10%	28%	38%	18%
About 25%	27%	33%	22%
About 50%	24%	21%	26%
About 75%	19%	8%	30%
About 100%	2%	0%	4%
Percent of staff who use the Internet			
0%(none)	21%	29%	13%
Below 10%	45%	50%	39%
About 25%	11%	13%	9%
About 50%	13%	4%	22%
About 75%	4%	4%	4%
About 100%	6%	0%	13%
Distribution of IT expenditure as a percentage of total organizational expenditure			
0%(none)	4%	8%	0%
Below 10%	60%	71%	48%
About 25%	34%	21%	48%
About 50%	2%	0%	4%
About 75%	0%	0%	0%
About 100%	0%	0%	0%
Deployment of computer systems			
Standalone computers	43%	60%	22%
Local Area Network (LAN)	40%	27%	57%
Backbone Network	6%	3%	9%
Wide Area Network (WAN)	11%	10%	13%
Development of organizational IT strategy and degree of computer resource utilization			
Organizations with IT policy/strategy or plan	47%	42%	52%
Organizations without IT policy/strategy	53%	58%	48%
Distribution of IT related problems faced by organizations			
Computer skill shortage within the organization	18%	20%	16%
Problem with staff acceptance of computers	2%	1%	3%
Problem with adjustment to computer systems	7%	7%	8%
Problems with computer systems installation, etc	16%	17%	14%

Source: National ICT Policy and Plan Development Committee, 2003

USEFUL LINKS:

Gender Profile

http://www.worldbank.org/afr/gender/ghana.pdf

http://www.oneworld.org/empoweringwidows/10countries/ghana.html

Ghana Human Resource Development Tertiary Education (1997 2002)
http://www.ict.gov.gh/pdf/REPORT-Ghana%27s%20HRD&RD.pdf

Ghana ICT for Accelerated Development (ICT4AD)

http://www.ict.gov.gh/pdf/Ghana%20ICT4AD%20Policy.pdf

HIV/AIDS in Ghana

http://www.dec.org/pdf_docs/PNACQ941.pdf
http://www.census.gov/ipc/hiv/ghana.pdf
http://www.dec.org/pdf_docs/PNACN254.pdf
http://www.irinnews.org/report.asp?ReportID_39393&SelectRegion_West_Africa&SelectCountry_GHANA
http://www.globalhealth.org/reports/report.php3?id_83
http://www.dec.org/pdf_docs/PNACQ478.pdf
http://www.ywto.4t.com/catalog.html
http://www.policyproject.com/pubs/SEImpact/ghana.pdf
http://www.synergyaids.com/Summaries_PDF/Ghana_profile_2003.pdf
http://www.jhuccp.org/pubs/ci/15/15.pdf
http://www.unfpa.org/swp/2004/english/ch8/index.htm

ICT in Public Sector Organisations:
http://www.ict.gov.gh/html/reports%20&%20documents.html

Internet usage

http://www.internetworldstats.com/africa.htm

ANNEX B

FAMILIARITY WITH HIV/AIDS SICKNESS AND DEATH

The Institute of Statistical, Social and Economic Research (ISSER) of the University of Ghana conducted a survey to find out whether apart from hearing about HIV/AIDS, people were also familiar with HIV/AIDS sickness and death in their households and communities and how this had influenced their lifestyles. The specific objectives included the level of awareness of HIV/AIDS sickness or death among the respondents and their perception on the mode of transmission and prevention.

The respondents, made up of 494 males and 452 females aged 17 years and above, comprised urban and rural residents from selected districts in all the 10 regions of Ghana selected through a multi-stage random sampling technique. The survey revealed, among others, that more respondents knew persons who had died of AIDS (62%) than people living with HIV/AIDS (55%). With regard to the respondents' relationship with persons who were sick or who had died of HIV/AIDS, almost 50% stated that they were not related to these persons. About 31 % of respondents who PLWHAs identified themselves as direct friends, close and distant relatives while 10% identified themselves as co-tenants, neighbours or residents in the same community of the sick persons. On the other hand, 29% of those who knew people who have died from HIV/AIDS identified themselves as direct friends, as well as close and distant relatives, while 11% stated they were co-tenants, neighbours or residents of the same community of the deceased persons.

The sources from which respondents obtained information on HIV/AIDS sickness and death included the sick or deceased persons themselves, as well as their relatives and friends. Suspicion of sick persons and deaths as a result of HIV/AIDS accounted for 31% and 26% respectively. According to the respondents, their awareness of the incurable nature of HIV/AIDS pandemic and deaths had influenced them to adopt more precautionary approaches to sex. Interestingly, only 1% of those who were aware of the disease had undergone testing as part of their preventive measures. Nevertheless, the respondents' interest in HIV testing was found to be quite high (80%). Again, females showed more interest in VCT than males in both urban and rural areas.

This Section provides some information on the study.

TABLE 1: DISTRIBUTION OF RESPONDENTS IN BOTH URBAN AND RURAL AREAS ACCORDING TO THEIR FAMILIARITY WITH HIV/AIDS SICKNESS AND DEATH

Region	Familiarity with HIV/AIDS Sickness		Familiarity with HIV/AIDS Death	
	Urban (%)	Rural (%)	Urban (%)	Rural (%)
Ashanti	77.6	86.0	81.6	100.0
Brong Ahafo	*	78.0	*-	82.0
Central	82.0	61.2	80.0	81.6
Eastern	45.2	46.4	73.8	64.3
Greater Accra	20.4	*	34.3	* -
Northern	68.8	31.3	68.8	56.3
Upper East	72.0	82.0	70.0	90.0
Upper West	42.9	36.0	44.0	38.0
Volta	45.8	31.7	87.8	43.9
Western	45.5	56.3	4.7	48.4
Average	**51.6**	**57.0**	**57.6**	**67.0**

*Interviews were conducted in urban and rural areas in Greater Accra and Brong Ahafo regions respectively.

TABLE 2: RESPONDENTS' RELATIONSHIP TO HIV/ AIDS SICK AND DECEASED PERSONS

Relationship	HIV/ AIDS Sick Persons		HIV/AIDS Deceased Persons	
	Frequency	%	Frequency	%
Not Related	244	47.8	264	44.9
Friend's Friend	64	12.5	70	11.9
Friend's Relative	3	0.6	2	0.3
Direct Friend/Acquaintance	49	9.6	72	12.3
Distant Relative	51	10.0	55	9.4
Close Relative	48	9.4	57	9.7
Co-Tenant / Neighbour	41	8.0	62	10.6
Lives in same Community	8	1.6	-	-
Church/Club member	2	0.4	5	0.9
Total	510	100.0	587	100.0

TABLE 3: DISTRIBUTION OF RESPONDENTS WILLINGNESS TO UNDERGO VCT RELATIVE TO THEIR LEVEL OF EDUCATIONAL ATTAINMENT

Level of Education	Urban				Rural			
	Yes	No	Total	%*	Yes	No	Total	%*
Primary	42	8	50	84.0	64	12	76	84.0
JSS/Middle	132	29	161	82.0	125	19	144	86.8
SSS/Post Sec.	98	38	132	74.2	40	11	51	78.4
Tertiary	31	9	40	75.9	12	3	15	80.0
Adult Literacy/ Apprenticeship	4	2	6	66.7	5	-	5	100.0
No Education	65	32	97	67.0	135	24	159	84.9
Total	370	116	486	76.1	381	69	450	84.6

* % of the total who were willing to undergo VCT

TABLE 4: WILLINGNESS TO UNDERGO VCT ACCORDING TO THEIR RELATIONSHIP TO HIV/AIDS SICK PERSONS (IN URBAN AND RURAL AREAS)

Relationship	Urban				Rural			
	Yes	No	Total*	%*	Yes	No	Total*	%*
Not Related	90	23	113	79.6	134	17	151	88.7
Friend's relative/ Friend	31	5	36	86.1	33	3	36	91.7
Direct friend/ close/ distant relative	71	17	88	80.7	86	9	95	90.5
Co-tenant/Neighbour	25	15	40	62.5	20	2	22	90.9
Club/Church member	4	-	4	100	-	-	-	-
Total	221	60	281	78.6	273	31	304	89.8

* % of the total who were willing to undergo VCT

ANNEX C

ANNOTATED BIBLIOGRAPHY ON HIV/AIDS-RELATED RESEARCH IN GHANA

This Section of the Report gives a bibliography of HIV/AIDS-related research in Ghana, some of which have been cited in the Report, as well as useful Internet link to materials on the disease. Many of the documents are unpublished.

- Anarfi, J. K, Ahiadeke, C., Appiah, E. N., Clement, N. F. **(**2003), **Formative Assessment Of " Roamer" Sex Workers**. ISSER/FHI IMPACT Project, Legon

  The formative study was intended to inform FHI IMPACT programme for commercial sex workers (CSWs). The objectives were: to describe the setting in which sex workers live and work and sex work culture; to identify barriers and solutions related to targeted behaviours, including condom use, voluntary counselling and testing (VCT); and care and support.

- Apt, N. A., & Blavo, E. Q. (1997), **Street Children and AIDS,** Centre for Social Policy Studies, University of Ghana.

  The main objective of the AIDS Project is to raise the awareness level of street children with respect to health maintenance, health management and health improvement. It also sought to sensitise and educate street children about sexually transmitted diseases in particular, AIDS and to encourage those children who might have health problems to seek medical attention. The project further aims to train some of the street children themselves to become health facilitators on the street with particular emphasis on AIDS prevention.

- Asare, Mark. (2001), **Perception of Prison Officers of HIV/AIDS in Ghana,** *Family Health International's (IMPACT) Project*, *Ghana, Implementing AIDS Prevention and Care.*

  The overall goal of the study was to provide data on the target group 'Prison Officers' in relation to HIV/AIDS, which would inform public health practitioners and offer input into the design of appropriate behaviour change interventions meant to reduce risks of HIV/STI transmission and increase health-seeking behaviour. The survey investigates social factors and aspects of work culture that affect sexual practices; how current knowledge levels have affected behaviour change; usage, availability and accessibility of condoms; perception of vulnerability and vulnerable groups; and channels of communication and preferred sources of information.

- Asiamah Godfried, Christine Kolars Sow and George Mensah, **(**1999) **A Survey of Knowledge, Attitudes, Beliefs and Practices on STD/HIV/AIDS with the Police in Ghana**, *Family Health International's (IMPACT) Project, Ghana, Implementing AIDS Prevention and Care, Police AIDS Control Programme,* Ghana.

  The aim of the survey was to obtain solid information on police risk of HIV, in order to inform the design of behaviour change interventions among this population. The objectives were to measure standard STD/HIV/AIDS KABP indicators.

- Boakye, Boadi Ayim K., (2004) **Relationship between Caregiver's Social Background and the Provision of Care for HIV/AIDS Orphans in Manya Krobo and New Juaben Districts.**

  The study looked at the relationship between the care levels that children orphaned by the HIV/AIDS disease are perceived to have and the social background of their caregivers, with a view to improving interventions for their survival.

- Church of Pentecost Health Services (2002), **Baseline Study: Knowledge, Attitude, Beliefs and Practices on HIV/AIDS among COP Members,** *Family Health International's* (*IMPACT) Project* **(**2002), *Implementing AIDS Prevention and Care*.

  The study was conducted among Church of Pentecost members to obtain baseline data to serve as input for appropriate programming. The data also provides a basis for evaluation and comparative analysis, and it will enable the evaluation of the impact of HIV/AIDS education from the pulpit and trained pastors in FBOs.

- Dela Afenyadu and Lakshmi Goparaju (2003), **Adolescent Sexual And Reproductive Health Behaviour In Dodowa**, **Ghana**

  This report presents findings from a study carried out in 2001of sexual and reproductive health status of in-school and out-of-school adolescents in Dodowa, Ghana. The research aim was to help design a programme to address adolescents' unmet needs and promote safer behaviours. The research design used both qualitative and quantitative methods, including focus group discussions, PLA techniques and surveys. Students of Junior and Senior Secondary Schools, out-of-school adolescents, teachers, parents and community opinion leaders were included in the study.

- **Directory of Care and Support Services for People Living with HIV/AIDS in Ghana**, *Family Health International's (IMPACT) Project, Implementing AIDS Prevention and Care,* Ghana, December 2003.

  One of the specific objectives of the December 2003 Study of Care and Support Services in Accra, Manya Krobo and New Juaben was to develop an inventory of HIV/VCT Care and Support services in these areas. This directory is the product of this undertaking and was included in the appendix of the report of the study.

- Family Health International's *(IMPACT) Project, Implementing AIDS Prevention and Care*, Ghana, *The Ghana National Fire Service AIDS Control Programme* (2003), **Baseline study on HIV/AIDS in Ghana National Fire Service.**

  This baseline study, commissioned by FHI/GNFS, aimed at providing information on the target population in order to design and implement educational programs that have the potential of positively affecting their behaviour and attitudes in relation to HIV/AIDS and other STIs in Ghana.

- Family Health International's *(IMPACT) Project, Ghana*, September (2003), **Working With Uniformed Services: Issues and Recommendations** (An Evaluation Report of the Ghana Uniformed Services HIV/AIDS Programme).

  IMPACT/Ghana supported six uniformed services in Ghana, namely: the Ghana Armed Forces, Ghana Police Service, Ghana Prisons Service, Ghana National Fire Service, Customs Excise and Prevention Service and the Ghana Immigration Service. The interventions with all these six partners followed a systematic pattern to ensure a gradual understanding of key issues in HIV/AIDS/STIs. Common programmatic areas included: advocacy sessions; official programme launch; formative research; capacity building for programme sustainability; peer education training; condom availability programme; BCC materials development and use; development of basic and in-service training curriculum and monitoring of activities. The intent of this study was to evaluate the programme's effectiveness in order to make recommendations for future interventions.

- Family Health International (*IMPACT) Project*, *Ghana* (2002)*,* **HIV/AIDS Baseline Report on Ghana Customs Excise and Preventive Services Personnel**.

  The survey was aimed at providing insight on the media habits, sexual history, behaviours, and knowledge level of the officers with regards to STIs including HIV/AIDS, with the intent of developing appropriate messages and more effectively designing HIV/AIDS prevention and care programmes for this target group in Ghana.

- Family Health International (*IMPACT) Project, Ghana* (2002), **HIV/AIDS Baseline Report on Ghana Immigration Service personnel. FHI, Accra.**

  This study was conducted to obtain baseline information about the target group of 'immigration service personnel' in terms of their knowledge levels around HIV/AIDS, their sexual histories and practices, their understanding of what behaviours can reduce the risk of HIV transmission, and their perception of vulnerability. Other objectives included determining usage, availability and accessibility of condoms, investigating respondents' media habits, and determining how their work culture may affect their risk of getting or transmitting HIV. The results of the study may help design more effective programs and messages tailored to this target group, while providing a baseline by which to measure the impact of future interventions.

- Family Health International *(IMPACT) Project*, *Ghana* (2001), **An Assessment of the Management of Sexually Transmitted Diseases in Ghana.**

  This study aimed to evaluate the proportion of people receiving correct treatment in public health facilities, private clinics and pharmacies. The data will assist MOH programme planners in targeting the content of training programmes for health professionals and assess adherence to the current guidelines. In addition, the data will create a baseline against which future studies can be compared to determine changes in the quality of STD care.

- Family Health International *(IMPACT) Project, Ghana (2000),* **The Targeted Behavioural Surveillance Survey (BSS I) in Ghana** (2000), *Implementing AIDS Prevention and Care* in collaboration with Research International Ghana, the National AIDS Control Programme and Ghana Health Service; Ghana.

  This survey is aimed particularly at providing baseline data that will enable future comparisons, and the start-up of a continual system of surveillance. Behavioural Surveillance Survey (BSS) findings serve many purposes: they yield evidence of project impacts, provide indicators of project successes and highlight persistent problem areas, identify appropriate intervention priority populations, identify specific behaviours in need of change, function as a policy and advocacy tool, and supply comparative data concerning behavioural risks.

- Ghana AIDS Commission/Family Health International's IMPACT Project; Ghana (*2004),* ***Knowledge, Attitudes, and Behaviours of Men who have Sex with Men, and Lesbians with Respect to HIV/AIDS in Greater Accra/Eastern Regions of Ghana****.*

  This study was conducted to provide preliminary information that will enable the design of effective communication strategies to help homosexuals in Ghana protect themselves against HIV. The study is also geared towards providing information that will enable the design of programmes to meet the specific health needs of homosexuals.

- *Ghana AIDS Commission/Family Health International's IMPACT Project; Ghana (*2004), **Knowledge, Attitudes, and Behaviours of the Physically Challenged with Respect to HIV/AIDS in Greater Accra/Eastern Regions of Ghana.**

  This study was conducted with the objective of providing information that will enable the design of effective communication strategies to reduce the constraints in access to health information and knowledge of HIV/AIDS among the physically challenged in Ghana. It was also executed to enable effective integrated programmes in the CBR that cater for the psychological needs of the physically challenged in their community.

- Ghana Health Service/ National AIDS/STI Control Programme (2003), **HIV Sentinel Surveys**

  The report presents the results of the 2003 HIV sentinel survey and trends in HIV prevalence over the years. The report provided the basis for projection, estimation and impact of HIV/AIDS in the general population. It is expected that the report will serve as a reference document, inform the designing of programmes and help accelerate the national response to HIV/AIDS

- Holmes et al. **VCT Treatment for HIV among Pregnant Women in Ghana When Antiretroviral Therapies are Available**

  This study was conducted to assess the acceptance or refusal of VCT for HIV and acceptance of treatment if positive among pregnant women aged 15-45years.

- Jackson D, Obiero W, Amoako N, Seth, Feinberg M, Essah K, Drah B, (2003), **HIV/AIDS Behavioural Surveillance Survey, Ghana 2002: Round II, and Rounds I & II Comparison Report,** *Family Health International's (IMPACT) Project, Research International Ghana/National AIDS Control Programme* and *Ghana Health Service*; 2002.

  The survey among others was intended to establish a monitoring system to track behavioural trend data for high-risk and vulnerable target groups that influence HIV/AIDS in Ghana and to provide information to help guide programme planning

- JSA Consultants Ltd. **Status of Home-based Care, PLWHAs Associations and Support Networks in Ghana**.

  The study was to map out all existing of Home-Based Care, PLWHAs Associations and Support Net Works in Ghana. The aim was to assess their institutional capacity, develop a method for cataloguing associations and identify 'best practices' and make appropriate recommendations.

- Ministry of Health, *Health Research Unit* (2000) **The Assessment of sexually Transmitted Disease (STD) Management in Ghana**, with support and technical assistance from *Family Health International's (IMPACT) Project; Ghana, Implementing AIDS Prevention and Care*.

  The study was designed to fill information gaps that existed in the quality of STD case management in both private and public sector, and to particularly assess the extent to which the syndromic management approach which was adopted in 1997 was being used. This research aimed at establishing a standard for appropriate diagnosis and treatment of STDs and evaluation the proportion of people receiving the correct treatment in all settings. It also evaluated the counselling of clients on the prevention of STDs, condom use and partner referral, which are all important components of STD case management. Finally, the survey provides baseline data on the two prevention indicators (PI 6 & 7) recommended by the World Health Organization's Global Programme on AIDS (WHO/GPA) for the assessment of STD case management, in order to assist

MOH programme planners in targeting the content and messages of interventions, while providing a baseline against which future studies can be compared.

- Navele A and Danikuu A, (2003), **Study and Inventory of Care and Support Services in Accra, Tema, Manya Krobo and New Juaben Districts**, Family Health International (FHI); *Implementing AIDS Prevention and Care (IMPACT) Project*, Ghana, December 2003.

  The goal of this survey was to identify the services available to PLWHA and their families, to assess the extent to which, and ways in which the services collaborate with each other, and to determine how to establish a network for referral and cross-referral between voluntary counselling and testing (VCT) and other Care and Support services, in order to meet the needs of PLWHA in Accra, Tema, Manya Krobo and New Juaben districts.

- Odei Gloria A, Lucy Brakohipa, De Paoli Marina, Klepp K. I., **Experiences of Infant Feeding Practices among a Group of HIV-Infected Mothers in the Manya Krobo District of Ghana,** Accra.

  This study investigated choice of infant feeding methods by HIV-infected mothers and the factors taken into consideration by these mothers in making the choice. The study also looks at their infant feeding experiences.

- Pappoe M, Jackson D, Essah K, Drah B. (2003), **Executive Summary of HIV/AIDS Qualitative Behavioural Surveillance Survey II (Supplement to BSS Round II)**, School of Public Health, University of Ghana, Legon, *Family Health International's (IMPACT) Project, Implementing AIDS Prevention and Care;* Ghana.

  The study was aimed at generating a better understanding of HIV/AIDS in national and regional terms, and to provide explanatory data on trends in knowledge, attitudes and behaviours among subpopulations at particular risk of HIV infection. The study is part of the USAID funded IMPACT Project implemented by FHI.

- Sefa-Dedeh A, Kamenga C, Fosua Clement, N, et al (2003), **National Guidelines for the Development and Implementation of HIV Voluntary Counselling and Testing in Ghana**, *Family Health International's (IMPACT) Project*, Ghana, *Implementing AIDS Prevention and Care,* November 2003.

  To serve as a guideline or protocol to regulate, standardize and monitor VCT across the country.

- UNDP/ Ghana AIDS Commission (2003), **Orphans and Vulnerable children (OVC): Mapping Study, Accra.**

  This study was designed to take stock of the number of orphans and vulnerable children in some selected districts in Ghana, estimate their numbers, know their whereabouts and determine their living conditions in relation to HIV/AIDS. It will also serve as a guide in the formulation of policies that can support the upkeep and maintenance of AIDS orphans and their caregivers.

- *World Vision Ghana*/Family Health International's *IMPACT Project*; Ghana **(**2002), **Baseline Assessment on HIV/AIDS in the Ahanta West District**

  This assessment was conducted in order to obtain baseline data for the design, implementation, monitoring and evaluation of the Behaviour Change Communication (BCC) program to be implemented by World Vision through a sub-agreement with FHI/IMPACT in the Ahanta West District of Ghana, where World Vision was working in eight of the ten operational zones.