



Under the Office of the President



# NATIONAL HIV & AIDS STRATEGIC PLAN 2021-2025



OCTOBER, 2020



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PRESIDENT OF THE REPUBLIC  
AND  
COMMANDER-IN-CHIEF OF THE GHANA ARMED FORCES



GHANA AIDS COMMISSION



Under the Office of the President

# NATIONAL HIV & AIDS STRATEGIC PLAN 2021-2025

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October 2020





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# Abbreviations and Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b> AIS</b>	AIDS Indicator Survey
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral Drug
<b>BCC</b>	Behavioural Change Communication
<b>CBO</b>	Community-Based Organization
<b>CHRAJ</b>	Commission on Human Right and Administration Justice
<b>CSO</b>	Civil Society Organization
<b>CSW</b>	Commercial Sex Workers
<b>CWC</b>	Child Welfare Clinic
<b>DHS</b>	Demographic and Health Survey
<b>dHTS</b>	Differentiated HIV Testing Services
<b>DSD</b>	Differentiated Service Delivery
<b>eMTCT</b>	Elimination of Mother-to-child Transmission
<b>FBO</b>	Faith-Based Organization
<b>FSW</b>	Female Sex Worker
<b>GAC</b>	Ghana AIDS Commission
<b>GDHD</b>	Ghana Demographic and Health Survey
<b>GHS</b>	Ghana Health service
<b>GoG</b>	Government of Ghana
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMIS</b>	Health Management Information System
<b>HIV SS</b>	HIV sentinel Survey
<b>HSS</b>	Health Systems Strengthening
<b>HTS</b>	HIV Testing Services
<b>ICT</b>	Information and Communication Technology
<b>IEC</b>	Information, Education and Communication
<b>IPD</b>	Inpatient Department
<b>JUTA</b>	Joint UN Team on AIDS
<b>KP</b>	Key Population
<b>LEAP</b>	Livelihood Empowerment Against Poverty
<b>LESDEP</b>	Local Enterprises and Skills Development Program
<b>LM</b>	Lead Ministry
<b>MARPs</b>	Most-At -Risk Population
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MDAs</b>	Ministries, Department, and Agencies
<b>MICS</b>	Multiple Cluster Indicator Survey
<b>MLGRD</b>	Ministry of Local Government and Rural Development



<b>MMDA</b>	Metropolitan, Municipal, and District Assemblies
<b>MoYS</b>	Ministry of Youth and Sport
<b>MoE</b>	Ministry of Education
<b>MoELR</b>	Ministry of Employment and Labour Relations
<b>MoFA</b>	Ministry of Food and Agriculture
<b>MoF</b>	Ministry of Finance
<b>MoGCSP</b>	Ministry of Gender, Children, and Social Protection
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men Who Have with Men
<b>MTCT</b>	Mother -To-Child-Transmission of HIV
<b>NACP</b>	National AIDS and STI Control Program
<b>NDPC</b>	National Development Planning Commission
<b>NDPF</b>	National Development Policy Framework
<b>NGO</b>	Non-Governmental Organization
<b>NHIS</b>	National Health Insurance Scheme
<b>NPC</b>	National Population Council
<b>NSF</b>	National HIV & AIDS Strategic Framework
<b>NSP</b>	National HIV & AIDS Strategic Plan
<b>NSPS</b>	National Social Protection Strategy Plan
<b>OP</b>	Operational Plan
<b>OPD</b>	Outpatient Department
<b>OVC</b>	Orphans and Vulnerable Children
<b>PC</b>	Programmes Committee
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PITC</b>	Provider Initiated Testing and Counselling
<b>PLHIV</b>	Persons Living with HIV
<b>PMTCT</b>	Prevention of Mother-To-Child Transmission
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>PWID</b>	Persons Who Inject Drugs
<b>RH</b>	Reproductive Health
<b>RSSH</b>	Resilient and Sustainable Systems for Health
<b>SDGs</b>	Sustainable Development Goals
<b>STI</b>	Sexual Transmitted infection
<b>TB</b>	Tuberculosis
<b>TC</b>	Testing and Counselling
<b>UNAIDS</b>	Joint United Nation Program on HIV and AIDS
<b>WHO</b>	World Health Organization

# Foreword

Since the first HIV case was identified in Ghana in 1986, the country has been consistent in designing and implementing national strategies to prevent and control the epidemic. This is the fifth national strategic document to drive the next phase of the HIV response. Over the last two decades, Ghana has implemented two Strategic Frameworks (2001-2005 & 2006 -2010) and two Strategic Plans (2011-2015 and 2016-2020). The implementation of these strategic documents has led to significant progress in Ghana's HIV response towards elimination of HIV and AIDS.

As we consolidate our efforts to effectively fast-track the national HIV response to achieve the 95-95-95 fast track targets, and end AIDS by 2030, the Ghana AIDS Commission (GAC), in collaboration with key partners and stakeholders, has developed the National HIV and AIDS Strategic Plan (NSP) 2021-2025 to guide the implementation of the national response over the next 5 years.

The NSP 2021-2025 is solidly grounded in scientific evidence and adjusts to the rapidly changing global health environment. The NSP 2021-2025 clearly defines impact results and lays out a roadmap for the five-year period, keeping in view the global target of ending AIDS by 2030. It also identifies social, environmental and programmatic enablers that could facilitate the speedy attainment of the set targets. It also provides strategies for ensuring dedicated inflow of funds to support its full implementation.

Given the reality of dwindling donor funds globally especially, for HIV, it is critical for stakeholders to be innovative in diversifying the funding base to ensure the national response does not suffer setbacks. It must be emphasized that for us to deliver comprehensive HIV prevention, treatment, care and support services as critical measures for achieving universal health coverage, it is absolutely crucial that adequate domestic funding and technical resources will be mobilized to sustain the HIV programmes. Universal coverage for HIV and AIDS services is attainable and we must do all it takes to achieve it.

My Government is committed to providing sustained financing towards ending AIDS by 2030 and achieving the 95-95-95 treatment targets: where 95% of people living with HIV know their status; 95% of people who know their status are on treatment; and 95% of people on treatment with suppressed viral load.

In view of the goal and objectives of this Strategic Plan, I call upon all stakeholders, partners and everyone to actively participate fully in its implementation to ensure that we achieve HIV epidemic control and end AIDS as a public health threat within this current decade.



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**Nana Addo Dankwa Akufo-Addo**  
President of the Republic of Ghana

# Acknowledgement

Developing the National HIV and AIDS Strategic Plan (NSP) 2021-2025 has been a demanding but enriching experience. The Ghana AIDS Commission (GAC) acknowledges with deep appreciation the contributions made by ministries, departments and agencies (MDAs); metropolitan, municipal and district assemblies (MMDA); development partners (DPs), the CCM, civil society organizations (CSOs), faith-based organizations (FBOs), the private sector, Networks of Persons Living with HIV (NAP+), National AIDS & STI Control Programme (NACP) and individuals at both national and sub national levels, without whom the successful preparation of the NSP 2021-2025 would not have been possible.

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# Executive Summary

Ghana has a generalized HIV epidemic with relatively low prevalence. However, the epidemic is characterised by pockets of high prevalence in some geographical areas and in sub-populations. The country has slowly but steadily made modest progress in its response to the HIV and AIDS epidemic. The 2020 National and sub-National HIV and AIDS Estimates Report indicates the national adult HIV prevalence of 1.68% (down from a prevalence of 1.70% in 2019) and the adult (15-49) incidence rate of 0.09%. The Report also reveals that 346,120 people are living with HIV and the HIV prevalence varies across all 16 regions of the country. Regional HIV prevalence ranged from 2.5% in the Bono Region as the region with the highest prevalence to the lowest of 0.6% occurring in Northern and North East Regions. Eight regions, Ahafo, Ashanti, Bono, Bono East, Eastern,



Greater Accra, Western and Western North regions exceeded the national prevalence, with the remaining regions below the national prevalence. HIV prevalence among young people (15-24 years), a proxy for new HIV infections, remains at 0.70%<sup>1</sup>.

Since the first case of HIV in Ghana was recorded in 1986, the country has systematically responded to the epidemic as it evolved by establishing appropriate coordination structures and developing policies and action plans to guide the implementation of activities designed to control the epidemic and eventually end AIDS as a public health concern. In chronological order, the national HIV response includes the establishment of the National AIDS Control Program (NACP) in 1987, the Ghana AIDS Commission (GAC) in 2000, and the development and implementation of four National HIV and AIDS Strategic Frameworks/Plans each lasting five years: The National HIV and AIDS Strategic Framework (NSF I) 2001-2005, NSF II 2006-2010, National HIV and AIDS Strategic Plan 2011-2015 and the National HIV and AIDS Strategic Plan 2016-2020.

This National Strategic Plan 2021-2025, the 5th national strategy since 2001, is guided by the four pillars and the four objectives of the National HIV and AIDS Policy 2016 while the activities are designed to achieve the objectives of the Policy. The four pillars are: (i) Greater involvement of people living with HIV and AIDS (ii) Alignment with global concepts and frameworks, (iii) Decentralized multi-sector and multidisciplinary planning and execution, and (iv) Partnership and collaboration with public, private, local and

international institutions. The four objectives are to (i) Empower the population to prevent new HIV infections, (ii) Ensure the availability of and accessibility to prevention, treatment, care and support services, (iii) Mitigate the social and economic effect of HIV on persons infected and/or affected by HIV, and (iv) Ensure the availability of adequate funding to execute the policy strategies.

December 2020, was the milestone for the 90-90-90 global fast track HIV treatment targets. Like many other African countries, Ghana's performance results of 63-95-73 were far lower than the global targets. Therefore, the NSP 2021-2025 represents Ghana's renewed commitment to achieve the new UNAIDS Global Strategy's 95-95-95 fast track treatment targets. The lessons learned and the momentum generated over the period of implementation of the previous NSP will drive the country's efforts at achieving the 95-95-95 treatment targets by 2025.

In addition to continuing the key programming areas of the NSP 2016-2020, new areas identified as critical for the national HIV response will be addressed in the NSP 2021-2025. These are: (i) Adolescent Girls and Young Women (AGYW): Providing HIV combination prevention for AGYW and their partners; (ii) PrEP and PEP: Providing PrEP and PEP for KPs and persons exposed to HIV, (iii) HIV Self-Testing (HIVST): Making this service available particularly for KP, AGYW with the participation of the private sector, and (iv) Integration of other health services: Taking HIV out of isolation to improve universal health coverage.

1 2020 National and Sub-national Estimates Report

The goal of the NSP 2021-2025 is to achieve epidemic control and the fast track targets of 95-95-95 by 2025.

The key outcome indicators for HIV Prevention, Treatment, Care, and Support program areas are:

1. HIV prevention program

- Reduce new HIV infections in the general population by 85% by 2025 from 18,928 new HIV infections in 2020 to 2,839 in 2025;
- Reduce new HIV infections in young people (15-24 years) especially AGYW by 85% by 2025 from 5,211 in 2020 to 782 by 2025; and
- Reduce new HIV infections among KPs (FSW and MSM) by 85% by 2025.

These outcome indicators will be achieved by providing HIV combination prevention interventions for the general population, AGYP and their male partners and key populations as well as interventions for eMTCT.

2. HIV treatment, care, and support program

The goal of the HIV treatment, care, and support program is to achieve the 95-95-95 fast track HIV treatment targets by 2025.

The outcome indicators for the fast track HIV treatment program are:

- 95% of PLHIV know their HIV status by 2025 through the provision of differentiated HIV testing services (dHTS) from a baseline of 63% in 2020;

- 95% of people diagnosed with HIV are receiving ART using differentiated service delivery (DSD) approaches from a baseline of 95% in 2020; and

- 95% of PLHIV on ART are virally suppressed by 2025 through accelerating the provision of quality viral load suppression services from a baseline of 73% in 2020.

To achieve these outcomes, the NSP 2021-2025 requires the strengthening of key social and programmatic enablers of the national HIV response with the greatest potential to helping the country to achieve HIV epidemic control by 2025 and end AIDS by 2030. The social enablers include political commitment policy environment, advocacy, community mobilization, stigma and discriminations; and the programmatic enablers include national HIV response coordination and management, monitoring & evaluation and research.

The management and implementation arrangements of the national HIV response are defined in this NSP 2021-2025 document. These arrangements are primarily designed to reduce duplication and role ambiguity of stakeholder efforts. These arrangements will enable the effective and efficient coordination, harmonization, and implementation of the NSP 2021-2025 by the various stakeholders. The arrangements are expected to take advantage of existing synergies and develop new synergies between Ministries, Departments and Agencies (MDAs) and other partners.



# SECTION 1: BACKGROUND

## 1.1 Introduction

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

- In 1987, the National AIDS/STI Control Program (NACP) was established.
- In September 2000, the Ghana AIDS Commission was established. The GAC was mandated by Act 2002 (Act 613) which was revised and repealed by the current Act 2016 (Act 938). The previous and current Acts provide policy direction as well as defined functions



of GAC to ensure that multi-sector responses are coordinated. GAC has since led the development of four National HIV and AIDS Strategic documents to guide the implementation of the national HIV response i.e. National HIV and AIDS Strategic Framework (NSF I) 2001-2005, subsequently NSF II 2006-2010, National HIV and AIDS Strategic Plan 2011-2015 and the National HIV and AIDS Strategic Plan 2016-2020.

- Significant progress has been made through the implementation of the various preceding national HIV policies, frameworks, and strategic plans.

## 1.2 The Current Situation

Ghana is classified as having a generalized HIV epidemic with pockets of high prevalence in some geographical areas and sub-populations. Since 1987, the country has been consistent in designing and implementing national HIV responses and has slowly but steadily made good progress in its response to HIV and AIDS. These responses seek to reduce the incidence of HIV and AIDS-related deaths, as well as mitigate the impact of HIV and AIDS on the population.

The 2020 <sup>2</sup> National and sub-national HIV and AIDS Estimates Report (Table 1) has the adult national HIV prevalence at 1.68%, with 346,120 (91.71% adults and 8.29% children) people living with HIV (PLHIV); 18,928 new HIV infections (80.54% adults and 19.46% children); and 12,758 AIDS-related deaths (76.78% adults and 23.22% children).

HIV infections in adults (15+ years) are considered to be largely sexually transmitted and infections in children (0-14 years) to be vertically transmitted (mother to child transmission). HIV transmission by injection (as in people who inject drugs (PWID)) and professional accidental exposure is rare. Nevertheless, a further HIV mode of transmission study, last conducted in 2014, is needed to determine current sources of HIV transmission in the country.

HIV prevalence among the young population (15-24 years), a proxy for new infections, was 0.70% in 2020. Of the estimated 42,016 youth 15 to 24 years living with HIV in 2020, 73.91% are females, highlighting the heightened vulnerability of adolescent girls and young women in this age group to HIV infection. In 2020, the coverage of PMTCT was 71.59% and the mother-to-child transmission of HIV (including the breastfeeding period) was 20.81% (Table 1).

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2 2020 State of the HIV and AIDS Epidemic Report; GAC, 2020

**Table 1: Summary of Key HIV Indicators: 2020 - Estimates by Age and Sex**

Indicator	All Ages	15+ years	15-24 years Adolescents and Young People (AYP)	0-14 years
Children				
# HIV Population	346,120	317,410	42,016	28,710
% HIV Prevalence	1.68%	1.65%	0.70%	0.23%
# New HIV Infections	18,928	15,245 (80.54%)	5,211 (27.53%)	3,683 (19.45%)
# AIDS Deaths	12,758	9,796 (76.78%)	923 (7.23%)	2,961 (23.21%)
# Needing ART	345,734	317,410	42,016*	28,324
ART Coverage (as % PLHIV)	52.34%	62.78%	Not Available	33.70%

Indicator	All Ages	2020 Estimates by Sex		
		Males	Females	
# HIV Population	346,120	116,364	229,755	
HIV Prevalence	1.68	Not Available	Not Available	
# New HIV Infections	18,928	6,485	12,443	
# AIDS Deaths	12,758	6,189	6,569	
# On ART	208,811	54,540	154,271	
% On ART	60.32%	46.87%	67.15%	
Need for PMTCT			17,694	
PMTCT Coverage			71.59%	
MTCT of HIV including breastfeeding			20.81%	

**Source:** 2020 National and Sub-National Estimates  
 \*Not estimated, but based on PLHIV Population (15-24)

The 2020 HIV Sentinel Survey (HSS) reported that the median HIV prevalence among pregnant women was 2.0% and HIV sub-type 1 was still the most dominant with a proportion of 99.1%. Dual infection of HIV types I and II was 0.7% while HIV Type II only infection was 0.2% of the total positive samples. HIV type I continues to be the predominant type of HIV in Ghana.

According to the 2020 Estimates and Projections report, HIV population is projected to increase by about 3.3% between 2020 and 2025 reflecting the combined effects of the HIV prevention program and the ART and PMTCT programs (Table 2). More females will be living with HIV than males (by a factor of about 1:2) between 2020 and 2025.

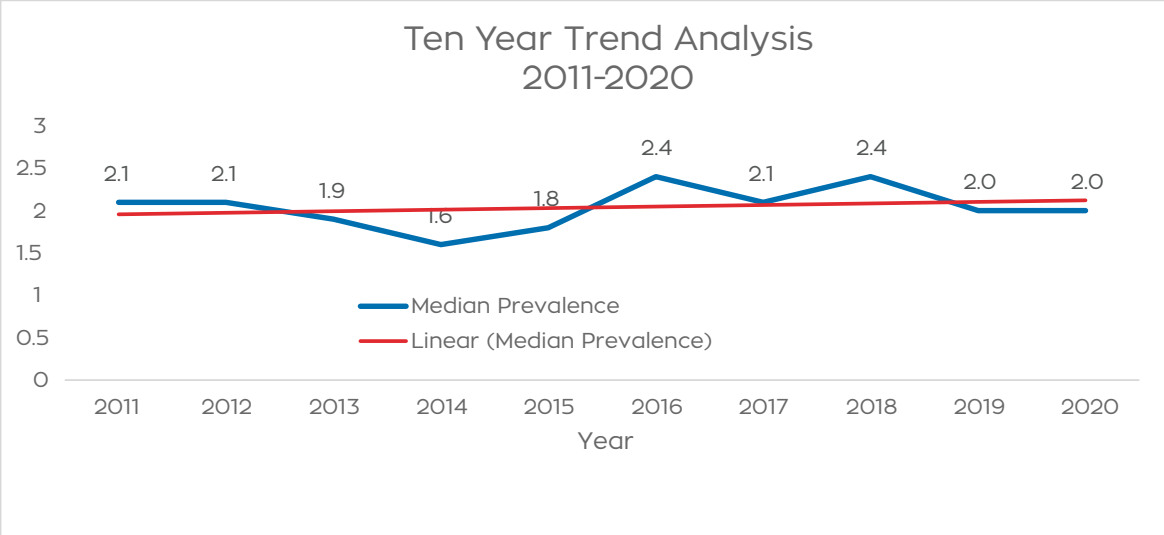
**Table 2: 2020 and Projected HIV Population 2021-2025**

Year	2020	2021	2022	2023	2024	2025
<b>Projected Population</b>	346,120	349,362	352,498	354,661	356,465	357,696
<b>Male</b>	116,364	115,994	116,124	116,117	116,049	115,803
<b>Female</b>	229,755	233,367	236,373	238,544	240,416	241,893

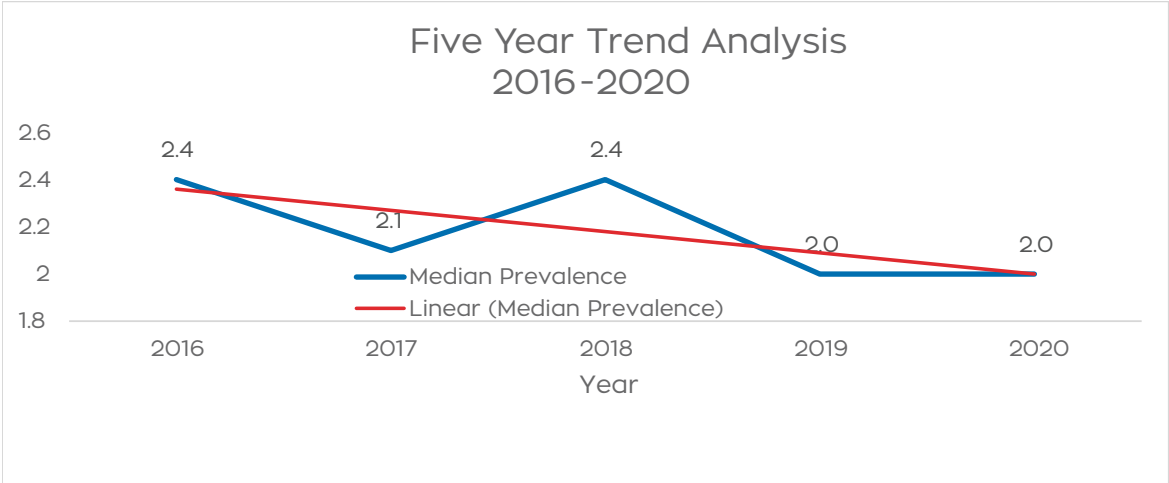
*Source: 2020 National and Sub-national HIV and AIDS Estimates*

A ten-year median linear trend analysis of HIV prevalence among pregnant women shows a slightly increasing trend (Fig. 1); however, a five-year linear median trend analysis shows a decreasing trend (Figure 2). There are also fluctuating regional prevalence and a higher urban disease burden.

**Figure 1: 10-Year Trend Analysis of HIV Prevalence among Pregnant Women**  
*Source: HIV Sentinel Surveys (HSS) Ghana Health Service 2011-2020*

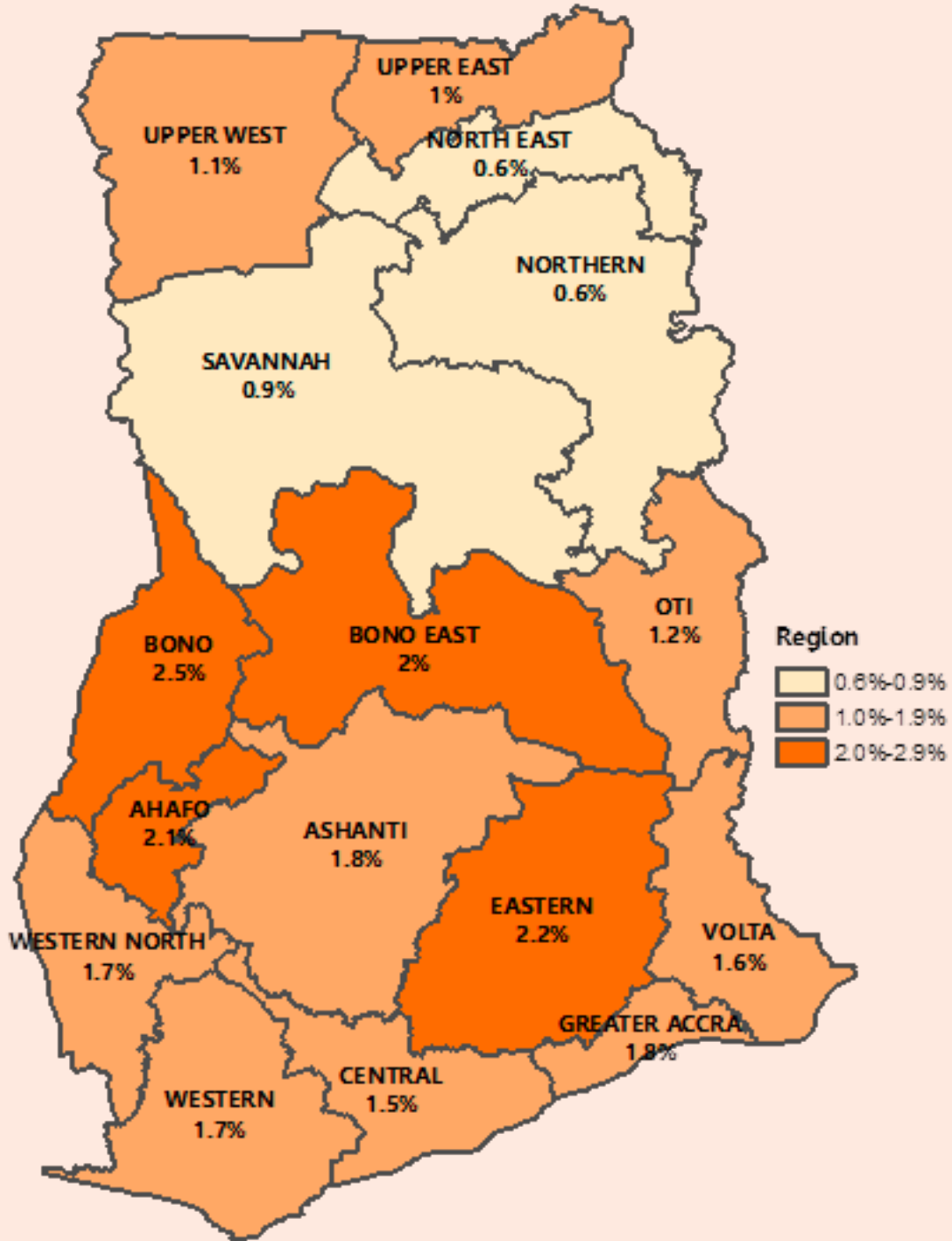


**Figure 2: 5-Year Trend Analysis of HIV Prevalence among Pregnant Women**



The national HIV prevalence for 2020 is 1.68% according to the 2020 National Estimates and Projections report. Regional HIV prevalence (Fig.3) ranged from 2.5% in the Bono Region as the region with the highest prevalence to the lowest of 0.6% occurring in Northern and North East Regions.

**Figure 3: HIV Prevalence by Region 2020 National and Sub-National Estimates**



Eight regions (Ahafo, Ashanti, Bono, Bono East, Eastern, Greater Accra, Western and Western North) exceeded the national prevalence, with the remaining regions being below the national prevalence.

Despite the evident progress Ghana has made to date in curbing the impact of HIV and AIDS on the population, there are prevailing institutional and programmatic challenges to the country's ability to further reduce the incidence, prevalence and risk of HIV and AIDS in the Ghanaian population. These include:

- (i) Limited availability and accessibility to evidence-based, culturally appropriate information to support the population adopt lifestyles that reduce their risk of getting infected with HIV;
- (ii) Limited availability of and accessibility to comprehensive preventive, treatment care and support services;
- (iii) Inadequate financial resources for prevention activities and the inability of government to meet its financial obligations towards the procurement of treatment, care and support logistics;
- (iv) The need to improve multi-sector and multi-stakeholder cooperation, collaboration and coordination in the execution of the national response; and
- (v) Gender inequalities and human rights related barriers that inhibit women, girls and key populations' access to, uptake of, and retention in HIV related services.

HIV remains a threat as evidenced by:

- i. New HIV<sup>3</sup> infections remained relatively high at almost 19,000 in 2020, but it is projected to decrease steadily, reaching a little over 9,000 by 2025;
- ii. AIDS related death was 12,758 in 2020 and it is expected to decrease to about 5,282 deaths by the year 2025.
- iii. Whilst a ten-year linear trend analysis shows a plateau in ANC HIV prevalence, the recent five-year linear trend analysis (2016-2020) shows a decreasing ANC prevalence; from 2.4 in 2016 to 2.0 in 2020
- iv. ANC HIV prevalence in Greater Accra region increased from 3.2% in 2019 to 3.5 in 2020 whilst that of Western region decreased slightly from 2.3% in 2019 to 2.2% in 2020;
- v. HIV prevalence in urban areas is higher than in rural areas for both mean and median prevalence. Urban areas had a median prevalence of 2.6% and a mean of 2.7% while rural areas had both median and mean prevalence of 1.8% in 2020;
- vi. FSW HIV prevalence of approximately 4.6% (IBBSS 2019) is significantly higher than the national prevalence of 1.7% in 2019;
- vii. MSM HIV prevalence increased from 17.5% (IBBSS 2011) to 18.1% (IBBSS 2017);

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3 National and Sub-National HIV and AIDS Estimates and Projections Report 2020

- viii. 27.7% of women and 20% of men experienced domestic violence (economic, social, psychological, physical, and sexual) in 2015<sup>4</sup> and 3.8% of women have undergone female genital mutilation/cutting<sup>5</sup>; and
- ix. 14% of men reported having multiple sexual partners in the past 12 months compared to 1% of women<sup>6</sup>.

In summary, HIV is firmly established in the general population. Although sub-populations at higher risk may continue to contribute disproportionately to the spread of HIV, risky sexual behaviours in the general population especially, unprotected heterosexual sex is the main driver of new infections and is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection.

### 1.3 Context of the National Strategic Plan 2021-2025

The National Strategic Plan 2021-2025 is informed and guided by the following:

#### 1.3.1 Universal Health Coverage

In December 2019, Ghana launched the Roadmap for Attaining Universal Health Coverage 2020-2030 (UHC)<sup>7</sup> with the goal of “Increased access to quality essential health care and population-based services for all by 2030”. The Roadmap is the commitment of the government and the people of Ghana to shape the future of health care in the country. It reflects carefully on the Sustainable Development Goals (SDGs), Global Action Plan for Healthy Lives and Well-being, Declaration on Primary Health Care in Astana (2018), UHC 2030 Compact, Initiatives of UHC 2030 and the Political Declaration of UHC adopted at the UN High Level Meeting in September 2019.

Through broad based consultations and consensus building with various stakeholders: public sector, civil society, private sector, and development partners, a set of priority services and interventions have been agreed to be made universally accessible to all persons living in Ghana.

The UHC Roadmap assumes priority over all strategies and plans; and sets the policy direction for the health sector. The Roadmap also emphasizes health in all policies with the aim to stir action in other sectors for health and Human Capital Development. The five-point guiding principles of the UHC roadmap are:

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4 Institute of Development Studies, Ghana Statistical Services and Associates. Domestic Violence in Ghana: Incidence, Attitudes, Determinants and Consequences, 2016

5 UNICEF global databases 2017, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative surveys. World Bank, World Development Indicators (WDI)

6 Ghana Statistical Service, Ghana Health Service, and ICF International. Ghana Demographic and Health Survey 2014, 2015

7 Ghana’s Roadmap for Attaining Universal Health Coverage 2020-2030, Ministry of Health. 2019

- Target group: Focusing on the poor and vulnerable particularly children and adolescents, women and the aged;
- Financial risk protection: Eliminating physical and financial barriers to accessing primary health care (PHC) services, especially for those most at risk of incurring catastrophic health expenditures at the incidence of ill health;
- Strategic partnerships: Build sustainable partnership and a harmonized agenda between government, private sector, non-state actors, and developmental partners to upscale service delivery and secure predictable financing for long-term results;
- Effective decentralized management: Cement district level service governance with the district assemblies and improve inter-sectoral collaboration to synergize resource mobilization, efficient use and accountability, particularly at the PHC levels of service delivery; and
- Domestic financing re-prioritized: Rationalize allocation and expenditure of domestic resources to focus on primary health care and manage existing and any new co-financing requirements within a realistic budgetary framework.

The Roadmap identifies HIV and AIDS, PMTCT and TB, amongst others, as basic essential facility-based primary and/or preventive services that need to be scaled up to attain universal health coverage. The NSP 2021-2025 is developed in alignment with and builds on the UHC roadmap.

### **1.3.2 The National HIV & AIDS Policy**

Ghana AIDS Commission developed a new National HIV & AIDS Policy in September 2019. This new policy provides the overarching direction for Ghana, as it continues on its journey to achieve the 90-90-90 treatment targets by 2020 and ultimately the SDG 3, specifically target 3.3, which calls for an end to the AIDS epidemic by 2030.

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

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

HIV and AIDS is recognized as a development issue. HIV has been appropriately and specifically included in the global developmental agenda, the SDGs. Interventions to

address the impact of HIV require a multi-disciplinary and multi-sectoral approach. In addition, as governments alone cannot address the issues, public-private-partnerships that leverage the strengths of both sectors, are important.

The policy sets out to achieve four objectives. These are:

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

The Ghana AIDS Policy is consistent with and supports other gender sensitive initiatives including those that reduce the impact of HIV and AIDS on women and girls. These include:

- National Gender Policy, 2015 that aims to mainstream gender equality and women's empowerment concerns into the national development process and promote commitment throughout the government to empowering women;
- Strategic Plan for a Comprehensive Response to Human Rights Related Barriers to HIV and TB Services in Ghana, 2020-2024 that seeks to remove human rights-related barriers to HIV and TB services and to improve access to quality HIV and TB healthcare and support services through pragmatic implementation strategies;
- Fast track commitments - UNAIDS 2016 to 2021 Strategy on the Fast-Track to end AIDS; and
- African Union Maputo Plan of Action on Sexual and Reproductive Health and Rights that promotes the delivery of integrated family planning, STIs, and HIV and AIDS services.

### **1.3.3 Outcome of Reprogramming of HIV Global Fund NFM II**

In 2019, a review of the implementation of the HIV Global Fund NFM II noted that minimal progress had been made to meet programmatic objectives. To mitigate this, the NACP and technical partners led by WHO, in consultation with key stakeholders, agreed to adopt a progressively focused and phased scale up approach to achieve the 90-90-90 targets. This approach employed differentiated care models implemented in selected facilities within priority regions.

The priority regions were Greater Accra, Brong-Ahafo, Eastern, Western and Ashanti. This accelerated plan focused on priority populations (Table 3) and sustained a phased implementation of enhanced community components of HIV care across the cascade. The HIV Acceleration Plan has shown impressive results since implementation from July 2019; lessons learned from the implementation have informed interventions proposed in the NSP 2021-2025.



**Table 3: Priority Populations and HIV Test Yields**

S/N	Category	Priority Populations who need to be reached	HIV Test Yield	Source
1.	Key Population	PWID	14.0%	Lee, 2017. What will it take for Ghana to achieve 90-90-90? Costing an Enhanced HIV Treatment Cascade.
		MSM	18.1%	Lee, 2017. What will it take for Ghana to achieve 90-90-90? Costing an enhanced HIV Treatment Cascade.
		FSW	11.0%	Lee, 2017. What will it take for Ghana to Achieve 90-90-90? Costing an enhanced HIV Treatment Cascade.
2.	Vulnerable Population	Pregnant Women	1.2%	NACP 2019 Data; ANC registers (0.9-1.5%). ANC prevalence 2.0%
		Partners of PLHIV (Index) (>15)	40.0%	NACP Index Pilot Data 2018
		Children of PLHIV (Index) (0-14)	15.0%	NACP Pilot Data 2018; Estimated
		High-Risk Young People (15-24)	0.06%	UNAIDS Adolescent HIV Infection
		OPD and IPD (using risk screening tool)	8%	Estimate based on consultation. Consider STI and TB estimates.
		High-risk men (clients of sex workers, entry points truckers, miners, uniform workforces (e.g. military, prison guards, security guards)	3.0%	Estimate based on 1.6% national prevalence and consultation.

### 1.3.4 Joint Program Review of the NSP 2016-2020

The Joint Program Review of NSP 2016-2020<sup>8</sup>, conducted in January 2020 in a consultative manner with key stakeholders, showed that the program implementation

8 Report on Joint Program Review NSP 2016-2020, 2020

was not on track to achieve targets set out in the Plan. The review identified successes as well as gaps in implementation that had negatively impacted the attainment of the set targets. The findings and recommendations of the Joint Programme Review informed the development of NSP 2021-2025. A few of the review findings are summarized as follows:

### **HIV Prevention**

- At the end of 2020, the percentage of pregnant women accessing ANC services and receiving HTS was 70%, with 87% of those testing positive and receiving ART, while mother-to-child transmission (MTCT) rate was 11.4%.
- Over 26 million condoms were distributed in 2020; about 7 million were given to KPs. Female condom uptake had continued to be low compared to male condoms due to many socio-cultural factors surrounding its use by women.
- Despite increased funding and rapid scale-up of KP programmes over the years, HIV prevalence among FSW (4.6%)<sup>9</sup> and MSM (18.10%)<sup>10</sup> remained several folds higher the national average. Stigma and discrimination were found to be significant hindrance to uptake of services by KPs.
- Program priority for HIV prevention in the NSP 2016-2020 for the general population was targeted at behaviour change intervention. However, available funds during implementation focused on KPs and pregnant women. There is still the need to identify innovative ways to implement HIV prevention interventions in the general population.

### **HIV Treatment**

- Despite generally low uptake, the provision of HTS had increased due to increased availability of services at all PMTCT sites and various entry points at the health facility. CSOs engaged in KP programming promoted and provided HTS for FSW and MSM.

9 2019 IBBSS and MPSE for FSW and Intimate Partners Report

10 Ghana Men's Study 2 Report, 2017 National Estimates and projections report 2020

- In 2020, a total of 208,811 PLHIV received antiretroviral drugs. The high uptake of treatment was attributed to regular supply of ARV drugs in the country, the provision of drugs at ANC centres for pregnant women, and the use of Models of Hope to provide counselling and support.
- There were efforts to ensure systematic enrolment of all HIV/TB co-infected patients on ART. The program reported an increased percentage of TB patients who tested for HIV; 1,856 TB patients who tested positive for HIV were on ART as at 2019. In 2020, a total of 138,507 HIV positive clients were screened for TB, and all 936 co-infected individuals were put on treatment.
- At the end of 2020, Ghana had achieved 63-95-73 of the 90-90-90 treatment targets. Out of a population of 346,120 PLHIV, 218,741 (63%) knew their HIV status; 208,811 (95%) of them were on ART, and 152,365 (73%) of those on ART were virally suppressed. Despite the introduction and implementation of the Test and Treat policy, high defaulter rates and poor access to viral load tests and receipt of results continued to be important challenges.

### Critical social and programmatic enablers

- The political commitment to tackling HIV in Ghana has been demonstrated through the development of appropriate policies, establishing leadership and coordination structures from national down to the district level.
- Communities (PLHIV, CSOs and NGOs) have been at the forefront of the national response to HIV. They are critical in both raising awareness and providing support for PLHIV or persons who are affected by HIV (orphans and vulnerable children).
- Stigma and discrimination at the facility level persist despite continuous efforts at mitigating them at health facilities. Key informants noted that internalised or self-stigma among PLHIV is also high. One-third of the FSW surveyed in IBBSS 2015 had negative attitudes towards PLHIV<sup>11</sup>. MSM in the 2017 Ghana Men's Study (GMS) II reported that they were treated well by healthcare providers when they accessed services.<sup>12</sup>

11 GAC Integrated BioBehavioural Survey among Female Sex Workers and Their Non-Paying Partners in Ghana 2015

12 GAC, Ghana Men's Study Report, 2017

- Young key populations face widespread discrimination, stigma and violence and specific vulnerabilities associated with youth, including power imbalances in relationships. They also have lower knowledge of HIV risks and lower ability to mitigate those risks.<sup>13</sup>
- Gender inequalities and barriers persist to the disadvantage of women, girls and key populations across sectors. These include harmful gender norms and gender-based violence, which fuel the disproportionate burden of HIV and economic inequality among women and girls.

### 1.3.5 Progress to Date: 90-90-90 HIV Treatment Targets

A key goal of the NSP 2016-2020 was to achieve the 90-90-90 fast-track treatment targets by 2020. Table 4 is a summary of the progress towards the 90.90.90 targets as at end of December 2020.

**Table 4: Progress Towards 90.90.90 Targets at the End of 2020**

	Indicator	2020		
	90.90. 90 HIV Treatment Targets	All	Male	Female
1.	Estimated PLHIV population	346,120	116,364	229,756
2.	PLHIV who know their status: 1st 90	63%	51%	69%
3.	PLHIV with diagnosed HIV receiving ART: 2nd 90	95%	91%	97%
4.	PLHIV on ART with viral suppression: 3rd 90	73%	62%	62%

Source: State of the National HIV Response Report 2020

Although significant progress had been made, Ghana, like many African countries, could not achieve the 90-90-90 fast track targets as at the end of 2020.

13 Young People, HIV and AIDS - AVERT April 2020. [https://: www.avert.org/professionals/hiv-social-issues/keyaffecteded-populations/youmd people](https://www.avert.org/professionals/hiv-social-issues/keyaffecteded-populations/youmd people)

# NSP 2021-2025 Investment Framework

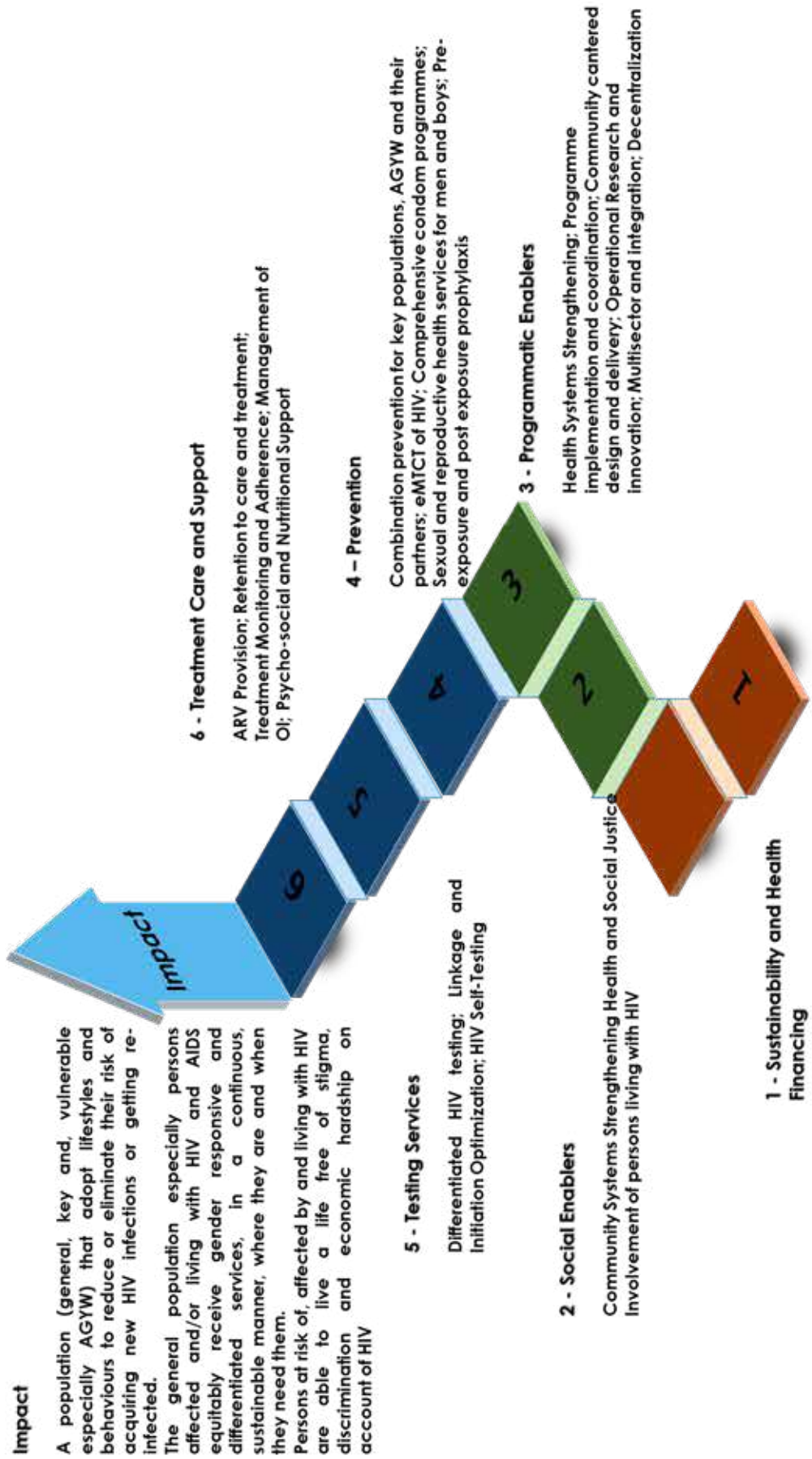


Figure 3: Investment Framework NSP 2021-2025

## 1.4 Guiding Principles, Vision, Goal, Strategic Objectives, and New Initiatives

### 1.4.1 Guiding Principles of the NSP 2021-2025

The NSP 2021-2025 is guided by the following principles:

- Greater Involvement of People Living with AIDS (GIPA) and people affected by HIV including key populations and the communities in general;
- Alignment with global strategies and commitments (UNAIDS 95-95-95 and 10-10-10 global targets);
- Decentralized, multi-sector and multi-disciplinary planning and execution;
- Partnership and collaboration with public, private, local and international institutions;
- Evidenced-based targeted interventions for HIV prevention, treatment and care;
- Integration of the national response into all national plans and strategies;
- Shared accountability and transparency for effective national response;
- Gender-transformative response; and
- Human rights-based approach.

### 1.4.2 Vision

The vision of NSP 2021-2025 is to accelerate progress to end the AIDS epidemic by 2030.

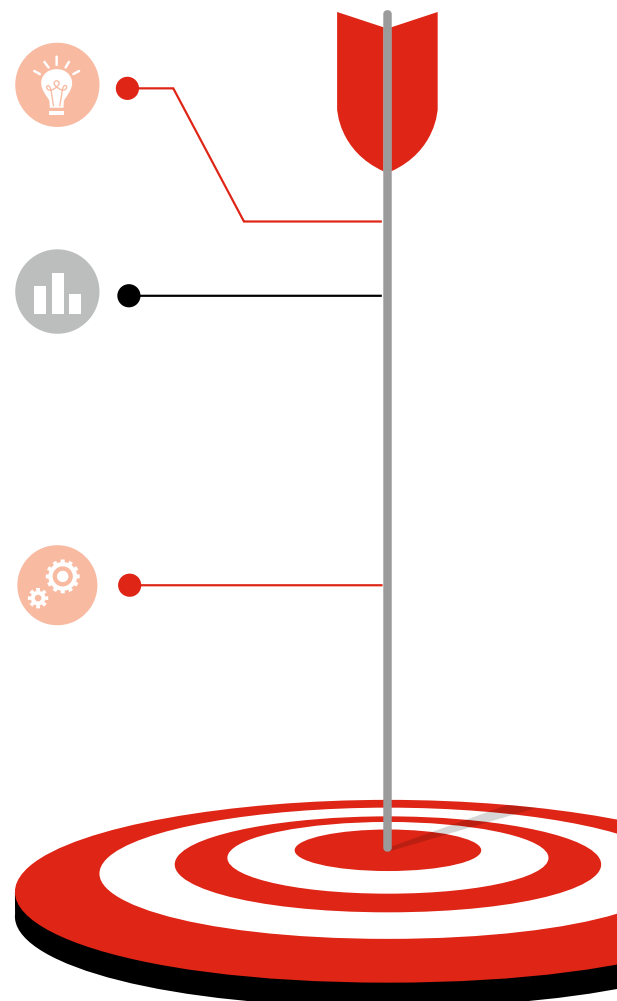
### 1.4.3 Goal

The goal of the NSP 2021-2025 is to achieve epidemic control and the fast track targets of 95-95-95 by 2025.

### 1.4.4 Strategic Objectives

This NSP seeks to achieve the objectives of the National HIV & AIDS Policy, September 2019 by translating them into programmatic actions. The objectives of the National HIV and AIDS Policy are as follows:

- Empower the population to prevent new HIV infections;
- Ensure the availability of and accessibility to prevention, treatment, care and support services;



- Mitigate the social and economic effect of HIV on persons infected and/or affected by HIV; and
- Ensure the availability of adequate funding to execute the policy strategies.

The NSP 2021-2025 details out more specific objectives and strategic activities to achieve the desired outcomes of these Policy objectives.

#### **1.4.5 New Initiatives under NSP 2021-2025**

In addition to current programming, new areas listed below will be embarked upon under the NSP 2021-2025:

- Adolescent Girls and Young Women (AGYW): Providing combination prevention for AGYW and their partners;
- PrEP and PEP: For KP and persons exposed to HIV;
- HIV Self-Testing: Making this service available particularly for KP and AGYW with the participation of the private sector; and
- Integration of other health services: Taking HIV out of isolation to improve universal health coverage.



## Section 2: HIV PRIMARY PREVENTION

### 2.1 Introduction

Globally, it has been recognized that while HIV treatment saves lives and has a significant preventive effect by suppressing HIV transmission, treatment alone will not be adequate to control the HIV epidemic. Primary prevention needs to be vigorously scaled up. A new effort is urgently needed to reinvigorate primary HIV prevention, building on lessons learned from previous prevention initiatives and other successful experiences that have contributed to the reduction of new HIV infections.



The sustained presence of HIV in Ghana is directly correlated to new infections in the youth, especially adolescent girls and young women who account for 23% of total new infections in the country. In addition to HIV education, the youth need to be empowered with comprehensive and context specific information around sex and sexuality, gender equality, and gender-based violence (GBV) to enable them to make decisions that prevent them from acquiring HIV and other sexually transmitted infections (STIs). Their empowerment should lead them to seek and use HIV tests and treatment services and develop respectful social and sexual relationships. In and out of school youth will be engaged with the appropriate information in the most culturally acceptable manner.

## 2.2 HIV Combination Prevention

Ghana has adapted HIV combination<sup>14</sup> prevention as her primary vehicle for preventing new infections. The NSP 2021-2025 seeks to provide combination prevention interventions on HIV and AIDS to the general public, with a focus on key populations, other at-risk groups and young people particularly adolescent girls and young women (AGYW) and their male partners.

Combination prevention interventions will include the provision of information, demand generation for HIV prevention, comprehensive sexuality education (CSE); engendering economic empowerment; addressing barriers to gender-responsive services, harmful masculinity and gender norms, and gender-based violence; improving access to sexual and reproductive health services (including PMTCT, eMTCT, PrEP, PEP, condoms and lubricants) and justice. All these will be done, mindful of the need to ensure cultural acceptability and age appropriateness.

These services will be offered through institutional and community-based delivery platforms across all sectors with a focus on high HIV prevalence regions.

## 2.3 Objectives

Table 5 shows the trends in projected HIV incidence in Ghana by age group and year. The objectives of the prevention component of the NSP 2021-2025 are to:

- Reduce new HIV infections in the general population by 85% by 2025 from 18,928 new HIV infections in 2020 to 2,839 in 2025;
- Reduce new HIV infections in the young people (15-24 years), especially AGYW, by 85% by 2025 from 5,211 in 2020 to 782 by 2025; and
- Reduce new HIV infections among KPs (FSW and MSM) by 85% by 2025.

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<sup>14</sup> Defined as rights-based, evidence-informed HIV prevention programming approaches that use a mix of biomedical, behavioural and structural interventions, prioritized to meet the current needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections.

**Table 5: Trends in Projected New HIV Infections 2020-2025**

	Age Group	2020	2021	2022	2023	2024	2025
New HIV Infections	0-14	3,683	2,752	2,143	1,543	1,471	1,387
	15-24	5,211	4,277	3,469	2,951	2,752	2,558
	15-49	14,238	11,723	9,535	8,135	7,605	7,082
	15+	15,245	12,571	10,240	8,747	8,188	7,633
	All Ages	18,928	15,323	12,383	10,290	9,659	9,020

Source: National and Sub-National HIV and AIDS Estimates and Projections 2020

### Impact Indicators

- Decreased HIV prevalence amongst the general population, AGYW, KPs and other at-risk groups; and
- Decreased HIV incidence amongst the general population and young people (15-24 years), especially AGYW, KPs and other at-risk groups.

### Desired Outcome

- A population that adopt lifestyles and behaviours to reduce or eliminate their risk of acquiring HIV;
- Reduced stigma and discrimination; and
- Adoption of more accepting attitudes towards people living with HIV, KP, and respect for the rights of adolescents and young people (AYP) to access sexual and reproductive health (SRH) services.

## 2.4 Combination Prevention Interventions for the Adult Population

### 2.4.1 Introduction

Program priority in the NSP 2016-2020 for the general population was targeted behaviour change intervention. The Joint Program Review of NSP 2016-2020 showed that over the last few years, HIV prevention programs focused on KPs and pregnant women at the neglect of prevention interventions for the general population throughout the country except in the Western Region. This has contributed to poor behaviour change outcomes among the general population. Comprehensive knowledge about HIV among the general population decreased between 2008 and 2014, yet improved knowledge is often a precursor to behaviour change. Programmers need to know what HIV messages are more likely to increase comprehensive knowledge about HIV. Stigma and discrimination are still prevalent and the proportion of the general population with accepting attitudes towards PLHIV is decreasing instead of increasing.

Within the general population there are vulnerable population such as persons with disabilities, female head porters (kayayei), migrants, and refugees. Specific intervention must be developed to address their HIV vulnerabilities in order to ensure their rights to HIV prevention information and services are protected.

### 2.4.2 Outcome Indicators and Targets

The HIV combination prevention outcome indicators and targets for adult population are shown in Table 6.

**Table 6: Outcome Indicators and Targets - Multiple Sexual Partners**

SN	Indicator	Target Population	2020	Source & Year	2021	2022	2023	2024	2025
1.	% of women and men aged 15-49 years who have had sexual intercourse with more than one partner in the past 12 months	Women (7,772,611)	1.5%	MICS (2018)	1.3%	1.25%	1.2%	1.2%	1%
		Men (7,384,332)	12.4%		12.2%	11.8%	12%	11%	10%
2.	% of women and men aged 15-49 who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during their last sexual intercourse	Women (7,772,611)	25.4%	GDHS 2008	30.5%	34%	37%	41%	45%
		Men (7,384,332)	45.1%		49.6%	55%	60%	66%	73%

## 2.4.3 Key Strategies and Activities

### Strategic Intervention 1

Sustaining behaviour change interventions (BCI) to improve comprehensive knowledge of HIV:

#### Activities

- Develop a fact sheet on what constitutes comprehensive knowledge;
- Develop specific target and gender-specific messages needed to improve comprehensive knowledge; and
- Include messages aimed at improving comprehensive knowledge in all behaviour change interventions.

### Strategic Intervention 2

Targeting interventions among selected general population including workplaces, tertiary institutions, and informal sector workers:

#### Activities

- Design interventions with specific groups to reflect interests;
- Engage with employers to continue to implement workplace interventions; and
- Work with appropriate partners to expand interventions in the informal sector.

### Strategic Intervention 3

Developing and promoting innovative approaches to improve accepting attitudes towards PLHIV:

#### Activities

- Design nationwide stigma reduction campaigns;
- Train programmers on how stigma and discrimination are measured and include the items in message design; and
- Incorporate stigma reduction campaigns into all HIV testing campaigns.

## Strategic Intervention 4

Designing and implementing specific interventions for vulnerable populations within the general population:

### Activities

- Undertake research to understand the HIV vulnerabilities of persons with disabilities, kayayei, migrants, and refugees to facilitate the design and implementation of interventions;
- Design general population interventions keeping in mind the needs of persons with disabilities and other vulnerable groups; and
- Understand the risky behaviours and HIV prevalence among kayayei, migrants, and refugees and use evidence to inform programming.

## 2.5 Combination Prevention Interventions for Young People, especially AGYW and their Partners

### 2.5.1 Introduction

Young people are defined as adolescents and young people (AYP) between the ages of 15 and 24 years. The 2020 National and Sub-national Estimates Report shows there were 5,211 new infections among young people, more than a quarter of all new HIV infections in the country. The national HIV prevalence for young people is 0.70% with an HIV population of 42,016.

Young people (15-24 years) are considered a vulnerable group for HIV infection as they are sexually active and are often involved in unprotected sexual intercourse. Comprehensive knowledge of HIV among young persons is declining along with condom use among young persons with two or more partners. Condom use with non-regular<sup>15</sup> partners is very low: 19% among young women and 39% among young men. In addition, young people have limited access to HIV and AIDS prevention, treatment, care and support services compared with adults.

### 2.5.2 Outcome Indicators and Targets

Table 7 shows the outcome indicators and targets for young people (especially adolescent girls and young women) and their partners.

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15 State of Prevention for Ghana from Global Prevention Coalition 2019

**Table 7: Outcome Indicators and Targets - Combination Prevention for AYP**

S/N	Indicator	Target Population	Baseline	Source & Year	Program Targets				
					2021	2022	2023	2024	2025
1.	% of AYP with comprehensive knowledge of HIV transmission and prevention	AGYW (1,496,724)	17.0%	MICS (2018)	45%	68%	74%	85%	90%
		AY Men (1,524,965)	20.0%	MICS (2018)	53%	63%	69%	71%	90%
2.	% Condom use with non-regular partners	Young Women	19%	Ghana - 2019	30%	50%	70%	80%	90%
		Young Men	39%	Global Prevention Coalition	50%	60%	70%	80%	90%
3.	New HIV Infections per 100,000 Population	AYP 15-24 years	89 (2020)						
	Ghana HIV Estimates and Projections 2020	72	57	48	44	41			
4.	% of women and men aged 15-24 years who have had sexual intercourse with more than one partner in the past 12 months	Women (2,870,105)	2.2%	GDHS 2014	2.2%	2.2%	2.1%	2.0%	1.7%
		Men (2,891,245)	7.9%		7.9%	7.7%	7.6%	7.2%	6.1%
5.	% of women and men aged 15-24 who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during last sex	Women (2,870,105)	28.2%	GDHS 2008	28.2%	29.6%	38.5%	53.9%	86.2%
		Men (2,891,245)	46.4%		46.4%	46.9%	56.2%	73.1%	95.0%

6.	% of never-married young people (15-24 years) who are sexually active	Women (2,870,105)	14.9%	GDHS (2014)	14.2%	13.4%	12.8%	12.1%	10%
		Men (2,891,245)	34.2%		32.5%	30.9%	29.3%	27.9%	28%

### 2.5.3 Key Strategies and Activities

#### Strategic Intervention 1

- Develop community and social media based SRHR and HIV messages that are gender responsive with the active engagement of young females and males; and
- Establish adolescent and gender friendly health services that are accessible to young people.

#### Activities

- Develop guidelines to support community and social media-based HIV health promotion programs for AGYW;
- Develop technology-driven programs that specifically target adolescent behaviours such as intergenerational sex, high-risk sex, and alcohol and drug abuse;
- Intensify media HIV education (social media, community radios, and information centres);
- Scale up school-based HIV prevention interventions;
- Develop specific target and gender-specific messages via social media platforms to improve comprehensive knowledge;
- Behaviour change communication interventions must include messages aimed at improving comprehensive knowledge of HIV; and
- Strengthen the youth-friendly corners at the health facilities.

#### Strategic Intervention 2

Identifying government and civil society organizations' (CSOs) communication channels to reach AGYW and integrating information on HIV and sexual and reproductive health (SRH) to change behaviour:

#### Activities

- Identify proper communication channels within government and CSOs for HIV prevention programs;
- Provide technical assistance and material support on HIV prevention information and services to government institutions such as Ministry of Gender Children and Social Protection, Ghana Education Service, and National Youth Authority; and
- Engage CSOs to implement community based targeted prevention interventions.

### **Strategic Intervention 3**

Creating an enabling or supportive environment for adolescents and youth population to access HIV prevention services:

#### Activities

- Develop guidelines to support access to and provision of adolescent and youth-friendly HIV prevention services;
- Build capacity of service providers – Train, retrain, mentor, and provide supportive supervision for service provision among adolescents in friendly environments; and
- Strengthen the linkage between HIV prevention programs and SHR programs.

### **Strategic Intervention 4**

Promoting young people’s participation in expanding the national responses to HIV and AIDS:

#### Activity

- Ensure youth led organizations in the communities are empowered to lead HIV prevention.

## **2.6 HIV Combination Prevention Interventions for Key Populations (KPs)**

### **i. Introduction**

FSW and MSM are the main KPs targeted with HIV combination prevention services in Ghana. A total of 44,184 FSW and 21,270 MSM were reached in 2020 with HIV prevention



information; and 39,770 (66.5%) FSW and 20,026 (33.5%) MSM were tested and know their test results.

The introduction of the Ghana Key Population Unique Identification System (GKPUIS) application is making tracking and monitoring of KP services more evidence based. A total of 26,018,918 (male condoms 25,961,570 and female condoms 57,348) condoms were distributed in 2020 with 25.8% of the total condoms distributed to key populations and the remaining 74.2% distributed to the general public.

Table 8 shows the outcome indicators and targets for KPs (FSW and MSM) for combination prevention services.

**ii. Outcome Indicators and Targets for KPs**

**Table 8: Outcome Indicators and Targets – KP HIV Comprehensive Knowledge & Sex**

S/N	Indicator	Target Population	Baseline	Source & Year	2021	2022	2023	2024	2025
1.	% of key population with comprehensive knowledge of HIV transmission and prevention	FSW (60,049)	36%	FSW IBBSS (2019)	43%	48%	52%	57%	63%
		MSM (54,759)	51.1%	MSM IBBSS (2017)	56%	62%	68%	75%	82%
2.	% of KPs who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during their last sexual intercourse	FSW (60,049)	70.6%	FSW IBBSS (2019)	74%	82%	90%	99%	97%
		MSM (54,759)	48.2%	MSM IBBSS (2017)	53.0%	58%	64%	71%	78%
3.	% of KPs who have had sexual intercourse with more than one partner in the past 12 months	MSM (54,759)	31.8%	MSM IBBSS (2017)	30%	27%	24%	20%	15%
		Prison Inmates	NA	NA	NA	NA	NA	NA	NA

## 2.6.1 Female Sex Workers (FSW)

### 2.6.1.1 Introduction

It is estimated that there are 60,049 FSW in Ghana. In 2020, 44,184 (73.58%) FSW were reached with HIV prevention interventions. Female sex workers remain a critical key population with HIV prevalence several times higher than the national average. Evidence from the 2019 Integrated Bio-behavioural Sentinel Survey (IBBSS) for FSW and Intimate Partners (IPs) showed that consistent condom use among paying clients has reduced substantially, from 90% in 2015 to 71% in 2019, while condom use with non-paying clients has stalled at a very low level (below 20%) over the past decade. Despite the lack of progress in consistent condom use among non-paying partners, there appears no interventions that specifically target non-paying clients.

Non-paying partners act as a potential transmission bridge for HIV from FSW to the general population. Interventions aimed at reducing HIV transmission among FSW are unlikely to achieve their full potential unless HIV prevention programs also focus attention on non-paying sexual partners of FSW regarding vulnerabilities for HIV infection.

### 2.6.1.2 Outcome Indicators and Targets

See Table 8: Outcome Indicators and Targets – HIV Combination Prevention for Key Populations

### 2.6.1.3 Key Strategies and Activities

#### **Strategic Intervention 1**

Scaling up HIV combination prevention interventions for FSW including their active involvement in:

- Social and behavioural change communication (SBCC);
- Combination prevention services; and
- An enabling environment (legal, policy, gender, stigma etc.)

#### Activities

- Review and revise the FSW standard operating procedure (SOP) to reflect biomedical preventive methods;
- Evaluate interventions for FSW;
- Encourage collective efficacy to use condoms among sex workers, particularly new entrants;
- Scale up interventions for hard to reach FSW (sex workers who operate via social media);
- Expand the network of condom and lubricant distribution including the use of condom vending machines;
- Develop self-efficacy skills for FSW on condom negotiation with paying and non-paying clients; and
- Motivate and provide pre-exposure prophylaxis (PrEP) when available for FSWs

### **Strategic Intervention 2**

Providing and supporting community and social media-based HIV health promotion programs targeted at FSW:

#### Activities

- Develop technology driven programs that specifically target FSW;
- Intensify media HIV education (social media, community radios, and information centres);
- Develop specific target and gender-specific messages via social media platforms to improve comprehensive knowledge of HIV; and
- Behaviour change interventions must include messages aimed at improving comprehensive knowledge of HIV.

### **Strategic Intervention 3**

Identifying government and CSOs communication channels to FSW and integrating information on HIV and SRH to change behaviour:

#### Activities

- Develop guidelines to support provision and access to friendly HIV combination prevention services for FSW;
- Strengthen the linkage between HIV prevention programs and SHR programs; and
- Provide sensitization training for legislating bodies, the judiciary, law enforcement officials, and healthcare providers.

## 2.6.2 Men Who Have Sex with Men (MSM)

### 2.6.2.1 Introduction

MSM are a stigmatized group and hard to reach with HIV-related services. The prevalence of HIV among MSM increased from 17.5% in 2011 to 18.1% in 2017. The prevalence among MSM is seven times higher than that of the general population. The Ghana Men's Study II found evidence of transactional sex with both male sex workers and partners amongst MSM.

In 2020, 21,270 MSM were reached with HIV prevention interventions. There is the need to identify the different sub-groups of MSM and those at the highest risk of HIV infection. Composite measures of HIV knowledge showed that MSM had low correct knowledge of HIV.

### 2.6.2.2 Outcome Indicators and Targets

See Table 8: Outcome Indicators and Targets – HIV Combination Prevention for Key Populations

### 2.6.2.3 Key Strategies and activities

#### Strategic Intervention 1

Scaling up HIV combination prevention interventions for MSM including their involvement in:

- Social and behavioural change communication (SBCC);
- Combination prevention services; and
- An enabling environment (legal, policy, gender, stigma etc.).

#### Activities

- Expand drop-in centres for MSM;
- Expand technology-driven interventions, particularly for hard to reach MSM;
- Scale up interventions for hard to reach MSM sub-groups;
- Expand the network of condom and lubricant distribution including use of condom (with lubricant) vending machines;
- Provide sensitization training for legislating bodies, the judiciary, law enforcement officials and health care providers; and
- Undertake size estimation and obtain data on sub-groups of MSM such as MSM who are sex workers.

### **Strategic Intervention 2**

Providing and supporting community and social media-based HIV health promotion programs targeted at KPs:

#### Activities

- Develop technology driven programs that specifically target hard to reach MSM;
- Intensify media HIV education (social media, community radios, and information centres);
- Develop specific target and gender-specific messages via social media platforms to improve comprehensive knowledge; and
- Behaviour change interventions must include messages aimed at improving comprehensive knowledge of HIV.

### **Strategic Intervention 3**

Identifying government and CSOs communication channels to KPs and integrating information on HIV and SRH to change behaviour:

#### Activities

- Develop guidelines to support provision and access to user-friendly HIV prevention services for MSM;
- Strengthen the linkage between HIV prevention programs and SHR programs; and
- Provide sensitization training for legislating bodies, the judiciary, law enforcement officials, and health providers.

## 2.6.3 People Who Inject Drugs (PWID)

### 2.6.3.1 Introduction

Sharing of drug injecting equipment is a very efficient means of transmitting HIV. This is compounded by high-risk sexual behaviours often under the influence of drugs. The size of and HIV prevalence in the PWID population are unknown and levels of risk behaviours are poorly understood.

### 2.6.3.2 Outcome Indicators and Targets

Outcome indicators and targets will be determined after PWID's size estimation and HIV prevalence studies are conducted in 2021. Meanwhile HIV prevention combination services will be provided to PWIDs who access health and HIV services.

### 2.6.3.3 Key Strategies and Activities

#### Strategic Intervention 1

Conducting size estimation and determining HIV vulnerabilities of PWID: The size estimation exercise will include understanding PWID's age, gender identity, sexual orientation, and socio-economic barriers and inequities in accessing health services.

##### Activities

- Carry out HIV prevalence studies among PWID;
- Carry out size estimation of PWID and determine their HIV vulnerabilities; and
- Use findings to design HIV combination prevention interventions for PWID and explore the feasibility of starting a Harm Reduction Program (HRP), Needle Exchange Program (NEP) and Opiates Substitution Program (OST).

#### Strategic Intervention 2

Identifying Government and CSOs communication channels to reach PWID and integrating information on HIV:

##### Activities

- Identify CSOs working with PWID;
- Develop guidelines to support provision and access friendly HIV prevention services for PWID; and
- Develop technology driven programs that specifically target PWID.

## 2.7 Comprehensive Condom Programming for the General and Key Populations

### 2.7.1 Introduction

Condoms are needed for family planning and preventing STIs including HIV as they are known to significantly reduce the risk of pregnancy and transmission of STIs. During a high-risk sexual activity, correct and consistent condom use considerably reduces the likelihood of HIV transmission. The National Strategic Plan (NSP) 2021-2025 therefore considers condom promotion and distribution as a high impact program activity based on a total market approach with the aim of reducing new HIV infections. The NSP 2021-2025 also directs the need to integrate it with the Sexual and Reproductive Health and Family Planning program, the Adolescent Health program, the STI program and key population programs in the country. A total of 26,018,918 condoms (25,961,570 male and 57,348 female condoms) were distributed across the country in 2020 by the public and private sectors, and CSOs.

### 2.7.2 Outcome Indicators and Targets

The outcome indicators and targets for the national condom programming are shown in Table 9.

**Table 9: Outcome Indicators and Targets - Condom Programming**

S/N	Indicator	Target Population	Baseline	Source & Year	2021	2022	2023	2024	2025
1.	Total number of condoms distributed to the population	Gen. Pop -15-49 (15,156,943)	26,018,918	National Quantification (2020)	28,620,810	31,482,891	34,631,180	38,094,298	41,903,728
2.	% of people who used a condom during their last high-risk sex act in the last 12 months	Women	11.30%	GDHS 2014	12%	15%	17%	19%	21%
		Men	18.90%	GDHS 2014	20%	23%	25%	27%	30%
3.	Total number of condoms distributed to KPs	FSW (60,049)	6,242,480	2020 State of the HIV and AIDS Epidemic Report	5,328,406 <sup>16</sup>	5,861,246	6,447,371	7,092,108	7,801,319
		MSM (54,759)	472,643		595,751	655,326	720,859	792,945	872,239
4.	% of people who used a condom during their last high-risk sex act in the last 12 months (disaggregated by KP and Gen Pop)	FSW	Clients (90%)	FSW IBBSS (2019)	92%	93%	94%	95%	96%
			Non-PP (21%)		23%	25%	29%	34%	40%
		MSM	65.0%	MSM IBBSS (2017)	67%	69%	71%	73%	75%

16 Projected figures based on 2020 National Quantification

## 2.7.3 Key Strategies and Activities

### Strategic Intervention 1

Strengthening condom and lubricant promotion and distribution for general and key populations, and sexually active adolescents/young persons:

#### Activities

- Scale up education on correct and consistent use of condoms/lubricants; Re-install and maintain condom vending machines across the country;
- Identify and create more condom distribution outlets; and
- Review and revise the National Condoms and Lubricants Strategy.

## 2.8 Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

### 2.8.1 Introduction

Ghana's draft policy on Oral PrEP for HIV prevention seeks to enable the use of ARVs by HIV negative persons or those determined to be at high risk of acquiring HIV to prevent them from acquiring HIV. Potential PrEP beneficiaries KPs and discordant couples may be found in the facility and within the community. PrEP programs should work with other health systems to design strategies that identify people both in health facilities and the community who are at a high risk of acquiring HIV.

Common service delivery points where potential PrEP users may be found include: STI clinics; outpatient departments (through active referrals from outpatient clinics or departments; family planning clinics, antenatal clinics; sexual and gender-based violence services; harm reduction and other drug treatment services; and PEP services. Notable locations to find potential PrEP users include: KP civil society organizations; hot spots; drop-in centres (DICs); community-based and outreach HIV testing; and accredited community pharmacies.

PrEP eligibility criteria include i) HIV seronegative status, ii) No suspicion of acute HIV infection, iii) At substantial risk of HIV infection, iv) Creatinine clearance (eGFR) >60ml/min, v) Willingness to use PrEP as prescribed, and vi) Client is requesting PrEP.



## 2.8.2 Priority Populations

- Priority populations include KPs (FSW, MSM, PWID, and Transgender People (TGs); and
- Others identified in the Ghana 2019 Consolidated HIV Treatment Guidelines, namely:
  - HIV negative persons in sero-discordant relationships;
  - Sexual partners of unknown HIV status;
  - Individuals with recent or recurrent STIs;
  - Multiple or concurrent sexual partners;
  - History of inconsistent or no condom use;
  - Recurrent PEP users; and
  - History of sex whilst under the influence of alcohol or recurrent drug use.

## 2.8.3 Rationale for the PrEP Program in Ghana

The rationale for the Oral PrEP program in Ghana includes the following:

- KPs in Ghana have a substantially increased risk of HIV infection than the general population;
- Provision of PrEP for KPs is a proven international best practice for preventing HIV in KPs;
- PrEP has been provided to KPs on a very limited scale in the country within the last couple of years; and
- Consensus exists among key HIV stakeholders in Ghana that providing PrEP has great potential to prevent HIV in KPs.

## 2.8.4 Outcome Indicators and Targets for Oral PrEP

The outcome indicators and targets for the Oral PrEP program are shown in Table 10.

**Table 10: Outcome Indicators and Targets – PrEP**

Indicators	2020	2021	2022	2023	2024	2025
# PLHIV currently on ART	208,811	246,953	280,014	244,365	308,457	321,673
# PLHIV with partners	76,580	94,626	110,645	126,317	143,704	156,930
# PLHIV with discordant couples	22,974	28,388	33,193	37,895	43,111	47,079
# Discordant couples receiving PrEP	4,595	7,097	9,958	13,263	17,245	21,186
# MSM eligible for PrEP	12,487	29,660	30,815	32,638	36,039	39,717
# MSM receiving PrEP	0	1,483	1,541	1,632	3,604	5,958
# FSW eligible for PrEP	29,372	41,088	43,134	45,774	48,476	51,309
# FSW receiving PrEP	0	2,054	2,157	2,289	4,848	7,696
# PWID eligible for PrEP*	0	0	0	0	0	0
# PWID receiving PrEP	0	0	0	0	0	0
# Total eligible PrEP users	64,834	99,136	107,142	116,307	127,626	138,105
# Total KPs receiving PrEP	4,595	10,634	13,655	17,184	25,696	34,840
Coverage for PrEP	7%	11%	13%	15%	20%	25%

\* PWID's target will be set after the PWID study

## 2.8.5 Key Strategies and Activities

### Strategic Intervention 1

Adoption of draft Oral PrEP policy:

#### Activities

- Adopt draft Oral PrEP policy;
- Widely disseminate Oral PrEP policy; and
- Adopt event-driven PrEP strategy.

### Strategic Intervention 2

Rolling out and scaling-up implementation of PrEP and PEP as part of HIV combination prevention approaches for KPs:

## Activities

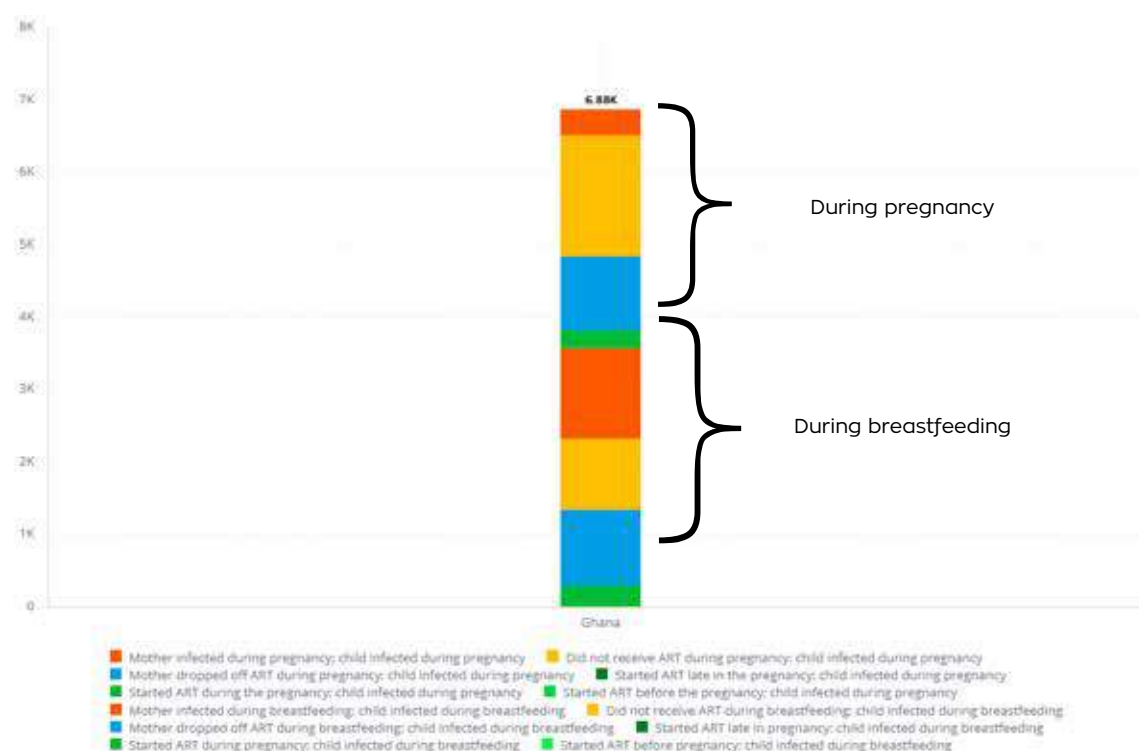
The key activities include:

- Develop guidelines to support the implementation of PrEP & PEP;
- Develop IEC materials to improve comprehensive knowledge on PrEP & PEP;
- Create awareness on PrEP among KPs and sex partners;
- Train KPs as PrEP peer-educators to spearhead awareness and demand creation;
- Support treatment adherence and retention on treatment;
- Conduct robust PrEP and PEP education and literacy using traditional communication channels and modern social media platforms patronized especially by KPs for PrEP;
- Train designated healthcare professionals on PrEP & PEP including treatment literacy and service provision;
- Provide ARVs and other commodities for PrEP & PEP;
- Develop M&E tools for monitoring PrEP & PEP; and
- Collaborate with DOVSU for data and information on rape, sexual and gender-based violence (GBV) including intimate partner violence (IPV).

## 2.9 Elimination of Mother-to-Child Transmission of HIV (eMTCT)

### 2.9.1 Introduction

Ghana is committed to the virtual elimination of MTCT of HIV and has adopted the global MTCT rate of 5% or less as the benchmark for the elimination of mother-to-child transmission of HIV. In 2020, 12,668 HIV positive pregnant women (71.59%) of the 17,694 HIV positive pregnant women received ARVs to prevent mother to child transmission of HIV. There was an estimated 3,683 (50.23% male and 49.77% female) new child HIV infections due to MTCT of HIV in 2020: this puts the rate of transmission of HIV from mother to child (including during the breastfeeding period) at 20.81%.



**Figure 4: New Infections among Children by Source of Infection**

The Joint Program Review of NSP 2016-2020 reported that about 74% of expected pregnant women were tested for HIV. This falls short of what is required for elimination of mother to child transmission of HIV. The deficit is because not all pregnant women attend ANC, loss to follow-up, and missed opportunities for early infant diagnosis (EID). The scale up of the number of pregnant women to be tested for HIV to 95% will require all ANC sites to be appropriately equipped and have trained health staff to conduct testing and follow up.

### 2.9.2 Outcome Indicators and Targets

The PMTCT outcome indicators and targets are shown in Table 11.

**Table 11: Outcome Indicators and Targets for PMTCT**

S/N	Indicator	Target Population	Baseline	2021	2022	2023	2024	2025	Source & Year or Remarks
1.	PMTCT testing coverage	Pregnant women	74%	100%	100%	100%	100%	100%	National PMTCT policy
2.	# of pregnant women needing HTS	Pregnant women	869,615	865,000	865,000	865,000	865,000	865,000	Birth Rate per Year <sup>17</sup> Ghana

17 The current birth rate for Ghana in 2020 is 28.826 births per 1000 people in 2020 in [www.macrotrends.net/countries>Ghana>birthrate](http://www.macrotrends.net/countries/Ghana/birthrate). Accessed 30 September, 2020

3.	ART coverage in pregnant women	HIV Positive Pregnant Women	74.92%	100%	100%	100%	100%	100%	National PMTCT Policy
4.	# of HIV-positive pregnant women on ART	HIV Positive Pregnant Women	12,668	14,633	16,378	17,933	17,472	16,944	HIV Estimates and Projections (2020)
5.	EID Coverage in HIV Exposed Infants (HEI)	HIV Exposed Infants	11,686	16,093	16,003	15,700	15,263	14,756	Program Targets
6.	% of child HIV infections due to MTCT	Child New Infections	20%	10.8%	8.5%	7.0%	5.0%	4.5%	Program Targets

## 2.9.3 Key Strategies and Activities

### Strategic Intervention 1

Provision of HTS to women in reproductive age range and prevention of unintended pregnancy among HIV positive women:

#### Activities

- Provide HTS services to women of reproductive age;
- Provide family planning services to HIV positive women to prevent unintended pregnancies;
- Support all HIV positive mothers to have access to antiretroviral prophylaxis for HIV exposed infants;
- Build capacity of health workers to ensure access of HIV exposed infants to ARV prophylaxis;
- Institute appropriate mechanisms to follow-up and defaulter tracking of mother-baby pairs;
- Ensure availability of paediatric ARVs;
- Institute appropriate mechanism to track test results of EID;
- Ensure quality assurance of the EID results; and
- Strengthen sample referral system.

### Strategic Intervention 2

Strengthen PMTCT service delivery at all facilities at all levels (including CHPS compounds):

#### Activities

- Strengthen community systems to improve access of HIV positive pregnant and breastfeeding mothers;
- Mobilize community support for eMTCT access and linkages of pregnant and breast-feeding women to eMTCT;
- Engage men, families, community and religious leaders to encourage women to access PMTCT services; and
- Improve linkage, initiation and retention of HIV pregnant and breastfeeding mothers using peer support groups.

## 2.10 Sexual and Reproductive Health Services for Men and Adolescent Boys

### 2.10.1 Introduction

Men have substantial sexual and reproductive health needs, including the need for contraception, prevention and treatment of HIV and other sexually transmitted infections, sexual dysfunction, infertility and male cancers. Yet these needs are often unfulfilled due to a combination of factors including lack of service availability, poor health seeking behaviour among men, health facilities often not considered “male-friendly” and a lack of agreed standards for delivering clinical and preventive services to men and adolescent boys.

### 2.10.2 Key Strategies and Activities

#### Strategic Intervention

Scale up HIV prevention and SRH services for men and adolescent boys (with emphasis on driver unions, security personnel, miners, fisher folks, and persons with disabilities):

#### Activities

- Include sexual and reproductive health services for men and adolescent boys in health provider training and SBCC/ awareness campaigns to generate demand;
- Integrate comprehensive clinical and non-clinical SRH services for men and adolescent boys into routine services; and
- Explore the feasibility of establishing male-friendly health corners outside the formal health settings to provide SRH services.

## 2.11 Availability of Safe Blood

### 2.11.1 Introduction

Transfusion care is a differentiated care opportunity that must be implemented in the context of attaining 95-95-95 fast track targets. There are five key components to eliminating the risk of HIV transmission through blood transfusion, namely:

- Establishment of well-organized, nationally coordinated blood transfusion services;
- Collection of blood from volunteer blood donors from low-risk populations;
- Quality-assured testing for transfusion-transmissible infections, blood grouping and compatibility;
- Safe and appropriate use of blood and a reduction in unnecessary transfusions; and
- Quality assurance and enhancement systems covering the entire transfusion process.

### 2.11.2 Outcome Indicators and Targets

The outcome indicators and targets for availability of safe blood are shown in Table 12.

**Table 12: Outcome Indicators and Targets for Availability of Safe Blood**

S/N	Indicator	Target Population	2020	Source & Year	2021	2022	2023	2024	2025
1.	% of health facilities providing blood transfusion that meet requirements for safe and sufficient blood transfusion	Health facilities providing blood for transfusion	100%	2020	100%	100%	100%	100%	100%
2.	% of blood units that are screened for blood-borne diseases in a quality-assured manner	Blood units for transfusion	100%	2020	100%	100%	100%	100%	100%

### 2.11.3 Key Strategies and Activities

#### Strategic Intervention 1

Ensure the availability of safe blood for transfusion:

##### Activities

- Collect blood from unpaid volunteer blood donors from low-risk populations;
- Carry out quality-assured testing for transfusion-transmissible infections, blood grouping and compatibility;
- Strengthen the supply of appropriate HIV rapid test kits to health facilities for blood screening;
- Strengthen the supply of consumables for screening for other blood-borne diseases to health facilities for blood screening;
- Conduct periodic post market surveys to assess the quality of test kits being used; and
- Improve testing accuracy by deploying HIV Nucleic Acid Testing devices for blood screening.





## Section 3: HIV TESTING SERVICES

### 3.1 Introduction

HIV testing is the entry point to HIV prevention, treatment, care, and support services and to achieving the first 90 of the fast-track strategy by 2020. Ghana adopted the “Treat-All” policy in 2016 in which every PLHIV is eligible for treatment, and this was expected to increase the number of PLHIV on ART. The 2020 national and sub-national estimates and projections estimated the PLHIV population to be 346,120. At the end of 2020 about 63% of this population knew their HIV status.

HIV testing services have increased significantly as the number of HIV tests done has almost increased from 1,024,048 in 2016 to 1,837,149 (128% out of a target of 1,440,103) in 2020. However, testing yields have declined from 5.6% in 2016 to 3.2% in 2020. Testing among men has also been low. Of the total HIV tests done in 2020, the percentage of men tested was 17% compared to 32% of non-pregnant women and 51% of pregnant women. The yield among the men who tested (4.1%) is higher than the yield among pregnant women (1.5%) but lower than non-pregnant women (5.0%), prompting the need to improve the testing coverage for men and non-pregnant women.

The challenges identified during program implementation include low coverage and uptake of HTS, low testing yield, and poor linkage to care due to a high level of repeat testing, low testing among the general population, lack of HTS services in hard-to-reach areas, poor demand creation, and stigma and discrimination of HIV related services, especially among KPs.

### **3.2 Differentiated HIV Testing Services (dHTS)**

The country has adopted differentiated HIV testing (dHTS) approaches with emphasis on index client testing that has shown yields as high as 34% in some settings. This plan seeks to scale up dHTS using both facility and community level interventions that target high-risk populations including key populations and hard-to-reach groups and under-served populations.

The dHTS approach will focus on priority populations and high volume/high yield facilities to increase program effectiveness and efficiency. The target populations include: pregnant women (PW); partners of PLHIV; children (0-14 years) of PLHIV; people who inject drugs (PWID); men who have sex with men (MSM); female sex workers (FSW); prisoners; TB patients; STI patients; young people (15-24 years) at high risk such as out of school youth; high risk outpatient department (OPD) and inpatient department (IPD) patients; and men with high risk behaviour such as clients of sex workers, truckers, miners, uniformed forces such as military personnel, prison guards, and security guards.

To identify more men living with HIV, optimized index testing will be offered to all newly diagnosed pregnant and breastfeeding mothers in PMTCT settings and non-paying partners of FSW using the peer approach. Aggressive targeted community testing will be carried out at high yield hubs for high-risk men who will, in addition, be reached through index testing. The index testing approach will be used across all entry points and HIV testing will be offered at workplaces to at-risk men as well as to men in known KP settings. Furthermore, targeted facility based PITC in high yield departments and the use of a risk assessment tool in high volume/low yield departments will be implemented to identify high-risk men for HIV testing.

HIV self-testing will complement standard testing services, expanding access to individuals who will otherwise not patronize these services. HIV self-testing has proven to be acceptable, convenient, and regarded as more confidential than standard testing services. It has been proven effective in reaching hard-to-reach and high-risk populations thereby improving testing yield. Delivery models include a facility-based approach where kits will be distributed to clients who are unwilling to take an HIV test at the facility; and, importantly, via secondary distribution to partners of clients who visit facilities. A community-based model will include utilizing existing community engagement and outreach programs, faith-based and workplace programs for free or at discounted cost. The private sector will also be engaged, distributing kits through pharmacies, licensed chemical sellers and private health facilities at cost.

### **3.2.1 Optimized Facility-based Testing**

Provider initiated testing and counselling (PITC) will be the modus operandi at antenatal clinics, TB DOTS, and in-patients being treated for STIs. Pre-test and post-test counselling will be offered to all who receive the test. HIV positive clients will be enrolled in care and treatment programs while comprehensive prevention services are provided to people who are found to be HIV negative.

### **3.2.2 Assisted Partner Notification and Index Client Testing**

Index Client Testing would be used in ART clinic settings for reaching people with HIV who do not know their status. Strategies will include offer of immediate voluntary provider referral (i.e. where provider contacts and offers HIV testing to all sexual partners and children of PLHIV index client). Peer support systems and case managers in the facilities would interface with the community client index testing.

### **3.2.3 Community-based Testing**

This approach will be used to reach a broad set of people who are at risk and may be less likely to visit a clinic for a test. This testing approach will include strategic outreach in hotspots and index testing (partner notification and social network-based testing). The services will be strategically timed to increase access (offering evening services) and offered in key population friendly locations. These key populations will be reached with HTS through peer-led approaches. Lay providers will be trained to provide testing and counselling including assisted partner notification and index testing.

Those testing positive for HIV will be referred for further HIV services. WHO recommendations will be followed and KPs will test for HIV at least annually and, depending on risk, every three to six months thereafter. Considering the prioritization of regions with a high HIV burden and where KPs are concentrated we will aim to test KPs at least, two times per year and utilize case managers and peers to facilitate

linkage to treatment and prevention. There will also be an expansion of services to new unsaturated KP networks in high burden, low coverage geographical locations.

### 3.2.4 Optimizing Linkage to Care and Initiation

To optimize linkage to care and ART initiation will require the following strategic approaches:

Implementation of testing provider accountability for effective and reported linkage of all clients diagnosed HIV positive for all testing sites and by every testing provider including minimum referral package and tracing of clients lost to follow-up, introduce registration on arrival at ART site before ART initiation.

Community involvement in linkage and ART initiation of HIV positive clients using peer support groups and lay providers such as case managers, Models of Hope, Mother Mentors and Community ART Teams (CATs).

### 3.2.5 Differentiated HIV Testing Services- Outcomes and Targets

The outcome indicators and targets for PLHIV who know their status through the provision of differentiated HIV testing services (dHTS) is shown in Table 13.

**Table 13: Outcome Indicators and Targets - HIV Testing Services (HTS)**

S/N	Indicator	2020	2021	2022	2023	2024	2025	Source & Year or Remarks
1.	HIV Prevalence	1.68	1.65	1.61	1.56	1.51	1.46	2020 Estimates
2.	# PLHIV (All)	346,120	349,362	352,498	354,661	356,465	357,696	2020 Estimates
3.	1st 95 (%)	63%	75%	83%	90%	93%	95%	Program Targets
4.	1st 95 (#)	218,741	265,310	295,693	324,721	340,050	348,318	Program Targets
5.	# PLHIV Undiagnosed	142,309	113,788	88,161	62,364	37,076	24,510	Program Targets
6.	% of KP members who tested for HIV in the past 12 months, or who know their current HIV status	FSW (60,049)	56.5%	68%	75%	83%	95%	Program Targets

7.	% of KP members who tested for HIV in the past 12 months, or who know their current HIV status	MSM (54,759)	52.3%	63%	70%	77%	95%	Program Targets
8.	% of KP members newly diagnosed with HIV initiated on ART	KPLHIV	38.2%	95%	95%	95%	95%	Program Targets

**Table 14: General Population and HIV Self-Testing**

Year	2020	2021	2022	2023	2024	2025
Total Tests per Year	65%	75%	83%	90%	93%	95%
Estimated Tests (Targets)	2,816,290	3,238,685	3,584,145	3,886,423	4,015,970	4,102,335
HIVST (Gen Pop)	0	97,161	107,524	194,321	200,798	205,117

### 3.2.6 Key Strategies and Activities

#### Strategic Intervention 1

Scale up HIV testing services among general population and adolescents at the community level:

##### Activities

- Provide targeted HIV testing services for identified groups with focus on AGYW and partners and KP; and
- Scale up index testing approaches to increase HIV case findings.

#### Strategic Intervention 2

Improve linkage to care and initiation on treatment:

##### Activities

- Implement testing provider accountability and reportage linkage of clients diagnosed; and
- Improve community involvement in linkage to and initiation on ART.

### **3.3 HIV Self-Testing (HIVST)**

#### **3.3.1 Introduction**

The National HIV and AIDS Policy identifies HIV self-testing (HIVST) as one of the critical policy gaps needed to be rolled out. To achieve the 1st 95% target in 2025, Ghana will need to find approximately 137,309 of the undiagnosed persons living with HIV, the majority of whom are in the seven high burden regions of Greater Accra, Eastern, Ashanti, Bono, Bono East, Ahafo and Western Regions. The priority is to use smarter testing strategies on sub-populations with an elevated risk of HIV infection and focusing on geographic areas with high numbers of undiagnosed PLHIV.

Governance and coordination of HIV diagnosis and treatment is largely implemented in the public sector and mostly pursued in a public sector approach.

The NSP 2021-2025 will identify the various private sector health care providers and offer them the opportunity to participate appropriately in HIV diagnosis and treatment within their scope of service delivery. Utilizing a private sector led approach for HIV self-testing is key to increasing HIV testing yield. In this approach, a client performs his/her own test and interprets the results. HIVST does not provide a diagnosis for HIV. All reactive self-test results should be confirmed using the approved national HIV testing algorithm. Currently, self-testing is still under pilot studies and has not yet been included among the service delivery approaches for HIV testing.

HIV self-testing will be considered for selected target populations such as discordant couples, key populations, and hard to reach populations. This strategy will be used as an intervention for encouraging a partner to test or as part of an index/assisted partner notification. HIV self-test kits will be distributed through facility and community-based approaches, social networks, partners, the private sector (pharmacies) and workplaces.

#### **3.3.2 Goal**

Overall, the goal is to implement targeted, evidence-based and innovative HIV testing strategies.

#### **3.3.3. Outcome Indicators and Targets**

The outcome indicators and targets for the HIVST are shown in Table 15.

**Table 15: Outcome Indicators and Targets - HIV Self-Test (HIVST)**

No.	Indicator	2020	2021	2022	2023	2024	2025
1.	PLHIV Currently on Treatment (COT)	208,811	246,953	280,014	244,365	308,457	321,673
2.	#PLHIV with Partners	76,580	94,626	110,645	126,317	143,704	156,930
3.	# Partners of PLHIV Self-tested	22,974	28,388	33,193	37,895	43,111	47,079
4.	MSM Eligible for HIVST	13,897	32,255	35,705	39,290	42,930	46,807
5.	# MSM Self-tested	0	3,226	5,356	7,858	8,586	9,361
6.	FSW Eligible for HIVST	30,438	43,235	45,937	48,643	51,345	54,177
7.	# FSW Self-tested	0	4,324	6,891	9,728	9,728	9,728
8.	PWID Eligible for HIVST	0	0	0	0	0	0
9.	# PWID Self-tested	0	0	0	0	0	0
10.	TOTAL Eligible for HIVST	120,915	170,116	192,286	214,250	237,979	257,915
11.	*# Total KPs Self-tested for HIVST	22,974	35,937	45,440	55,481	61,425	66,169
12.	Coverage of Self -Test	19%	21%	24%	26%	26%	26%

\* Total KP Self-Tested includes Partners of PLHIV

### 3.3.4 Key Strategies and Activities

#### Strategic Intervention 1

Engage the private sector for HIV self-testing:

##### Activities

- Map out regions, districts and cities in Ghana with strong private sector presence;
- Develop guidelines to support a private sector engagement approach for HIV self-testing;
- Develop all capacity building and training tools in accordance with national standards; and
- Build capacity of designated service providers within the private sector.

## Strategic Intervention 2

HIV self-testing awareness and demand creation:

### Activities

- Develop guidelines to support the implementation of HIV self-test;
- Actively disseminate guidelines to service providers in the private sector and KP implementing partners;
- Develop IEC materials to improve comprehensive knowledge on self-testing;
- Scale up the use of HIV self-test kits among AGYW, KPs and the general population;
- Organize public education on self-testing (traditional and electronic media); and
- Ensure the availability of required test kits and logistics in adherence to WHO recommended algorithms.

## Strategic Intervention 3

Ensure proper reporting of data on self-testing within the private sector:

### Activities

- Engage private sector institutions on the need for HIV and AIDS data reporting and its impact on control activities in the country;
- Develop an appropriate data management system for the private sector;
- Develop a data collection tool to monitor and evaluate HIV self-testing;
- Conduct training for private sector staff on data management and use;
- Ensure all recording and reporting tools are made available for DHIMS2 and e-Tracker reporting; and
- Conduct periodic reviews of data reporting systems.





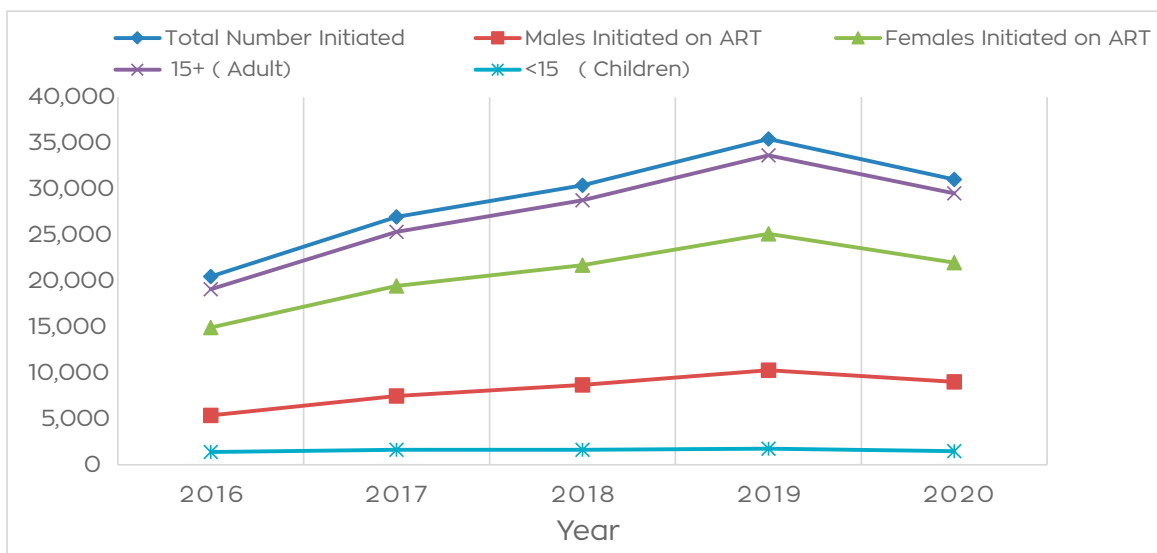
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## Section 4:

# HIV TREATMENT, CARE AND SUPPORT

### 4.1 Introduction

The Antiretroviral Treatment (ART) program is the flagship of the national HIV response as it prevents the transmission of HIV as well as reduces HIV and AIDS morbidity and mortality. The number of PLHIV diagnosed and initiated on ART from 2016 to 2020 has increased from 2016 to 2019 but saw a decrease in 2020. More females than males and more adults than children were initiated on ART between 2016 and 2020. This sub-optimal performance must be improved significantly.



**Figure 5: Trend Analysis of Newly Initiated Clients on ART by Sex and Age Cohort 2016-2020 Ghana**

Stigma and discrimination, unavailability of ARVs for all patients at the time they need them, poor treatment adherence, significant loss to follow up of patients on treatment, gender inequalities, and policies and practices that hinder access to HIV services by PLHIV are the common reasons for the sub-optimal performance of the ART program.

The NSP 2021-2025 seeks to actualize the goal of the National HIV and AIDS policy of ensuring the availability of and accessibility to treatment, care and support services for all PLHIV. The provision of these services will continue to be based on equity, the principles of the WHO Treat All Policy, and Ghana's commitment to reaching the 95-95-95 HIV treatment targets by 2025 and ending the AIDS epidemic by 2030.

## 4.2 Goal and Objectives

### Goal

Ensure availability of and accessibility to quality treatment, care and support services for all persons resident in Ghana living with HIV.

### Objective 1

95% of people diagnosed with HIV will receive ART by 2025

### Objective 2

95% of PLHIV on ART will achieve viral load suppression by 2025

### Desired outcome

The desired outcome is for the general population, especially persons affected by and/or living with HIV to equitably receive gender responsive and differentiated services in a continuous, sustainable manner wherever they are by 2025.

### 4.3 Outcomes and Targets

About 208,811 (95%) PLHIV who know their status received ART and 73% were virally suppressed in 2020. The ART program activities under the current NSP 2016-2020, as and where appropriate, will be modified, intensified, scaled up, and strengthened with a view to reaching the 95-95-95 HIV treatment targets by 2025.

Under NSP 2021-2025 the ART program will include the provision of ARVs according to national guidelines, monitoring of PLHIV on treatment (adherence counselling, retention in care, track patients lost to follow up and return them to care, adverse drug reactions, and acquired drug resistance), and management of co-infections and comorbidities including TB and other infections, and psychosocial and nutritional problems. These services will be delivered at health facilities and community levels using differentiated service delivery (DSD) approaches based on group characteristics: i) PLHIV for same day ART initiation, ii) Stable on ART, iii) Unstable on ART, iv) ART for adolescents, and vi) ART for children. Strategies that will improve linkage to care and retention of PLHIV on treatment will be strengthened.

Table 16 shows the outcome indicators and targets for the ART program including treatment monitoring and adherence between 2021 and 2025.

**Table 16: Outcome Indicators and Targets - ART**

S/N	Indicator	Target Population	Program Data 2020	2021	2022	2023	2024	2025	Source & Year or Remarks
1.	% of adults and children on ART	Adults and children living with HIV	58%	76.4%	84.4%	92.0%	94.0%	95.0%	Program Targets
2.	# Adults and children living with HIV	Adults and children living with HIV	346,120	349,362	352,498	354,661	356,465	357,696	National HIV Estimates 2020
3.	# Adults and children on ART	Adults and children on ART	208,811	246,953	280,014	244,365	308,457	321,673	Program Targets
4.	# Adults on ART	Adults on ART	199,267	233,561	264,915	277,981	291,028	303,650	Program Targets
5.	# Children on ART	Children on ART	9,544	17,325	17,885	18,109	16,469	15,935	Program Targets
6.	Total attrition from ART	PLHIV on treatment	45%	36%	27%	18%	12%	9%	Program Targets

7.	VL testing coverage (# of people on ART (for at least 6 months) with VL test results	Adults on ART	88,695	252,727	284,316	314,744	325,696	332,606	Program Targets
		Children on ART	3,999	22,677	21,191	19,684	17,520	16,774	
		All on ART	92,694	275,404	305,507	334,428	343,216	349,380	
8.	VL testing coverage (% of people on ART (for at least 6 months) with VL test results	All PLHIV on ART	68%	69%	71%	78%	82%	95%	Program Targets

## 4.4 Key Strategies and Activities

### Strategic Intervention 1

Intensify scaling up and strengthening of the ART program including treatment monitoring and adherence:

#### Activities

- i. Intensify facility based DSD approaches for ART: The country will scale up and improve facility based DSD interventions to ensure access to and availability of quality ARV services for all PLHIV. This will include scale up of standardized three or six-month ART refills for clinically stable clients and implementation of systems to reduce missed visits and defaulters at all ART sites including active tracing of defaulting clients.
- ii. Build capacity of Human Resources for Health (HRH): The health workforce for providing ARV services will be improved by scaling up task sharing and task shifting approaches. There will also be interventions to clarify and re-orient prescribers on the treat all and early initiation policy and requirement for and timing of baseline laboratory tests.
- iii. Intensify community-based DSD for ART: PLHIV peer support groups (Models of Hope, Mentor Mothers, Community ART Teams, and Peer Navigators) and lay providers (Case Managers) will take on specified roles and responsibilities at high volume ART sites to improve retention and reduce

stigma within their communities, among PLHIV, and within the health facility. Religious, traditional, and opinion leaders will be supported to provide leadership in advocacy efforts on demand creation for and utilization of HIV treatment services including treatment adherence and monitoring.

iv. Implement other proven ART interventions: Other client-friendly services known to improve retention and other ART outcomes will be scaled up across all facilities but prioritized in high volume sites. Key interventions will include:

- Adopting community DSD approaches such as use of community pharmacies and CHPS to provide refills of ART for stable patients on treatment;
- Empowering the community of PLHIV and civil society to own and lead viral load demand creation and service uptake;
- Ensuring availability of and accessibility to viral load (VL) testing facilities by full implementation of 24-hrs testing in all supported mega PCR laboratories and use of point of care (POC) devices such as GeneXpert and optimize the viral load sample referral system;
- Ensuring that all viral load testing facilities have adequate infrastructure, technical expertise, and quality improvement and assurance programs to ensure the quality of viral load tests;
- Reducing turnaround time for viral load tests by enhancing the laboratory information management system (LIMS) to enable remote log-in of the viral load and EID results and downloading of same at facility levels as well as the full implementation of the LIMS-EMR interface for direct transmission of viral load and EID results from PCR labs to the patient's electronic medical records;
- Achieving client-level efficiencies through accelerated transition to WHO recommended optimized regimen for ART such as Tenofovir-Lamivudine-Dolutegravir (TLD) and LPV/r pellets/granules for children;
- Expanding the appropriate use of modern information, technology, and communication (ICT) platforms including social media to remind clients of upcoming appointments; and
- Conducting ARV drug resistance and toxicity studies.

## Strategic Intervention 2

Provide comprehensive and integrated HIV treatment services for patients with TB and other co-infections and comorbidities:

The country will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. The core activities will include TB screening for all PLHIV; timely TB diagnosis; early initiation and treatment completion for PLHIV; scale up of TPT (TB Preventive Treatment); transition to more optimal regimens such as 3HP (once-weekly isoniazid-rifampicin for 12 weeks); sustained joint TB/HIV programming and monitoring including scaling up One Stop Shop (OSS) for PLHIV dually infected by TB and HIV. As part of the monitoring process, the country will conduct ARV drug resistance and toxicity studies.

In addition, prevention and management of co-infections and co-morbidities will include cervical cancer and genital warts, viral infections (human papilloma virus, Hepatitis B, and Hepatitis C), mental health problems associated with HIV infection, and non-communicable diseases (NCDs) such as hypertension and diabetes. Counselling and psychosocial and nutritional support will be provided including packages for HIV orphans and vulnerable children.

### Activities

- Integrate and strengthen referral systems for PLHIV with TB, Hepatitis B and Hepatitis C, Cervical Cancer, mental health related to HIV infection, and non-communicable disease co-infection management (One Stop Shop);
- Create awareness and demand for integrated HIV services;
- Decentralize integrated HIV service delivery; and
- Ensure availability of and strengthen compliance with treatment policies, guidelines and other SOPs.

Table 17 shows the outcome indicator and targets for HIV-TB co-infection Management for the period 2021 to 2025.

**Table 17: Outcome Indicators and Targets - HIV - TB Co-infection (HIVTB)**

Indicator	2021	2022	2023	2024	2025
# TB case notification (projected)	14,691	26,324	27,432	29,026	30,500
%/#/Estimated TB clients tested for HIV	85% (12,431)	100% (26,324)	100% (27,432)	100% (29,026)	100% (30,500)
# Estimated TB clients tested positive for HIV	2,620	5,528	5,761	6,095	6,405
% Estimated TB clients tested positive enrolled on ART	75% (1,965)	100% (5,528)	100% (5,761)	100% (6,095)	100% (6,405)
% of PLHIV newly initiated on ART and diagnosed with active TB who initiated TB treatment	100%	100%	100%	100%	100%

**Strategic Intervention 3**

Ensure optimal care and support of PLHIV:

**Activities**

- Develop and improve age-appropriate education and awareness for treatment literacy including benefits of and common adverse reactions related to drug treatment, and stigma and discrimination;
- Support PLHIV to “Know Your Rights” education and access justice;
- Expand distribution of treatment service delivery points whilst developing case linkages and follow-up surveillance systems;
- Provide information and life skills training for adolescents infected or affected by HIV;
- Link PLHIV households and OVC severely impacted by the HIV and AIDS epidemic to appropriate social protection programs such as the government-run Livelihood Empowerment Against Poverty (LEAP) program and social services provided by NGOs and FBOs;
- Sensitize key service providers to promote and protect the rights of PLHIV and KPs such as:
  - o Law enforcement agents on promoting and protecting the human rights of KPs and PLHIV: this could reduce police harassment of KPs and PLHIV; and
  - o Healthcare providers on human rights and medical ethics and the provision of quality healthcare services in a non-judgmental manner to all who need the services: this could also reduce S&D towards PLHIV and KPs.





# Section 5: COMMUNITY ENGAGEMENT & SYSTEMS STRENGTHENING

## 5.1 Introduction

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

This strategy requires that all interventions at the community level are carried out in partnership and collaboration with the chiefs and other



traditional rulers, community elders, family/clan heads, religious and opinion leaders, organizations of people living with HIV, including women living with HIV, and key populations amongst others. The intention is to ensure that interventions are culturally sensitive, and community owned for improved access, effectiveness and sustainability of the interventions being implemented.

### 5.2 Goal

Strengthen community systems to promote appropriate gender and cultural norms and practices.

### 5.3 Outcome

An empowered community that increasingly participates and contributes to the successful implementation of the national HIV response.

### 5.4 Strategies and Activities

#### Strategic Intervention 1

Increase community involvement in the planning and implementation of the national response:

Activities

- Build the capacity of community-based organizations (CBOs) to support the implementation of the HIV NSP 2021-2025;
- Strengthen collaboration between service providers and community stakeholders at the district and sub-district levels;
- Improve the collaboration with the Ministry of Health and regulatory agencies to address unsubstantiated cure claims;
- Develop community capacity for community-led advocacy and research;
- Improve community-based monitoring of barriers to accessing services;
- Involve communities to support service delivery, social mobilization and demand creation across the treatment cascade; and
- Develop CSO institutional capacity for organizational sustainability, especially resource mobilization.

#### Strategic Intervention 2

Improve the knowledge of community-level stakeholders in national HIV response:

#### Activities

- Map out community-level stakeholders in HIV and TB;
- Develop and implement an engagement strategy with faith-based organizations, community leaders and cure claimants;
- Explore innovative ways (social media, traditional media, art and theatre, community radios and information centres) to provide age-appropriate HIV, TB, and related co-morbidities information; and
- Create a common platform for HIV, TB, and related co-morbidities knowledge sharing and exchange.

### **Strategic Intervention 3**

Strengthen collaboration between service providers and community stakeholders at the District and sub-District levels:

#### Activities

- Reactivate and leverage on common platforms for interaction between service providers and community stakeholders for priority setting, implementation and monitoring;
- Improve feedback mechanisms between district and sub-district levels and community stakeholders; and
- Enhance social mobilization and build community linkages with the health system.

### **Strategic Intervention 4**

Collaborate with Ministry of Health and regulatory agencies to manage unsubstantiated cure claims, increase adherence and thus improve treatment outcomes;

#### Activities

- Develop and implement an engagement strategy with the HIV cure claimants at all levels;
- Collaborate with regulatory authorities to enforce relevant laws on cure claimants at all levels;
- Embark on effective education and counselling on the falsity of cure claimants at all levels; and
- Empower community-based systems (e.g. SAMCs, case managers, community health nurses, and Models of Hope) to monitor and report cure claims from the community.



# Section 6: HEALTH AND SOCIAL JUSTICE

## 6.1 Introduction

HIV has and continues to exert significant socio-economic burden on individuals, households, communities and the country. These include HIV-related stigma, discrimination and issues of sexuality and gender.

Human rights, age, and gender-related barriers have been identified as major obstacles to accessing HIV and TB services, and negatively affecting the global response to the two diseases. Fast-tracking the TB and HIV response will be almost impossible without addressing the

pressing needs of human rights and gender inequalities. Human rights barriers such as stigma and discrimination; violence and other abuses; negative social attitudes; legal obstacles; intimidation by law enforcement agencies; negative attitudes and behaviours of healthcare practitioners; and general hostility in the healthcare sector towards key populations need to be addressed urgently.

Evidence shows that biological, behavioural and structural factors are associated with violence against women and girls (VAWG), with attendant increased risk of HIV infection. Moreover, VAWG is a barrier to effective uptake of HIV prevention and treatment. According to GDHS 2014, 27.7% of women experienced domestic violence (economic, social, psychological, physical, and sexual). FSW also report high levels of violence by their partners. Barriers to access to justice by women survivors of intimate partner violence include: costs of transport and medical examinations; limited access to Domestic Violence and Victim Support Units (DOVVSU) due to long distance; re-traumatizing practices in DOVVSU; as well as limited knowledge of the law and personal beliefs that domestic violence is a criminal act among policemen.

These barriers contribute significant vulnerability to HIV and TB among key and vulnerable populations and limit their access to prevention, testing, treatment and care services. The national response seeks to draw on the expertise, resources, and specialties of various stakeholders, particularly civil society organizations (CSOs) to carry out interventions that address stigma, discrimination and human rights barriers relating to people living with HIV (PLHIV), FSW, MSM, AGYW, persons affected by TB and other key and vulnerable populations (KVP) (HR Strategy 2020-2024).

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

The Ghana AIDS Commission Act 938 prohibits or criminalises discriminatory treatment of people affected by and living with HIV. Institutions such as Legal Aid and CHRAJ are available for the protection of the rights of the population in general, and are equally available to persons at higher risk of, affected by and living with HIV. This NSP recognizes the unique nature of HIV related stigma and discrimination and how this is affecting their rights to healthcare, education and work especially. This strategy will identify issues that are unique to persons affected by and living with HIV that are not adequately addressed by existing laws and legislative instruments for the purpose of

reviewing or crafting new ones to address the issue in the interest of persons affected by and living with HIV as well as the general public.

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

### 6.2 Objective and Impact

**Objective**

Mitigate the social and economic impacts of HIV on persons affected by and living with HIV.

**Desired Impact**

The desired impact of this objective is that persons at risk of, affected by and living with HIV live a life free of stigma, discrimination and economic hardship on account of HIV.

### 6.3 Outcome Indicators and Targets

The outcome indicators and targets for stigma and discrimination are shown in Table 18.

**Table 18: Outcome Indicators and Targets for Stigma and Discrimination**

No.	Indicator	Target Population	Most Recent Data	Source & Year	2021	2022	2023	2024	2025
1.	Stigma Index among PLHIV	PLHIV	18.06%	Stigma Index Study (2014)			15%		10%
2.	% of general population who exhibit accepting attitudes for KPs	General Population	Men 26%	MICS 2018	27%	29%	32%	34%	36%
			Women 20%		21%	23%	25%	28%	30%

## 6.4 Strategies and Activities

### Strategic Intervention 1

Promote and protect the rights of KPs access to HIV services:

#### Activities

- Remove gender-based barriers to human rights and healthcare service interventions, and to eliminate HIV-related gender discrimination and violence against women and adolescent girls;
- Build capacity of healthcare workers and managers on HIV-related stigma, discrimination and human rights barriers that affect KPs; and
- Reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV and KPs.

### Strategic Intervention 2

Create a supportive and protective legal and legislative environment:

#### Activities

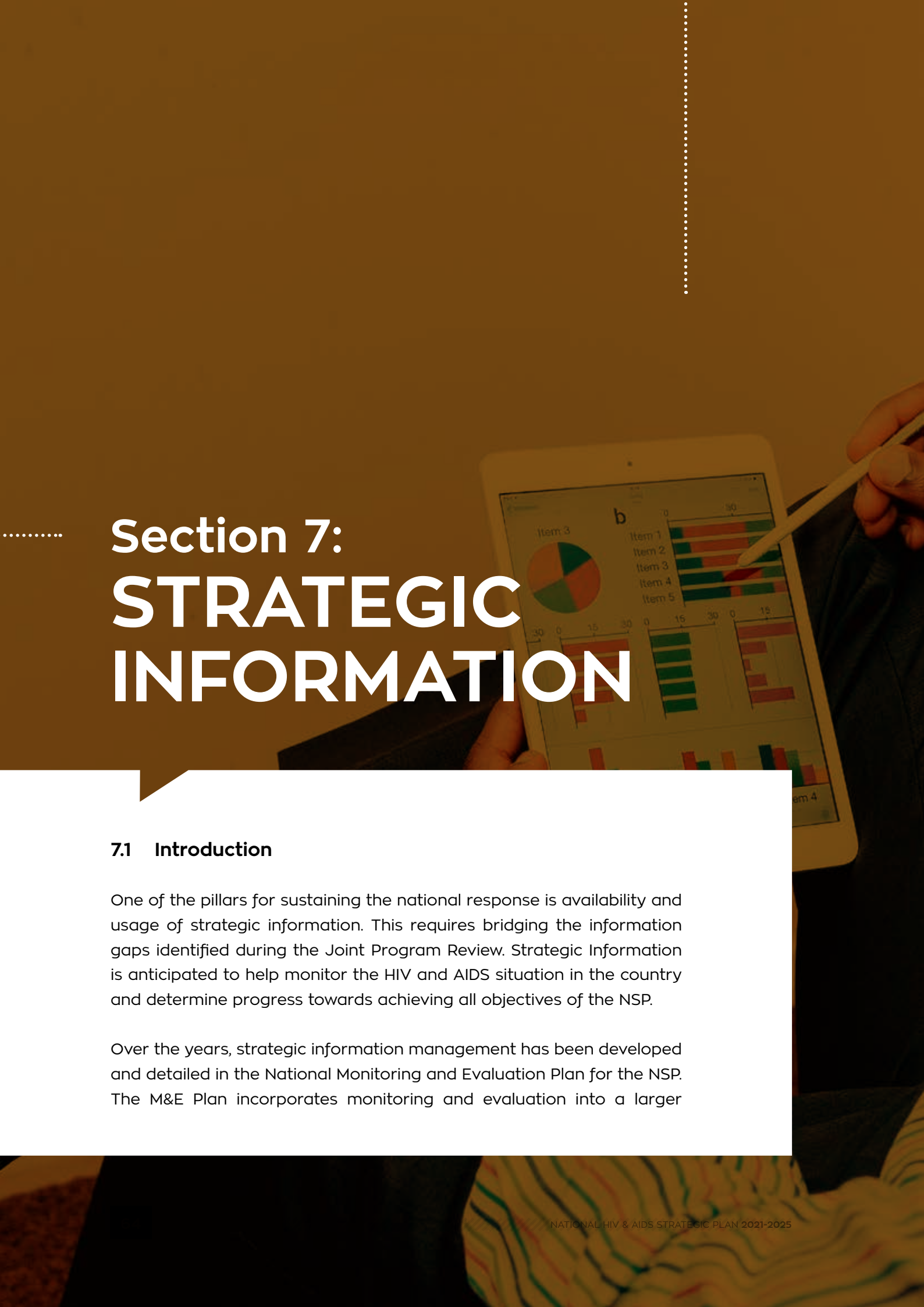
- Coordinate human rights interventions and advocate for reformation of laws, regulations and policies relevant to HIV, TB and human rights-related barriers to care services; and
- Promote access to justice, HIV-and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy (“Know Your Rights”).

### Strategic Intervention 3

Provide social protection to persons affected by and living with HIV:

#### Activities

- Provide enablers’ package for orphans and other vulnerable PLHIV population; and
- Support the enrolment of all PLHIV on the NHIS.

A person is holding a tablet computer. The screen displays a dashboard with several data visualizations. On the left, there is a pie chart labeled 'Item 3' divided into four colored segments. To the right, there is a bar chart labeled 'b' with five items on the y-axis (Item 1 to Item 5) and a scale from 0 to 50 on the x-axis. Below this, there are more bar charts with scales of 0-30 and 0-15. The background is a dark, warm-toned image of a person's hands holding the tablet.

# Section 7: STRATEGIC INFORMATION

## 7.1 Introduction

One of the pillars for sustaining the national response is availability and usage of strategic information. This requires bridging the information gaps identified during the Joint Program Review. Strategic Information is anticipated to help monitor the HIV and AIDS situation in the country and determine progress towards achieving all objectives of the NSP.

Over the years, strategic information management has been developed and detailed in the National Monitoring and Evaluation Plan for the NSP. The M&E Plan incorporates monitoring and evaluation into a larger



information management system to guide and ensure that the effectiveness of the NSP is adequately tracked and documented.

The M&E system is required to help bring together key stakeholders and institutions involved with the national response under one umbrella, thereby improving coordination in generation and management of information across the national program.

A set of core indicators for the national HIV and AIDS program developed and standardized through participatory and consultative engagements will be the backbone of the strategic information/M&E system and will form the basis of monitoring the national response.

The guiding principle for SI/M&E will continue to be the “three ones”, and building on existing systems that were created and are available during the implementation of previous national strategic plans to ensure continuity and uniformity.

SI would be oriented towards generating and using information based on program results and will create opportunities for results and evidence-based learning, planning and implementation at various levels. It will focus on monitoring program outputs at regular intervals with timely and accurate analysis enabling corrective action and maintaining strategic direction.

The following would form the core of strategic information:

## **7.2 Human Resources and Synergies**

This NSP will focus on investing in building human resource capacity, especially of surveillance and monitoring and evaluation officers, information technology, and management information system specialists at all levels. This will be done through training, mentoring, coaching and supervision in conjunction with partners and stakeholders.

As programs are scaled up to achieve epidemic control, there is the need to protect the security and confidentiality of data as well as the infrastructure and resources to scale up research. Strengthening information systems requires appropriate policies, management and financial commitment.

Moreover, National HIV and AIDS programs’ implementers, Ministry of Health and all other stakeholders will collaborate on the design, implementation and strengthening of national SI/M&E systems. A national strategy for M&E in key sectors implementing HIV and AIDS interventions will include tools and processes to generate a wide range of required data, plus analysis and reporting on HIV prevention, treatment and care interventions at the national, sub-national, facility and community levels.



### **7.3 Data Generation, Processing and Use**

As interventions expand, it is important to monitor the quality of services and to measure impacts on the country using the data that come from several sources such as routine medical and other records that are part of the broader health and non-health information management system; mapping available services in health facilities, other health settings and non-health implementing entities; health/non-health but HIV related facility surveys; population-based surveys; cohort studies of people living with HIV; monitoring procurement and supply of HIV commodities; and impact assessment. Other sources include surveillance data (e.g. behavioural and biological surveys) and mortality records and reports.

Special studies should be considered when routine data collection and analysis is inappropriate or not feasible. Data from organizations providing community-based HIV services are also essential.

M&E activities would/should use on-going data collection systems as far as possible to minimize the burden of data collection and optimize use of resources. It is important that indicators are defined and measured in a consistent and standard manner to assess trends and measure progress towards program goals. It is also important that M&E systems are gender sensitive and capture data disaggregated by age, sex, and population groups (including KPs). Priority must be given to setting up institutionalized mechanisms of data quality assurance at all levels.

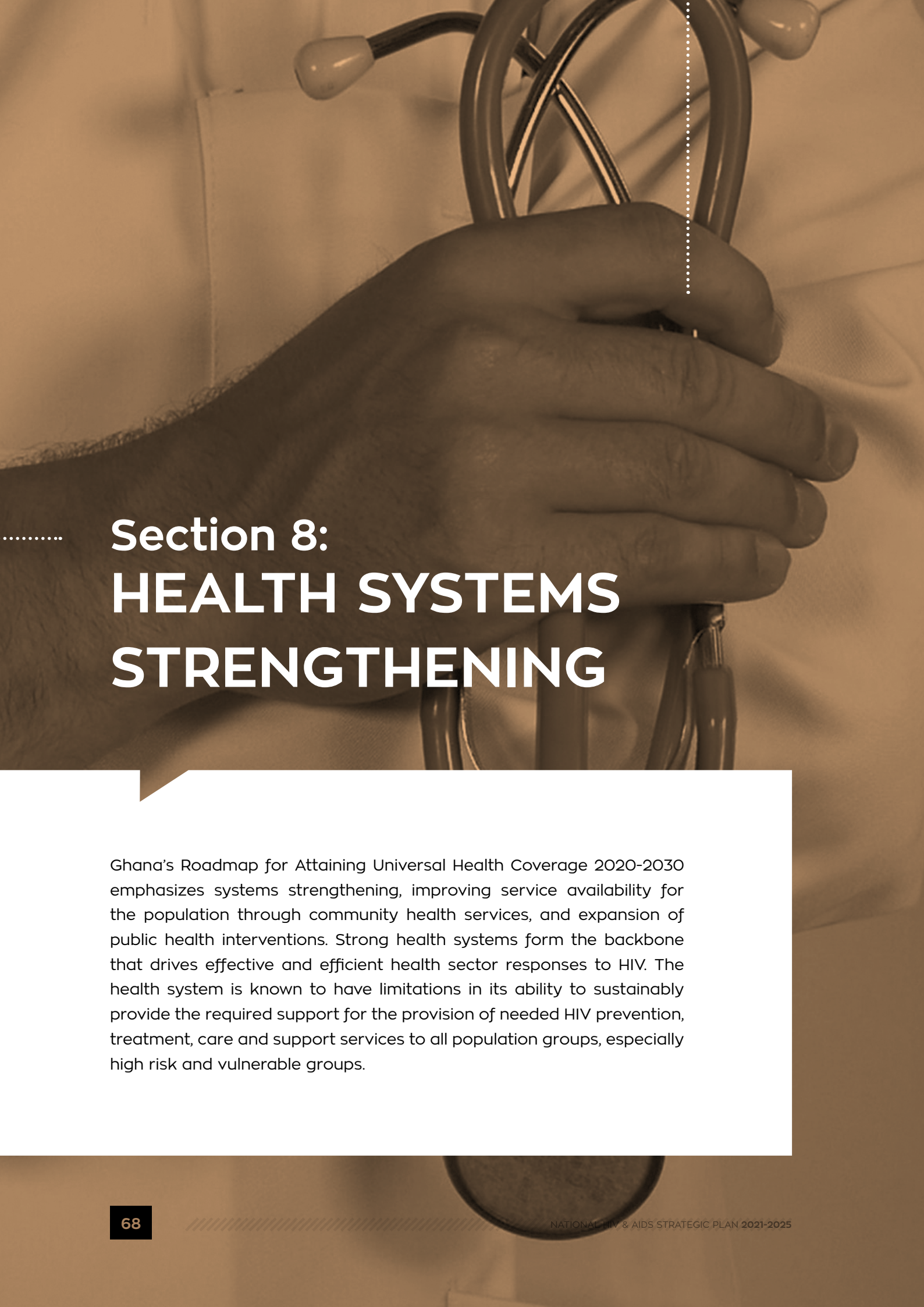
### **7.4 Community Data Systems Creation, Utilization and Institutionalization**

There is increased emphasis on the need for community data system creation, utilization and the generation of community level information for community level decision making.

The strategy is to develop a viable, simple and robust community-based monitoring system that will meet the needs of communities and integrate into the national information system as well. The community-based monitoring system must involve drawing in, activating, motivating, capacity building and allowing the communities and its representatives to directly provide inputs and feedback about the functioning and products of HIV and AIDS services.

Challenges of community level service providers such as difficulties in managing community level data collection process and procedures; providing services that meet quality standards; incomplete and piecemeal feedback, reduced incentives and inadequate capacity must be addressed.

There is also the need to facilitate and promote the determinants of data use, which includes the technical aspects of data processes and tools; the behaviours of individuals who produce and use data; and the system or the organizational context that support data collection, availability and use.



## Section 8: HEALTH SYSTEMS STRENGTHENING

Ghana's Roadmap for Attaining Universal Health Coverage 2020-2030 emphasizes systems strengthening, improving service availability for the population through community health services, and expansion of public health interventions. Strong health systems form the backbone that drives effective and efficient health sector responses to HIV. The health system is known to have limitations in its ability to sustainably provide the required support for the provision of needed HIV prevention, treatment, care and support services to all population groups, especially high risk and vulnerable groups.

Health systems' strengthening interventions to improve the overall capacity of the health system to support the effective and efficient execution of HIV interventions are key. To achieve the desired results, the following systemic challenges need to be addressed: human resources; health management information; health technology especially laboratory capacity; product and supplies management; community participation; health service delivery; private sector partnership; emergency preparedness and response; and workplace HIV and AIDS programs.

### **Desired outcome**

A health system that is sensitive and responsive to the needs of the national HIV response.

The system strengthening requirements are further elaborated upon below:

## **8.1 Human Resources**

### **8.1.1 Introduction**

Staff quality and quantity, in general, are in-adequate and this is further compounded by the inequitable distribution of staff, and high staff attrition either out of the service or transferred to other facilities. High staff turnover results in gaps in service provision by trained staff. Task shifting, use of formal community health workers, community volunteers and other non-formal peer groups are possible options to be considered and developed as appropriate to support the various aspects of HIV prevention, treatment and care services.

There are frequent changes to treatment protocols and guidelines as new information and evidence is gathered for better treatment, and as management in these is rapidly scaled up.

### **8.1.2 Outcome, Key Strategies and Activities**

#### **Desired Outcome**

HIV prevention, treatment and care services are provided according to best practices and standards.

#### **Strategic Intervention**

Improve upon the knowledge, attitudes and skills required for the identification and provision of the full continuum of care, treatment and management of HIV and AIDS:

### Activities

- Work with and support the MoH to strengthen HIV and AIDS in-service trainings for health workers;
- Support efforts by public, private and civil society health managers to work together to increase the pool of trained health workforce needed to provide quality care across the continuum of HIV services; and
- Review and effectively implement workplace HIV and AIDS safety and protection policies and procedures for health workers.

## 8.2 Health Management Information Systems

### 8.2.1 Introduction

Governance frameworks to support data collection and reporting tools including ICT infrastructure to ensure completeness and timeliness of HIV and AIDS (and other disease) data is inadequate. There are weaknesses in data quality control and adherence to standard operating procedures for high data integrity on HIV and AIDS data: skills and competence to undertake data analysis, review and utilization of HIV service delivery indicator data is also low. Data from the tertiary level of care and the private sector service providers are not captured into the national DHIMS2 platform. Data quality in general is a challenge with gaps in assurance, data capture, timeliness, accuracy and completeness at the facility level.

Currently there are patient monitoring systems for ART/HIV, TB and malaria (e-Tracker system, TB GxAlert and Malaria Integrated Database (MID), respectively). As integrated care for patients with both HIV and TB becomes the norm, the integration of these parallel systems is of importance. There is a need for efficiency and access purposes to integrate all these solutions with DHIMS 2. As part of data integration, HIV folders should be integrated into the national client folder system. With most interventions for HIV occurring at the community level, data capture and reporting will be strengthened.

### 8.2.2 Outcome, Strategies, and Activities

#### Desired Outcome

Accurate data is available for monitoring and evaluation of HIV interventions.

#### Strategic Intervention

Enhancing the functionality of HIV data management systems:

#### Activities

- Strengthen data quality management at the community level;
- Finalize the harmonization and inter-operability of HIV data management systems (DHIMS2 and e-Tracker);
- Review and update data management protocols and guidelines for health information officers at all levels; and
- Distribute and disseminate protocols and guidelines to all staff in the health information management units.

## 8.3 Health Technology including Laboratory Systems

### 8.3.1 Introduction

Quality laboratory services are an essential component for treatment, care and control for HIV as well as other diseases. New diagnostic methods and treatment protocols emphasize the importance of high quality, timely and reliable laboratory tests and results. 'Strengthening Laboratory Management toward Accreditation' has been used to support the implementation of the WHO/AFRO Stepwise Laboratory Quality Improvement Process towards Accreditation with success. There are still many laboratories that have not benefited from this intervention and the continued improvement for laboratories to achieve national as well as the international ISO15189 standards is a desired outcome.

Critical to effective laboratory support for HIV case management is the transportation of samples for analysis. An HIV specimen referral system, piloted in 2018 in Greater Accra Region and later rolled out nationwide in 2019, resulted in a 71% increase in specimen referrals between 2018 and 2019, for viral load testing. Despite the progress made, some challenges persist. These include frequent breakdown of viral load machines and long turnaround time for receipt of results.

An additional weakness of the laboratory services impacting HIV service delivery is the current manual approach to administering and managing laboratory service data for HIV as well as TB and malaria. This results in i) long turnaround times for test requisition, and ii) limited data utilization for continuous quality improvement for service delivery.

The TB program has a referral system that has yielded good results. To ensure effectiveness, it will be necessary to integrate both systems to increase access and coverage.

### 8.3.2 Outcome, Key Strategies and Activities

#### Desired Outcome

Improved treatment outcomes because of timely, accurate and reliable laboratory results.

#### Strategic Intervention

Strengthen supply and management of health technologies especially laboratory systems;

#### Activities

- Expand laboratory quality improvement process towards accreditation;
- Explore the use of technology including POCs for EID and viral load testing;
- Explore innovative and cost-effective approaches to increasing access to viral load testing; and
- Integrate HIV and TB referral systems to increase access and coverage.

## 8.4 Products and Supply Management

### 8.4.1 Introduction

Significant improvements have been recorded in the availability and access to relevant medical products and medicines required for HIV care. This is because of the introduction of the Ghana integrated Logistics Management Information System (GhiLMIS). GhiLMIS is currently rolled-out to the Central Medical Stores, 10 Regional Medical Stores (RMS), five Teaching Hospitals, 10 Regional Hospitals, 50 District Hospitals and four Zipline Distribution Centres. GhiLMIS has been rolled out, in some areas to the sub district level (health centres) as well. Use of GhiLMIS has resulted in a significant recorded reduction in Order Processing Cycle Time. These significant improvements notwithstanding, there is the need to increase uniformity in distribution, essential commodity visibility, security, availability and access of HIV products.

### 8.4.2 Outcome, Strategies and Activities

#### Desired Outcome

HIV prevention and treatment commodities are equitably accessible, timely available and of the right quality to all persons requiring them.



## Strategic Intervention

Improve supply and management of HIV commodities:

### Activities

- Increase efficiencies in utilization of GhiLMIS and ensure its institutionalization and sustainability;
- Strengthen GhiLMIS and governance to improve availability of logistics for patient care and reduce artificial stock-outs; and
- Strengthen district level availability and accessibility of HIV commodities.

## 8.5 Health Service Delivery

### 8.5.1 Prevention and Testing

With 83% of HIV among adolescents being peri-natally acquired, eliminating MTCT is a priority towards achieving epidemic control. The PMTCT coverage (72%) is below the national target of 95%. Twenty-one percent (21%) of children born to HIV positive mothers are HIV positive at complete cessation of breastfeeding. Only 37% of HEI exposed infants received a virologic test within two months of birth.

Past efforts to scale-up HIV testing services using mass screening through routine facility-based testing and campaigns have not been efficient and have not reached many of those most affected by and at risk of HIV. Case finding strategies, e.g. index testing and partner notification, are very limited. There are high rates of re-testing of low-risk persons and PLHIV previously diagnosed who are “checking their status”. This situation accounts for HIV linkages being underestimated due to high rates of re-testing and unreported knowledge of HIV-positive statuses. Furthermore, HIV testing is almost exclusively within health facilities. Outside select geographic settings, there are limited services for STI clients and key populations.

### 8.5.2 Treatment

With respect to treatment, efforts are being made to provide integrated care for persons with HIV, TB, SRHR, cervical cancer, GBV, mental health, NCDs and other co-morbidities at the same point of care; client retention with limited and poor data on retention and number of PLHIV currently on ART. Supportive policy for differentiated ART delivery is yet to be fully implemented and there is limited ability to track appointments and conduct tracing of clients late for appointments or in a treatment interruption.



### 8.5.3 Outcome, Strategies, and Activities

#### Desired Outcome

- A population that knows its status and adopts lifestyles and behaviour to reduce or eliminate their risk of acquiring new HIV infections or getting re-infected; and
- The desired outcome is for the general population, especially persons affected by and/or living with HIV and AIDS, to equitably receive gender responsive and differentiated services in a continuous, sustainable manner, where they are and when they need them.

#### Strategic Intervention

Ensure availability of and access to comprehensive prevention, testing and treatment services:

Activities

- Support private sector to provide HIV testing and treatment services;
- Develop supportive policies for differentiated ART service delivery; and
- Implement differentiated ART service delivery.

## 8.6 Community Participation

### 8.6.1 Introduction

Partnering with civil society, community-based organizations and working with and through community governance and leadership structures has significantly supported access to and coverage of HIV prevention, treatment and care services, especially by key populations in both urban and rural communities. Improved community ownership of, active participation in and more effective coordination of program interventions is required to maximally leverage the potential of an empowered community to facilitate the adoption of appropriate behaviours and practices that support the achievement of the desired program goals. Strengthening the ability of communities to play a more active role in the design, implementation and monitoring of program interventions is considered a top priority.

Scaling up data related to human rights and gender is critical for safeguarding the safety of women, girls, men and boys, other genders and KP. Gender integration in the prioritized interventions will be an integral component of the community systems strengthening. The role of community-based organizations, including organizations of

women living with HIV, AGYW and KP in data collection and program monitoring will be strengthened.

## 8.6.2 Outcome

Desired outcome: An empowered community that increasingly participates and contributes to the successful implementation of the national HIV response.

## 8.6.3 Strategies and Activities

### Strategic Intervention

Strengthening the community's role in the implementation and monitoring of program interventions:

#### Activities

- Develop and adopt detailed implementation arrangements for collaborative service delivery;
- Train service providers to deliver community level services collaboratively;
- Support and facilitate well-coordinated and mutually beneficial HIV program implementation arrangements amongst community-based service providers; and
- Map and sort service providers by target-group (AGYW, FSW, PWID, and MSM) and by program area (BCI, CHBC, and HTS).

## 8.7 Partnership, including Private Sector Participation

### 8.7.1 Introduction

The private health sector contributes significantly across the country to health service delivery. Ghana's UHC Roadmap prioritizes a sustainable partnership and harmonized agenda between government, the private sector, non-state actors and development partners to upscale service delivery and secure predictable financing for long-term results.

Although the 2016-2020 NSP recognizes the role of the private sector in contributing to the national response, the private sector has been unable to fully and appropriately respond to the needs of the national response compared to the public sector. Critical challenges faced include:

- Inadequate involvement of the private sector in health sector policy and strategy implementation, monitoring and evaluation;
- Weak capture and documentation of private sector data within national reporting systems;

- Weak integration of private and public sector services into a unified health service delivery system; and
- Inadequate capacity and limited access to HIV and AIDS and TB in the private sector.

## 8.7.2 Outcome

A sustained partnership and harmonized agenda between government and the private sector to upscale HIV service delivery.

## 8.7.3 Strategies and Activities

### Strategic Intervention 1

Private sector mobilization and participation in HIV diagnosis and treatment:

#### Activities

- Map out regions, districts and cities in Ghana with strong private sector presence;
- Develop guidelines to support private sector HIV and TB service provision at all levels;
- Engage professional associations within the private sector;
- Identify private sector focal persons at all levels of implementation; and
- Develop capacity building and training tools in accordance with national standards.

### Strategic Intervention 2

Strengthen M&E capacity of the private sector to effectively track and assess HIV service provision:

#### Activities

- Engage private sector institutions on the need for HIV and AIDS data reporting and its impact on control activities in the country;
- Develop an appropriate data management system for the private sector including data collection tools;
- Conduct training for private sector staff on data management and use;
- Ensure all recording and reporting tools are made available for DHIMS2 and e-Tracker reporting; and
- Conduct periodic reviews of recording and reporting systems.

## **8.8 Emergency Preparedness and Response**

Emergency preparedness and response is identified as a priority intervention in Ghana's Roadmap to Attaining Universal Health Coverage 2020-2030. The COVID-19 pandemic has seen a robust and dynamic Government-led multi-sectoral response that has brought various stakeholders together to combat the epidemic in the country. Measures to control the situation may have negatively impacted service delivery for vulnerable populations, such as PLHIV, on long term treatment, care and support. A dispensation has been made to provide PLHIV on treatment with multi-month dispensing of medication to ease the challenge of access to services during the pandemic.

The enrolment of all PLHIV on the NHIS will enable them to better withstand and recover from crisis situations.

The successful implementation of the NSP 2021-2025 is dependent on the network of systems and key stakeholders at National, Regional, District and Community levels from Governmental, NGOs, CSOs and the private sector working together in the HIV and AIDS national response. These networks and linkages that have been established will be leveraged to support national efforts in combating COVID-19 or any future unexpected pandemic or epidemic event.

## **8.9 Workplace HIV Programs**

There is a slow uptake of workplace HIV programs by both formal and informal establishments. Most of these establishments do not have working policies or programs. The workplace is a recognized environment to easily reach a significant number of the population. Workplace HIV programs not only directly benefit the worker but indirectly their families, friends and the community as well. This is a significant contribution towards improving access to and availability of HIV prevention, treatment, care and support services. This strategy will advocate for and create a supportive environment for the use and adherence to existing Ghana AIDS Commission HIV Workplace Policy and others to establish workplace HIV programs in public, private, formal and informal workplaces.



# Section 9: SUSTAINABILITY AND HEALTH FINANCING

## 9.1 Introduction

Funding to support the execution of the NSP 2021-2025 is key. Ghana, as a lower middle-income country, is expected to increase its domestic financing capacity for its developmental and social needs. With the transition to the status of a lower middle-income country, Ghana has experienced a reduction in external funding.

## 9.2 Objective and Outcome

### Objective

Ensure the availability of adequate funding to execute the NSP 2021-2025.

### Desired Outcome

The desired outcome of this objective is that there will be a proportional increase in domestic funding towards the funding of the NSP 2021-2025.

## 9.3 Strategies and Activities

The following strategies have been identified and agreed upon:

### 9.3.1 Strategy 1 - Increase Domestic Financing for HIV Activities

The GAC Act 938 makes provision for a National HIV and AIDS Fund. There must be a conscious effort to sustain domestic funding already earmarked for HIV activities. The intent is to ensure that the HIV and AIDS Fund is resourced and utilized appropriately. In addition, new options for local mobilization of funds, including private sector involvement, for HIV and AIDS work must be identified and pursued.

#### Resource Mobilization to Finance Funding Gap

The Resource Mobilization Strategy 2020-2025 has outlined various innovative strategies to scale up funding for the national response to HIV and AIDS with a focus on domestic resource mobilization. Furthermore, the establishment of the National HIV and AIDS Fund by the GAC Act 2016, Act 938 is seen as a lasting solution to any funding squeeze in future. Accordingly, the GAC Act has established, among others, the Resource Mobilization Committee and the National HIV and AIDS Fund Management Committee, both Standing Committees of the Governing Board, to vigorously pursue the function of mobilizing adequate resources for HIV and AIDS activities.

Unlike the donor dependent funding experienced in the past (up to 80% donor support), measures being introduced are expected to systematically scale up domestic resources to achieve a target of at least 80% of resource contribution from domestic sources in line with the “Ghana Beyond Aid” agenda.

Major sources of domestic funding for the national HIV response will come from (1) public sector, (2) the private sector, and (3) Non-Governmental and Faith-Based Organizations to ensure that domestic funding provides at least 80% of the funding needs for the national HIV response to achieve the 95-95-95 fast-track targets by 2025.


### **Key activities**

- i. Undertake targeted awareness creation and advocacy engagements for GoG to substantially increase and sustain funding for the national HIV response;
- ii. Secure adequate funding in annual budgets for HIV and AIDS interventions implemented by GAC and key line ministries;
- iii. Increase access for PLHIV to social protection programs;
- iv. Operationalize the National HIV and AIDS Fund (NHAF) Act (Development of a Framework & LI Formulation);
- v. Increase and strengthen sustainable private sector involvement in the national HIV response through high level meetings with captains of Club 100 members and other corporate entities;
- vi. Workplace policy on HIV should be fully integrated into all MMDAs and the uniformed services to scale up prevention campaigns in the workplace;
- vii. Increase budgetary allocation for HIV interventions by the Ministry of Finance;
- viii. Tourism levy of 1% - hotels, drinking spots and restaurants should be levied 1% of the charges to their clients as their contribution to HIV prevention and treatment;
- ix. Mining firms should contribute at least 2% of their CSR budget to HIV due to the high-risk behaviour in their communities;
- x. Ghana Ports and Harbors Authority must submit a portion of its revenue (1%) to HIV due to the influx of most-at-risk persons to the ports;
- xi. A portion (2%) of the Communications Service Tax (CST) should be allocated to the National HIV and AIDS Fund; and
- xii. The 0.5% District Assembly Common Fund allocated to HIV should be increased to 2% and released regularly to ensure funding for HIV activities at the districts.

### **9.3.2 Strategy 2 - Increase External Funding for HIV Activities**

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





# Section 10: COORDINATION AND IMPLEMENTATION ARRANGEMENTS

## 10.1 Introduction

The NSP 2021-2025 management and implementation arrangements are designed to ensure the effective coordination and harmonization of the various stakeholders and their activities. The arrangements are expected to take advantage of existing relationships as well as develop new synergies between stakeholders. In addition, the arrangements will reduce duplication, role ambiguity and improve the overall efficiency of the implementation of the NSP 2021-2025.

10.2 Coordination and Management



The Ghana AIDS Commission (GAC) under the Office of the President is responsible for the coordination of the national HIV response. The Commission also has the mandate to formulate policies on HIV and AIDS. As part of the implementation of the NSP 2021-2025, GAC will co-ordinate the response and provide guidance to the relevant stakeholders at the national, regional and district levels.

National level: At the national level, the GAC Secretariat will lead the coordination, monitoring and evaluation of the NSP 2021-2025. The key coordination activities to be undertaken shall be:

- i. Provide technical guidance for the implementation of the NSP 2021-2025
- ii. Undertake advocacy for increased domestic funding for implementation
- iii. Promote communication and collaboration between Development and Implementing partners
- iv. Provide capacity building to Regional and Districts level implementation structures and key stakeholders
- v. Monitor and evaluate implementation of interventions of the NSP 2021-2025 at the various levels

Regional level: The Regional Committee of the Commission (ReCCom) led by the Technical Support Unit (TSU) is responsible for the coordination of HIV and AIDS activities at the regional and district levels. The key coordination activities to be undertaken shall be:

- i. Collate and review HIV and AIDS data and reports from Metropolitan, Municipal and Districts Assemblies (MMDAs) and all other implementing partners
- ii. Support MMDAs in the planning and implementation of HIV and AIDS activities
- iii. Undertake support supervision to the MMDAs and Implementing partners
- iv. Coordinate regional HIV and AIDS fora and events
- v. Undertake advocacy and communication initiatives

District level: The District Committee of the Commission (DiCCom) is responsible for the coordination of HIV and AIDS activities at the district level. The District Focal Person under the guidance of the TSU shall ensure the efficient implementation, monitoring and reporting of HIV and AIDS activities.

### **10.3 Implementation Arrangements**

A detailed Operational Plan (OP) shall be developed to articulate the priority activities that should be implemented by stakeholders/implementing partners for the intervention areas and strategic activities as contained in the NSP. The OP will spell out output results and timeframe for implementation. Additionally, an M&E Plan detailing all indicators and their specific targets and measurements shall be developed to support effective implementation of the Strategic Plan.

Considering the multi-sectoral nature of the national HIV and AIDS response, key sectors that will be involved in the operationalization/implementation of the NSP 2021-2025 and their specific roles are outlined beneath:

- **Public Sector:** Government Line Ministries, and Metropolitan, Municipal, and District Assemblies (MMDAs) are responsible for the implementation of HIV and AIDS activities within their jurisdictions. The Ministry of Health (MoH) is a key player in the national HIV response and the National AIDS Control Program (NACP) within the Ghana Health Service (GHS) provides implementation guidance and support for HIV prevention, treatment, care, and support interventions.
- **Civil Society and Faith-Based Organizations:** Local and international non-governmental organizations (NGOs), faith-based organizations (FBOs), and community-based organizations (CBOs) are important stakeholders providing HIV prevention, treatment, care, and support services. Local NGOs, CBOs, and FBOs are at the forefront of providing HIV and AIDS services at the community level.
- **Private Sector:** Some large and medium size firms provide workplace HIV prevention services for employees, their families, and local communities. Private pharmacies are poised to play a key role in the sale of HIV self-test kits to the general public when the HIV Self-Test (HIVST) program is rolled out during the NSP 2021-2025 period.

# HIV AIDS

## Section 11: COSTING OF THE NSP 2021-2025

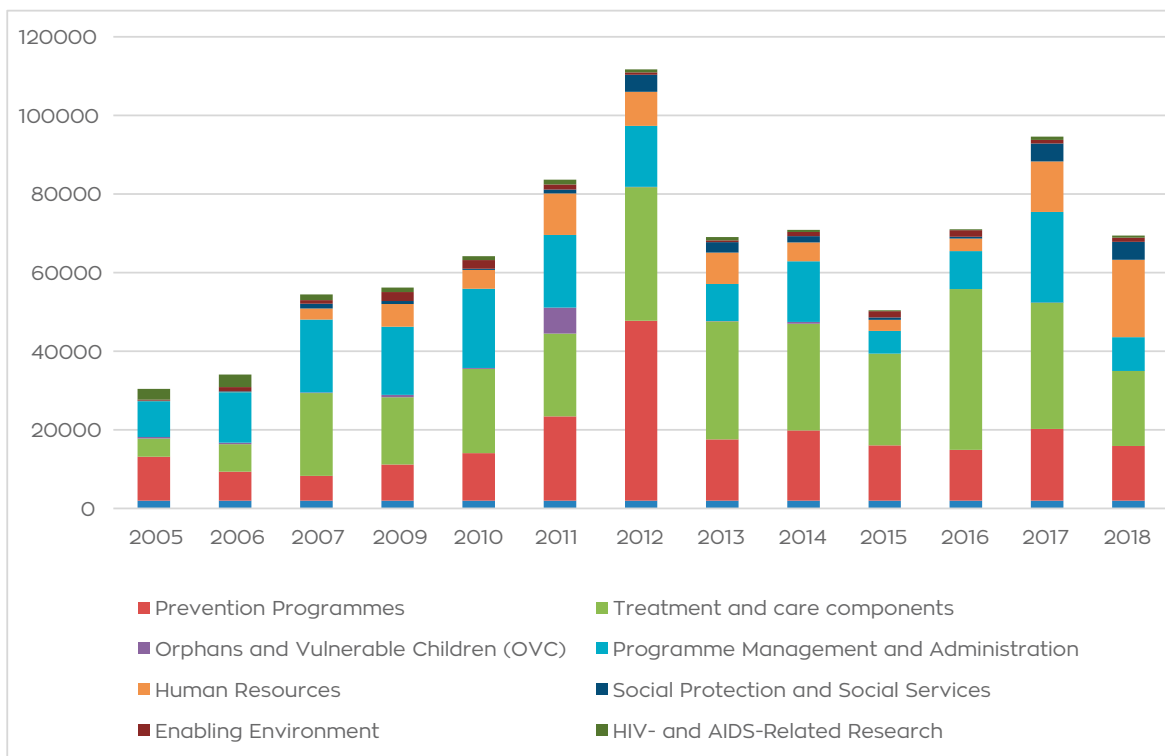
### 11.1 Approach

The costing of the NSP was carried out using unit cost and institutional data based on actual expenditure. Unit cost approach was used in estimating the resources needed for the direct intervention areas of the NSP: (i) Prevention of new HIV infections; and (ii) HIV treatment, care and support.

Institutional unit cost data from the Ghana AIDS Commission based on historical expenditures and the National AIDS Spending Assessment (NASA) for various years were used for the remaining sections (program support) of the NSP, which are (i) Community Engagement and System Strengthening; (ii) Health and Social Justice; (iii) Strategic Information; (iv) Health System Strengthening; (v) Sustainability and Health Finance; and (vi) Coordination and Management of National HIV Response.

The basic method of resource estimation was first to estimate the number of people in need of HIV and AIDS-related services in the target group. A coverage target was then established, which is the universal access target, to estimate the population that would use the service. The next step was to estimate the unit cost of providing the intervention or service and this was used to calculate the total cost of the intervention. Unit cost estimates were obtained from field studies conducted by the Ghana AIDS Commission, international organizations such as the Futures Group, information collected from organisations currently implementing HIV and AIDS interventions such as the National AIDS/STI Control Programme (NACP), among others.

Average estimates for the various program support areas under the NSP was obtained from various National AIDS Spending Assessments (NASA) conducted over the last 10 years. The first NASA was conducted for 2005 and the most recent ones were for 2017 and 2018 (see Figure 7). These average estimates were obtained using ratios obtained as a percentage of the direct expenditure on prevention and treatment, care and support.



**Figure 6: Total Spending on Key NASA Priority Areas, 2005 – 2018 ('000 of US\$)**  
*Source: Various Ghana NASA Reports, 2007 to 2018*

## 11.2 Estimated Financial Resources Needed

This sub-section summarises the cost of the national response for the period 2021 to 2025. It presents the cost by the main priority area and where applicable by

the intervention area of the NSP (Table 19). The total cost estimated for the NSP is US\$661,562,182 increasing from US\$113.0 million in 2021 to US\$145.3 million in 2025.

**Table 19: Ghana: Costing of National HIV and AIDS Strategic Plan (NSP) 2021 - 2025**

	COST IN U.S. DOLLARS					TOTAL
	2021	2022	2023	2024	2025	
TOTAL ESTIMATED RESOURCES	113,004,411	127,655,250	133,447,201	142,184,841	145,270,479	661,562,182
<b>1. HIV PRIMARY PREVENTION</b>	<b>19,803,017</b>	<b>22,967,248</b>	<b>24,508,377</b>	<b>24,989,784</b>	<b>26,418,911</b>	<b>118,687,336</b>
<b>Elimination of Mother-to-Child Transmission of HIV (eMTCT)</b>	<b>8,045,301</b>	<b>8,031,752</b>	<b>7,986,135</b>	<b>7,920,345</b>	<b>7,844,016</b>	<b>39,827,548</b>
Pregnant women needing HTS	5,622,500	5,622,500	5,622,500	5,622,500	5,622,500	28,112,500
HIV-positive pregnant women on ART	2,296,793	2,283,948	2,240,704	2,178,335	2,105,976	11,105,757
EID Coverage in HIV Exposed Infants (HEI)	126,008	125,303	122,931	119,509	115,539	609,291
<b>HIV Testing Services (HTS)</b>	<b>7,853,801</b>	<b>10,755,232</b>	<b>12,033,619</b>	<b>12,106,179</b>	<b>13,105,606</b>	<b>55,854,435</b>
1st 95 - PLHIV	6,175,000	9,100,000	10,400,000	10,400,000	11,310,000	47,385,000
Number of PLHIV Undiagnosed	573,047	405,366	240,994	159,315	119,165	1,497,886
PLHIV with Partners - HIV Self-Testing (HIVST)	615,069	719,193	821,061	934,076	1,020,045	4,109,443
MSM Eligible for HIVST	209,658	232,083	255,385	279,045	304,246	1,280,416
FSW Eligible for HIVST	281,028	298,591	316,180	333,743	352,151	1,581,691
<b>Blood Safety</b>	<b>1,225,000</b>	<b>1,225,000</b>	<b>1,225,000</b>	<b>1,225,000</b>	<b>1,225,000</b>	<b>6,125,000</b>
Number of safe blood units received from low risk population	1,225,000	1,225,000	1,225,000	1,225,000	1,225,000	6,125,000
<b>Comprehensive Condon Programming for the General and Key Populations</b>	<b>929,895</b>	<b>1,022,885</b>	<b>1,125,173</b>	<b>1,237,690</b>	<b>1,361,459</b>	<b>5,677,102</b>
Condoms for General Population	745,950	820,545	902,600	992,859	1,092,145	4,554,099
Condoms: FSW	165,447	181,992	200,191	220,210	242,231	1,010,070
Condoms: MSM	18,498	20,348	22,383	24,621	27,083	112,933
<b>Sexually Transmitted Infections (STIs)</b>	<b>1,430,000</b>	<b>1,522,700</b>	<b>1,622,930</b>	<b>1,729,660</b>	<b>1,837,630</b>	<b>8,142,920</b>
Number of patients receiving diagnosis and treatment for STIs according to national guidelines	1,430,000	1,522,700	1,622,930	1,729,660	1,837,630	8,142,920
<b>Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)</b>	<b>319,020</b>	<b>409,680</b>	<b>515,520</b>	<b>770,910</b>	<b>1,045,200</b>	<b>3,060,330</b>
Discordant couples for PrEP	212,910	298,740	397,890	517,350	635,580	2,062,470
MSM for PrEP	44,490	46,230	48,960	108,120	178,740	426,540
FSW for PrEP	61,620	64,710	68,670	145,440	230,880	571,320
<b>2. HIV TREATMENT, CARE AND SUPPORT</b>	<b>61,582,149</b>	<b>69,516,455</b>	<b>76,560,585</b>	<b>78,800,082</b>	<b>80,329,035</b>	<b>366,788,306</b>
<b>ART</b>	<b>61,220,902</b>	<b>68,556,393</b>	<b>75,560,067</b>	<b>77,741,535</b>	<b>79,216,664</b>	<b>362,295,561</b>
Adults on ART	36,069,197	40,577,580	44,920,264	46,483,333	47,469,528	215,519,902
Children on ART	3,417,183	3,527,637	3,571,819	3,248,346	3,143,019	16,908,005
Viral Load (VL) Testing: Adults on ART	21,734,522	24,451,176	27,067,984	28,009,856	28,604,116	129,867,654
Viral Load (VL) Testing: Children on ART	1,950,222	1,822,426	1,692,824	1,506,720	1,442,564	8,414,756
<b>HIV-TB Co-Infection (HIVTB)</b>	<b>361,246</b>	<b>960,062</b>	<b>1,000,518</b>	<b>1,058,547</b>	<b>1,112,372</b>	<b>4,492,745</b>
TB Clients tested Positive for HIV	80,802	171,106	178,308	188,669	198,250	817,135
TB Clients tested Positive Enrolled on ART	280,445	788,956	822,210	869,878	914,122	3,675,611
<b>3. COMMUNITY ENGAGEMENT AND SYSTEM STRENGTHENING</b>	<b>448,702</b>	<b>661,455</b>	<b>874,207</b>	<b>1,086,960</b>	<b>1,236,576</b>	<b>4,307,900</b>
<b>Community Involvement</b>	<b>122,160</b>	<b>153,728</b>	<b>185,296</b>	<b>216,864</b>	<b>185,296</b>	<b>863,345</b>
Capacity building for Community Based Organisations (CBOs)	90,592	90,592	90,592	90,592	90,592	452,962
Community Monitorin	31,568	63,136	94,704	126,272	94,704	410,383
<b>Improve Knowledge of Community-level Stakeholders</b>	<b>326,542</b>	<b>507,726</b>	<b>688,911</b>	<b>870,096</b>	<b>1,051,280</b>	<b>3,444,555</b>
Stakeholder Mapping	50,174	50,174	60,209	60,209	60,209	280,976
Knowledge Management Platform	190,990	372,175	553,360	734,544	915,729	2,766,798
Strengthening Community and district level stakeholder collaboration	130,531	130,531	130,531	130,531	130,531	652,655
Collaboration of Ministry of Health and regulatory agencies	5,020	5,020	5,020	5,020	5,020	25,102
<b>4. HEALTH AND SOCIAL JUSTICE</b>	<b>2,444,478</b>	<b>4,047,028</b>	<b>6,590,344</b>	<b>11,466,827</b>	<b>13,558,510</b>	<b>38,107,188</b>
Promote and Protect the rights of KPs access to HIV services	734,212	771,712	809,212	827,962	884,212	4,027,308
Provide social protection	1,710,267	3,275,316	5,781,133	10,638,866	12,674,299	34,079,880
<b>5. STRATEGIC INFORMATION</b>	<b>15,219,638</b>	<b>15,250,038</b>	<b>8,722,683</b>	<b>9,231,606</b>	<b>6,718,523</b>	<b>55,142,488</b>
National HIV M&E System	15,219,638	15,250,038	8,722,683	9,231,606	6,718,523	55,142,488
<b>6. HEALTH SYSTEM STRENGTHENING</b>	<b>2,519,430</b>	<b>2,727,727</b>	<b>2,546,695</b>	<b>2,597,951</b>	<b>2,597,951</b>	<b>12,989,753</b>
<b>7. SUSTAINABILITY AND HEALTH FINANCE</b>	<b>2,034,629</b>	<b>2,312,093</b>	<b>2,526,724</b>	<b>2,594,747</b>	<b>2,668,699</b>	<b>12,136,891</b>
<b>8. COORDINATION AND MANAGEMENT OF NATIONAL HIV RESPONSE</b>	<b>8,952,368</b>	<b>10,173,207</b>	<b>11,117,586</b>	<b>11,416,885</b>	<b>11,742,274</b>	<b>53,402,321</b>

HIV Treatment, Care and Support makes up the largest share of the estimated cost over the 5-year period, representing 55.4%. This is mainly driven by ART, which is about 98% of the cost. HIV Primary Prevention follows next with 17.9% driven mainly by HIV Testing Service (47.1%); Elimination of Mother-to-Child Transmission of HIV (33.6%); Sexually Transmitted Infections (6.9%); Blood Safety (5.2%); Comprehensive Condom Programming for the General Population (4.8%); and Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis (2.6%).

HIV Treatment, Care and Support and HIV Primary Prevention constitute the direct cost of the NSP and this forms 73.3% of the total resources in the 5 years. The remaining priority areas of the NSP forms the indirect cost (program support) and this is 26.7% of the total resources. The breakdown is as follows: Community Engagement and System Strengthening, 0.7%; Health and Social Justice, 5.8%; Strategic Information, 8.3%; Health System Strengthening, 2.0%; Sustainability and Health Finance, 1.8%; and Coordination and Management of the National HIV Response, 8.1%.

Under the Strategic Information priority area, Table 20 shows some of the planned studies to be carried out within the 5 years.

**Table 20: Planned Studies, 2021 - 2025**

Study	Coverage/Scale	Remarks
Men's Study III (IBBSS)	National	Last study was conducted in 2017
IBBSS for FSW	National	Last study was conducted in 2019
IBBSS for PWID	National	Formative study
IBBSS for PWD	National	Formative study



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**Section 12:**  
**CORE INDICATORS  
AND THEIR  
DEFINITIONS**

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
HIV PREVENTION SERVICES				
1.	Percentage of MSM reached with HIV prevention programs- defined package of services	Number of MSM who have received a defined package of HIV prevention services	Estimated number of MSM in the targeted area	Research Studies (IBBSS)
2.	Percentage of sex workers reached with HIV prevention programs- defined package of services	Number of sex workers who have received a defined package of HIV prevention services	Estimated number of sex workers in the targeted area	Research Studies (IBBSS)
3.	Percentage of people in prisons and other closed settings reached with HIV prevention programs- defined package of services	Number of people in prisons and other closed settings who have received a defined package of HIV prevention services	Number of people in prisons and other closed settings in the targeted area	Research Studies (IBBSS)
4.	Percentage of people who inject drugs reached with HIV prevention programs- defined package of services	Number of PWID who have received a defined package of HIV prevention services	Estimated number of PWID in the targeted area	Research Studies (IBBSS)
5.	Percentage of adolescent girls and young women reached with HIV prevention programs- defined package of services	Number of adolescent girls and young women reached with HIV prevention programs- defined package of services	Estimated number of AGYW in the targeted area	Routine Data
PrEP				
6.	Percentage of eligible men who have sex with men who initiated oral antiretroviral PrEP during the reporting period	Number of eligible men who have sex with men who initiated oral PrEP during the reporting period	Number of eligible men who have sex with men who were newly offered PrEP during the reporting period	Routine Data



No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
7.	Percentage of eligible sex workers who initiated oral antiretroviral PrEP during the reporting period	Number of eligible sex workers who initiated oral PrEP during the reporting period	Number of eligible sex workers who were newly offered PrEP during the reporting period	Routine Data
8.	Percentage of eligible adolescent girls and young women who initiated oral antiretroviral PrEP during the reporting period	Number of eligible adolescent girls and young women who initiated oral PrEP during the reporting period	Number of eligible adolescent girls and young women who were newly offered PrEP during the reporting period	Routine Data
9.	% of eligible people who initiated oral antiretroviral PrEP in the last 12 months			
10.	% of PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP in the last 12 months			
11.	# of people who received oral PrEP at least once during the reporting period			
HIV TESTING SERVICES				
12.	Number of new HIV infections per 1000 uninfected population	Estimated number of people newly infected during the reporting period	Total number of uninfected population (or person-years exposed) x 1000	Routine Data

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
13.	Percentage of people aged 15-49 completing the testing and counselling process	Total number of people aged 15-49 who have been tested for HIV and received post-test counselling – disaggregated by district and region, and by sex (male and female)	Total adult population aged 15-49 – disaggregated by district and region; and by sex (male and female)	Routine Data
14.	Percentage of HIV-positive results among the total HIV tests performed during the reporting period	Number of HIV positive tests	Number of HIV tests performed (testing volume)	Routine Data
15.	Percentage of people living with HIV who know their HIV status at the end of the reporting period	Number of people living with HIV who know their HIV status	Number of people living with HIV	Routine Data
16.	Percentage of sex workers who are living with HIV	Number of sex workers who tested positive for HIV	Number of sex workers tested for HIV	Research Studies (IBBSS)
17.	Percentage of sex workers that have received an HIV test during the reporting period and know their results	Number of sex workers who have been tested for HIV during the reporting period and who know their results	Estimated number of sex workers in the targeted areas	Research Studies (IBBSS)
18.	Number of adolescent girls and young women who were tested for HIV and received their results during the reporting period	Number of adolescent girls and young women who were tested for HIV and received their results in the reporting period		Routine Data

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
19.	Percentage of MSM that have received an HIV test during the reporting period and know their results	Number of MSM who have been tested for HIV during the reporting period and who know their results	Estimated number of MSM in the targeted areas	Research Studies (IBBSS)
20.	Percentage of people in prisons and other closed settings that have received an HIV test during the reporting period and know their results	Number of people in prisons and other closed settings who have been tested for HIV during the reporting period and who know their results	Estimated number of people in prisons and other closed settings in the targeted areas	Research Studies (IBBSS)
21.	Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results	Number of other vulnerable populations who have been tested for HIV during the reporting period and who know their results	Estimated number of other vulnerable populations in the targeted areas	Routine Data
<b>PREVENTION OF MOTHER TO CHILD TRANSMISSION</b>				
22.	Percentage of pregnant women who know their HIV status	Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery, or those who already knew they were HIV-positive at the first antenatal care visit	Estimated number of pregnant women giving birth in the past 12 months	Routine Data

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
23.	Percentage of HIV-positive pregnant women who received ART during pregnancy and/or labour and delivery	Number of HIV positive pregnant women who delivered during the reporting period and received ART during pregnancy and/or labour and delivery	Estimated number of HIV positive pregnant women who delivered during the reporting period	Routine Data
24	Percentage of HIV-exposed infants receiving a virological test for HIV within two months of birth	Number of HIV exposed infants born during the reporting period who received a virological HIV test within two months of birth	Estimated number of HIV-positive women who delivered during the reporting period	Routine Data
25.	Proportion of HIV exposed infants who are HIV positive at 18 months	Number of HIV exposed infants who are HIV positive at 18 months of birth	Number of HIV exposed infants screened for HIV at 18 months of birth	Routine Data
26.	Percentage of antenatal care attendees tested for syphilis	Number of women attending ANC services during the reporting period who were tested for syphilis	Number of women attending ANC services during the reporting period	Routine Data
<b>SEXUALLY TRANSMITTED INFECTIONS</b>				
27.	Percentage of patients receiving diagnosis and treatment for STIs according to national guidelines (including advice on prevention)	Number of STI patients for whom the correct procedures were followed in diagnosis and treatment	Number of STI patients for whom provider-client interactions were observed	Routine Data
<b>TREATMENT CARE AND SUPPORT SERVICES</b>				
28.	Percentage of people living with HIV	Number of people living with HIV	Total population	Routine Data


No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
29.	Percentage of people living with HIV not on ART at the end of the reporting period among people living with HIV who were either on ART at the end of the last reporting period or newly initiated on ART during the reporting period	Number of PLHIV reported on ART at the end of the last reporting period plus number of PLHIV newly initiated on ART during the current reporting period who were not on treatment at the end of the current reporting period (including those who died, stopped treatment, and have been lost-to-follow-up (LTFU))	Number of people reported on ART at the end of the last reporting period plus new on ART during the current reporting period	Routine Data
30.	Percentage of people newly diagnosed with HIV initiated on ART	Number of people newly diagnosed with HIV during the reporting period who started ART	Number of people newly diagnosed with HIV during the reporting period	Routine Data
31.	Percentage of people on ART among all people living with HIV at the end of the reporting period	Number of people on ART at the end of the reporting period	Estimated number of people living with HIV	Routine Data
32.	Percentage of adults (15 and above) on ART among all adults living with HIV at the end of the reporting period	Number of adults (15 and above) on ART at the end of the reporting period	Estimated number of adults (15 and above) living with HIV	Routine Data
33.	Percentage of children (under 15) on ART among all children living with HIV at the end of the reporting period	Number of children (under 15) on ART at the end of the reporting period	Estimated number of children (under 15) living with HIV	Routine Data

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
34.	Percentage of people living with HIV and on ART who are virologically suppressed	Number of people living with HIV on ART for 12 or more months, with at least one routine VL test result who have virological suppression (<1000 copies/mL) during the reporting period	Number of people living with HIV on ART for 12 or more months with at least one routine VL result during the reporting period	Routine Data
TB/HIV				
35.	Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period	Number of PLHIV on ART who initiated TB preventive therapy (TPT) during the reporting period	Number of PLHIV on ART who are eligible for TPT during the (same) reporting period	Routine Data
36.	Percentage of people living with HIV newly initiated on ART who were screened for TB	Number of PLHIV newly initiated on ART who were screened for TB during the reporting period	Number of PLHIV who newly initiated ART during the reporting period	Routine Data
	% of PLHIV on ART who completed the course of TB preventive treatment			Routine Data
CONDOM USE AND DISTRIBUTION				
37.	Number of condoms distributed	Total number of condoms procured		
38.	Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, and of those who have had sex with such a partner in the last 12 months	Number of respondents who report using a condom the last time they had sex with a non-marital, non-cohabiting partner	Total number of respondents who report that they had sex with a non-marital, non-cohabiting partner in the last 12 months	Research Studies

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
39.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Number of MSM who report that a condom was used the last time they had anal sex with a non-regular partner in the last six months	Number of MSM who report having had anal sex with a male partner in the last six months	Research Studies (IBBSS)
40.	Percentage of sex workers reporting the use of a condom with their most recent client	Number of sex workers who reported using a condom with their last paying client	Number of sex workers who reported having commercial sex in the last 12 months	Research Studies (IBBSS)
<b>STIGMA AND DISCRIMINATION</b>				
41.	Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	Number of respondents (15-49 years old) who respond no to either of the two questions	Number of all respondents (15-49 years old) who have heard of HIV	Research Studies
42.	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Women 15-49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from at least one of these partners in the past 12 months	Total number of women 15-49 years old surveyed who currently have or have had an intimate partner	Research Studies
43.	Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings	Number of respondents who respond in the affirmative (“Yes”) to at least one of the seven items per question	Number of all respondents	Research Studies

No.	INDICATORS	NUMERATOR	DENOMINATOR	DATA SOURCE
44.	Percentage of MSM who avoid health care because of stigma and discrimination	Number of respondents who answer yes to one of the following questions	Number of respondents	Research Studies (IBBSS)
45.	Percentage of sex workers who avoid health care because of stigma and discrimination	Number of respondents who answer yes to one of the following questions	Number of respondents	Research Studies (IBBSS)
46.	Percentage of people who inject drugs who avoid health care because of stigma and discrimination	Number of respondents who answer yes to one of the following questions	Number of respondents	Research Studies (IBBSS)
46.	Percentage of people living with HIV reporting their rights were violated who sought legal redress	Number of people living with HIV who reported their rights were violated who sought legal redress	Percentage of people living with HIV reporting their rights were violated in the last 12 months	Routine Data
<b>BLOOD SAFETY</b>				
47.	Proportion of blood units of HIV safe blood available for transfusion	Number of blood units screened for HIV in the previous 12 months according to national guidelines	Total number of blood units donated in the previous 12 months	Routine Data





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# Section 13: PROCESS OF DEVELOPING THE NSP 2021-2025

## 13.1 Background

The implementation of the National HIV and AIDS Strategic Plan 2016-2020 expired at the end of December 2020. To assure a seamless transition from the current NSP 2016-2020 to the 2021-2025 implementation period as well as forestall any gaps in implementation in pursuance of the goal of ending AIDS as a public health threat by 2030, GAC initiated the process for the development of a new NSP (2021-2025) to guide the next five years' implementation.

The development process of the new National HIV and AIDS Strategic Plan entails different phases and activities such as identification of data gaps; synthesis of studies and program review reports from 2016-2020; documentation of evidence on achievements; consultations at national and sub-national levels; drafting of plans including consensus building; thematic groups to be led by consultants; and costing, among others.

### **13.2 Joint Review of NSP 2016-2020**

As a prelude to the development of the new NSP 2021-2025, the Commission, in collaboration with stakeholders, embarked on the process of conducting a Joint Review and synthesis of reports of the NSP 2016-2020 to assess the extent to which the goal and objectives of the NSP 2016-2020 were achieved and drew lessons that can be useful for program improvement as well as provide recommendations to inform the development and implementation of the next National HIV Strategic Plan 2021-2025.

A road map to guide the process was prepared and shared with relevant stakeholders with the aim of ensuring that they had a common understanding of the approach to the Strategic Plan as well as their respective roles in the various stages of the processes.

### **13.3 Establishment of a Coordinating Mechanism**

The development of a Strategic Plan requires a coordination mechanism responsible for the management of the process. Based on this, a steering Committee and Technical Working Group were constituted to manage the entire development process of the NSP 2021-2025. Membership of the Steering Committee comprised of a range of stakeholders including: GAC, Ministry of Health, Ghana Health Service, UNAIDS, USAID, and NAP+ Ghana. Specific terms of reference were developed and shared with members to guide their work.

The role of the Steering Committee (SC) was to provide overall policy guidance to planning and make decisions on key issues that would emerge during the planning process. The SC was to direct the entire planning process and periodically review progress.

A Technical Task Team was set up to guide the development of the NSP 2021-2025. The TWG comprised of experts from among stakeholders in the national response drawn from GAC, NACP, UNAIDS and WHO.

Three consultants comprising of a lead and two thematic consultants were contracted to lead and direct the process. An NSP Secretariat was set up to provide administrative

support and coordination function of both the Joint Review of NSP 2016-2020 and NSP 2021-2025 development process.

### **13.4 Technical Working Group Meetings**

A Writing Team, made up the Technical Task Team and a wide range of key stakeholders (including GAC, GHS (NACP/Facility Representatives, GHS/HED) CSOs, Youth led organisations, NAP+, Development Partners and CCM was constituted and tasked with the drafting of the NSP 2021-2025.

The Writing Team, together with the NSP Consultants, embarked on two boot camps. The first boot camp was used to tease out the key issues in broad terms based on findings from the joint review report.

The second boot camp was held after the review of the zero draft by wider stakeholders. The team was required to further review the objectives, targets and activities. The occasion was also used to develop the structure of the NSP and decide on what was to go into each section.

At every stage of the NSP development process, TWG meetings were held both in-person and virtually for members to deliberate and agree on critical issues to ensure an all-inclusive process.

### **13.5 Zonal Stakeholder Reviews/Consultations**

Following a Joint Review of the NSP 2016-2020, a stakeholder validation was held where key findings and recommendations were presented to a wider range of stakeholders. To ensure the needs of regions and districts are adequately captured in the NSP 2021-2025, three virtual zonal stakeholder consultations/reviews were held with the goal of soliciting for inputs from all stakeholders to inform the development of a comprehensive NSP 2021-2025, and to ensure the NSP 2021-2025 reflects the needs of all the regions and districts.

### **13.6 Development of Targets**

As part of the process for the development of the National Strategic Plan 2021- 2025, a technical team was constituted to set targets for all indicators in the National Strategic Plan. The team had several meetings to set and agree on the targets. After the team had set targets, there was a virtual national stakeholder review of targets to afford wider stakeholders the opportunity to review the targets set by the technical team.

## 13.7 Records of Meetings

All meetings held as part of the development of the NSP 2021-2025 were documented. Records of the agenda, minutes of meetings and list of names of participants and other relevant records have been kept as evidence of stakeholder involvement.

## 13.8 Engagement of Technical Reviewers

Given the importance of the NSP, stakeholders agreed on the need for the engagement of two technical reviewers (international and national) to review the technical context of the entire NSP 2021-2025 to ensure it reflected both national and global needs.

## 13.9 Engagement of Editor

As part of the efforts to have a robust and error-free Strategic Plan, the services of a professional editor/editorial firm was engaged to be responsible for thoroughly reviewing the Plan to ensure a robust and error-free NSP.

## 13.10 List of Members for the Development of National Strategic Plan 2021-2025

### I. Steering Committee

Mr Kyremeh Atuahene, Director General, Ghana AIDS Commission  
Dr Patrick Kumah Aboagye, Director General, Ghana Health Service  
Dr Emmanuel Odame, Director, PPME, MOH  
Ms Angela Trenton-Mbonde, Country Director, UNAIDS  
Dr Nabil Alsoufi, Head, HIV Section, USAID  
Mrs Elsie Ayeh, President of NAP+ Ghana

### II. Technical Task Team Members

Dr. Kwame Essah	Lead Consultant
Dr. Gilbert Buckle	Thematic Group Consultant
Dr. Ernest Kenu	Thematic Group Consultant
Mr. Cosmos Ohene-Adjei, Chair	GAC
Dr. Anthony Ashinyo	NACP
Dr. Kafui Senya	WHO
Dr. Nish McCree	UNAIDS
Dr. Fred Nana Poku	GAC
Mr. Emmanuel Larbi	GAC
Ms. Dinah Akukumah	GAC



### III. List of Members Thematic Working Groups – Writing Retreat

#### A. Prevention

Dr. Ernest Kenu	Thematic Consultant
Dr. Fred Nana Poku	GAC
Mr. Jacob Sackey	GAC
Mr. Raphael Sackitey	GAC
Ms. Gladys Semefa Agbenyo	GAC
Dr. Raphael Adu-Gyamfi	NACP
Mrs. Cecilia Senoo	CCM
Mrs. Comfort Asamoah-Adu	WAPCAS
Mr. Kofi Owusu-Anane	WAPCAS
Mr. Victor Attah Ntumi	GHANET
Mr. Phinehas K. Ayeh	WAAF
Mr. Samuel Owiredu	CEPEHRG
Ms. Gladys Damalin	HFFG

#### B. Treatment

Dr. Anthony Ashinyo	NACP
Dr. Raphael Adu-Gyamfi	NACP
Dr. Kafui Senya	WHO
Dr. Nii Hanson-Nortey	Aurum Institute
Dr. Divine Atupra	PPAG
Dr. Amida Rahman	GARH
Mr. Deogratus Kimera	GHSC-PSM
Ms. Ivy Ansah	NACP
Ms. Irene E. Kpodo	NAP+ Ghana
Ms. Priscilla Addo	YHAG

#### C. Strategic Information

Mr. Emmanuel Larbi	GAC
Ms. Cynthia Adobea Asante	GAC
Ms. Marijanatu Abdulai	NACP
Rev. Kenneth Danso	NACP
Mr. Ekow Wiah	NACP
Mr. Richard Selormey	CHAG
Mr. Emmanuel N. Mahama	WAPCAS
Mr. Kwame Adu	PPME

#### D. Social and Programmatic Enablers

Dr. Gilbert Buckle	Thematic Consultant
Mr. Cosmos Ohene-Adjei	GAC
Mr. Isaiah Doe Kwao	GAC

Mr. Daniel Epeh	GAC
Ms. Rita Afriyie	GAC, TSU - GAR
Ms. Dinah Akukumah	GAC
Mr. Paul Ayamah	GAC
Mr. Benjamin Spears N. Cheabu	CCM
Mr. Daniel Norgbedzie	CCM
Dr. Nish McCree	UNAIDS
Mr. George Owoo	HRAC
Mr. Jonathan Tetteh-Kwao Teye	NAP+ Ghana
Mr. Freeman Stephen	YHAG

#### **IV. TARGET SETTING**

Mr. Emmanuel Larbi	GAC
Mr. Cosmos Ohene-Adjei	GAC
Dr. Fred Nana Poku	GAC
Mr. Jacob Sackey	GAC
Ms. Cynthia Adobea Asante	GAC
Mr. Daniel Epeh	GAC
Mr. Isaiah Doe Kwao	GAC
Mr. Dennis Annang	GAC
Mr. Kwasi Okai Gyimah	GAC

#### **V. Participants for The 1st Joint Stakeholder Review Meeting of HIV and TB NSP**

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# NOTES

A series of horizontal dotted lines for taking notes.



**Photos:**

1. UNICEF/ Mauricio Bisol  
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