THE UNITED NATIONS AND THE AIDS PANDEMIC- AN
ASSESSMENT OF THE ROLE OF UNAIDS IN GHANA

BY

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AUGUST, 2001
DECLARATION

I, Ernest Yaw Amporful declare that this work is the result of an original research conducted by me under the supervision of Prof. Ebenezer Laing and that no part of it has been duplicated from other sources without proper academic acknowledgement.

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Prof. E. Laing
Supervisor

May 4, 2002
**ACKNOWLEDGEMENT**

To begin with, my sincere thanks goes to the Lord Almighty for his bountiful mercies and protection that made it possible for me to go through this programme successfully and unscathed. Unto Him be all Praise and Glory!

I will also like to acknowledge the contributions of the following persons and organizations for their invaluable contributions towards the successful completion of this work.

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Mr. Alex Amponsah, the LECIA librarian also needs special recognition for his patience, tolerance and for making available the relevant materials that aided the successful completion of this work. To him I say “AYEKOO”!!

In conclusion, I wish to state that I remain solely responsible for any errors, substantial or marginal which may be in this work.
DEDICATION

This work is dedicated to the Glory of God and to all the gallant men and women involved in the search of a cure for the deadly disease AIDS.
ABSTRACT

It is an indisputable fact that HIV/AIDS is not only a health problem, but also a developmental problem that impacts negatively on the world’s economies and societies at large. In recognition of this, the United Nations in the mid-1990s, took an innovative approach drawing six organizations namely UNICEF, WHO, UNDP, UNESCO, UNFPA and the WB together in a joint and cosponsored programme known as UNAIDS to fight the spread of the disease worldwide.

As the leading advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support for those infected, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

The study therefore assesses the performance of UNAIDS in Ghana. It also discusses the main constraints encountered by UNAIDS in the effective implementation of its programmes. Some of the constraints identified include the problem of understaffing, insufficient funds to assist all those involved in fighting HIV/AIDS, the proliferation of NGOs countrywide all trying to compete for scarce resources and the overall funding problem to fight the disease. The study finally makes recommendations for addressing the identified constraints.
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AIDSCAP</td>
<td>AIDS Control and Prevention</td>
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<td>ARCH</td>
<td>Adolescent Reproductive &amp; Child Health</td>
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<td>CARICOM</td>
<td>Caribbean Community</td>
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<td>CBO</td>
<td>Community Based Organizations</td>
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<td>CCO</td>
<td>Committee of Cosponsoring Organisations</td>
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<td>CDC</td>
<td>United States Center for Disease Control</td>
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<td>CPA</td>
<td>Country Programme Adviser</td>
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<td>DRI</td>
<td>District Response Initiative</td>
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<td>FCUBE</td>
<td>Free, Compulsory, Universal Basic Education</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>GAC</td>
<td>Ghana AIDS Commission</td>
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<td>GAPP</td>
<td>Ghana AIDS Partnership Programme</td>
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<td>GARFUND</td>
<td>Ghana HIV/AIDS Response Fund</td>
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<td>GRIDS</td>
<td>Gay Related Immune Deficiency Syndrome</td>
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<td>GSMF</td>
<td>Ghana Social Marketing Foundation</td>
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<td>GTZ</td>
<td>German Technical Cooperation</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICT</td>
<td>Information, Communication and Training</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IPAA</td>
<td>International Partnership Against AIDS</td>
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<td>MAP</td>
<td>Multi-Country HIV/AIDS Programme</td>
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<td>MTCT</td>
<td>Mother-To-Child-Transmission</td>
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<td>MTP</td>
<td>Medium Term Plan</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NACB</td>
<td>National Advisory Co-ordination Board</td>
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<td>NACP</td>
<td>National AIDS/STD Control Programme</td>
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<td>Acronym</td>
<td>Description</td>
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<td>NGOs</td>
<td>Non-governmental Organizations</td>
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<td>PLWA</td>
<td>People Living with HIV/AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>POP/FLE</td>
<td>Population and Family Life Education</td>
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<td>RH</td>
<td>Reproduction Health</td>
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<td>RTI</td>
<td>Reproductive Tract Infections</td>
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<td>SAPIMA</td>
<td>STD/AIDS Programme in Mining Areas</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>STP</td>
<td>Short Term Plan</td>
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<td>SWAA</td>
<td>Society for Women Against AIDS</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
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<td>UNDCP</td>
<td>United Nations Drug Control Programme</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WWRH</td>
<td>Wassa West Reproductive Health</td>
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CHAPTER ONE

1.1 INTRODUCTION/BACKGROUND TO PROBLEM

HIV/AIDS is a disease, which continues to baffle medical experts the world over. With no known drug or cure in sight, HIV/AIDS poses a serious threat to the survival of mankind. The Joint United Nations Programme on AIDS (UNAIDS) estimates the number of HIV infections worldwide at about 33.4 million by the end of 1998, of which 22.5 million were found in sub-Saharan Africa. UNAIDS reports that about 13.9 million persons mostly in Africa, have already died from the disease since the beginning of the epidemic and that about 590,000 infants now become infected each year, of whom about 90 percent are African children. It further projects that by the year 2000 a total of 30 to 40 million people will have been infected, and that there will be 10 million adult AIDS cases.¹

The first reported cases of AIDS in the world were recorded in the United States of America in 1981 and were largely confined to homosexual men and drug injectors. Since then, however, the disease has become a pandemic affecting millions of men, women and children. In December 1998, UNAIDS/WHO estimated that there were over 34.5 million people living with HIV/AIDS worldwide. AIDS deaths totaled some 2.5 million in 1999.² Since the start of the epidemic around two decades ago, more than 47 million people have
been infected by the virus, out of which nearly 14 million adults and children have lost their lives to AIDS. There are 16 thousand new HIV infections every day and the epidemic is virtually out of control in some countries.³

By the mid-1990s, it became clear that the relentless spread of HIV, and the epidemic’s devastating impact on all aspects of human lives and on social and economic development, were creating an emergency that would require a greatly expanded United Nations effort. In addressing these challenges head on, the United Nations took an innovative approach in 1996, drawing six UN organisations in a joint and cosponsored programme - the Joint United Nations Programme on HIV/AIDS (UNAIDS).⁴ The six original Cosponsors of UNAIDS include UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources and networks of influence that each of these organisations offers. Working together through UNAIDS, the Cosponsors expand their outreach through strategic alliances with other United Nations agencies, national governments, corporations, media, religious organisations, community based groups, regional and country networks of people living with HIV/AIDS, and other nongovernmental organisations.⁵

Indeed, the seriousness with which the United Nations views the global HIV/AIDS scourge became evident when for the first time in the history of the United Nations, the Security Council debated on the issue of HIV/AIDS at its 55th Session held in New York in January 2000. The UN Secretary General expressed
grave concern about the increasing global HIV/AIDS scourge during the debate. He noted that some 50 million people have been infected with HIV since the early 1980s, out of which 16 million have since died. Also, out of the 5.6 million people who became infected with HIV in 1999 alone, half were under 25 years old. He further stressed that of the nearly 36 million people now living with HIV/AIDS worldwide, more than 23 million were in sub-Saharan Africa, and that by the year 2010 there will be 40 million orphans in sub-Saharan Africa, largely because of HIV/AIDS.6

According to a UNAIDS report, the human immunodeficiency virus (HIV) that causes AIDS has brought about a global epidemic far more extensive than what was predicted even a decade ago. UNAIDS and WHO now estimate that the number of people living with HIV or AIDS at the end of the year 2000 stands at 36.1 million. This is more than 50% higher than what WHO’s Global Program on AIDS projected in 1991 on the basis of the data then available.7

In Africa, statistics about the pandemic are disturbing. The continent is the most seriously affected with over 20 million Africans infected with the virus and 2 million people already dead, including nearly half a million children.8

Contributing to the debate on HIV/AIDS at the 55th session of the UN Security Council held in January 2000, the former US Vice President Al Gore observed that AIDS in Africa is the worst infectious disease catastrophe in the history of modern medicine. He stated that 12 million people in sub-Saharan Africa have died of AIDS in the past decade and that by 2005, the death toll
could reach 13,000 people per day. He averred that for the nations of sub-
Saharan Africa, AIDS is not just a humanitarian crisis but also a security crisis. He intimated that HIV/AIDS threatens not just individual citizens but the very institutions that define the character of a society.9

What makes HIV/AIDS disease very threatening is that, in contrast to other epidemics in human history, which predominantly affected the young and the elderly, AIDS strikes hardest at the economically active population, the cornerstone of a nation’s development.

1.2 STATEMENT OF THE PROBLEM

Ghana, according to UNAIDS, has the eleventh highest rate of reported cases of Acquired Immunodeficiency Syndrome in the world, and the second in West Africa. To date, there have been almost 43,587 confirmed cases.10 It is even estimated that for every case confirmed, there could be as many as four or more unconfirmed cases in Ghana. This problem is of utmost importance as AIDS cannot be cured and those who have it will die from it. Furthermore, our government does not have the resources to provide even symptomatic treatment for the number of people who are and will be affected. As the number of patients rises, the resulting pain and suffering, the demands on our already strained health facilities, and the loss of productive workers could literally devastate the social and economic framework of the country. Indeed, the problem is not one of individual survival. AIDS threatens the survival of the nation.
In recent time, the focus and anxiety seems to have been shifted on Africa south of the Sahara and much attention is being expended in this part of the world to address the problem. This research therefore, is an attempt by the writer to examine why in spite of the numerous efforts made by the United Nations to curb the HIV/AIDS pandemic globally and especially in Ghana, the disease seems to be getting out of control. According to the National AIDS Control Program, about 200 Ghanaians are infected daily with the HIV virus.\textsuperscript{11} The research will also discuss the constraints UNAIDS faces in carrying out its functions in Ghana. These and other related issues to the control of HIV pandemic in sub-Saharan Africa have informed the undertaking of this research work.

1.3 OBJECTIVES OF THE STUDY

The study will be guided by the following objectives:

(i.) to understand the current global HIV/AIDS situation;

(ii.) to assess the role of the United Nations in combating the HIV/AIDS pandemic in sub-Saharan Africa and in particular Ghana;

(iii.) the constraints faced by UNAIDS in the performance of its functions in Ghana.

1.4 HYPOTHESIS

This study is guided by the fact that the effective coordination of UNAIDS activities at multiple levels (internationally, nationally, locally) and across sectors
of the economy as well as the involvement of different funding agencies, will assist in the management of HIV/AIDS in Ghana.

1.5 RATIONALE FOR THE STUDY

This study is motivated by the fact the HIV virus affects young people who constitute the productive force very vital for the socio-economic development of every country. Available statistics in Ghana for instance, indicate that about 200 people contract the HIV virus every day and this should be a source of concern to all Ghanaians. The peak ages for AIDS cases in the country is said to be 25-29 for females and 30-34 for males.

The study also seeks to bring to the fore the numerous constraints experienced by UNAIDS in combating the spread of HIV/AIDS in Ghana and how best such constraints can be eliminated.

1.6 METHODS AND SOURCES OF DATA COLLECTION

Both primary and secondary sources were used in the gathering of data for this project. The primary sources included interviews with officials of UNAIDS, the Ministry of Health, National AIDS Control Programme as well as other non-governmental agencies involved in the fight against HIV/AIDS. For the secondary sources, I reviewed books, journals, magazines, and newspapers that addressed the subject. I also relied on the internet for additional information on the subject.

1.7 THEORETICAL FRAMEWORK

The term ‘international’ thought to be the creation of Jeremy Bentham, is often seen as a misnomer. Instead, it is claimed, the term ‘interstate’ or
intergovernmental’ should be used when describing an activity—war, diplomacy, relations of any kind conducted between two sovereign states and their governmental representatives. Thus, talk of an ‘international agreement’ between state A and state B to limit arms production or to control the selling computer technology refers not to an understanding between the armament manufacturers of A and B or to a pact between their computer firms, but to an arrangement by state A’s governmental representatives with those of state B.¹²

According to Clive Archer (1992) the use of the term ‘organisations’ is confused by the dual meaning of its singular form and its interchanging in many books with the word ‘institutions’. International relations, whether between governments, groups or individuals, are not totally random and chaotic but are, for the main part, organized.¹³

Duverger observes that one form of the organisation of international relations can be seen in the institutions— the collective forms or basic structures of social organisation as established by law or by human tradition, whether these are trade, commerce, diplomacy, conferences or international organisations.¹⁴

According to Selznick (1957), an international organisation in this context represents a form of institution that refers to a formal system of rules and objectives, a rationalised administrative instrument and which has ‘a formal technical and material organisation: constitutions, local chapters, physical equipment, machines, emblems, letterheads, stationery, a staff, an administrative hierarchy and so forth.’¹⁵
Clive Archer\textsuperscript{16}, states that an understanding of the reasons why these organisations started to grow in the nineteenth century can be reached by asking the question: why were there no interstate organisations prior to that time? The most obvious reason is that these organisations had to await the creation of a relatively stable system of sovereign states in Europe.

The crucial turning point was the Peace of Westphalia in 1648, ending the Thirty Years War, which had torn apart late medieval Europe. Prior to 1648, the concept of a unified Christian Europe dominated the thinking, if not the practice, of political life in Europe. The waning temporal power of the papacy and the Holy Roman Empire demonstrated the difficulties of unifying such a diverse geographical area as the continent of Europe, even when its peoples were threatened by the march of the Ottoman Empire.\textsuperscript{17}

Under such an anarchical and hostile environment, the acquisition of military power was seen as paramount to further the interests of a state. Two different theoretical traditions namely realism and liberalism dominated the thinking of the period. The dominant tradition realism, with its main proponent Hans Morgenthau, saw international organisations as interstate institutions, important in so far as they are used in the search for power or in solving the problem of peace. According to Morgenthau, international politics, like all politics, is a struggle for power. In this regard a political policy seeks either to keep power, to increase power or to demonstrate power.\textsuperscript{18} In the words of the realists, the central problem of international politics is war and the use of force.
Liberalists or neo-liberalists on the other hand believe that cooperation in the international system in recent times, as a result of improved communication between state actors has reduced the anarchical nature of the international system. Thus, although the international system is still anarchical, we now have an ordered anarchy as a result of cooperation. The liberalists maintain that certain changes in the international system have made the world an interdependent one, a global society. They further contend that global problems needed global solutions based on institutions that can take a global perspective. Against this background, Sterling (1974) noted that it is not unreasonable to anticipate that the member states will be moved to consider equipping the United Nations with more comprehensive powers as global pressures build.19

Traditionally, the dominant goal of states has been military security because of the anarchic nature of the international system. In the modern world, although countries care about military security, it is obvious that they also care a lot about economic wealth and about social issues such as drug trafficking, AIDS or ecological problems.

Jessica Matthews has observed that recent global developments suggest the need for a broader, analogous definition of national security to include resource, environmental and demographic issues. In her view, military threats are not the threats that confront the world today. Rather problems such as drug trafficking, environmental degradation, poverty and HIV/AIDS transcend national
borders and their potential to wreak havoc have fallen under the purview of international security.\textsuperscript{20}

The deadly disease AIDS has in recent times been given wide range media coverage because it has reached pandemic levels and transcends national boundaries. The seriousness which the international community now attaches to the disease became manifest when for the first time in the history of the United Nations Security Council, HIV/AIDS in Africa was placed at the top of its agenda during the Council’s 55\textsuperscript{th} meeting held on January 10, 2000 in New York. The heads of all UN development agencies were at the meeting to strategise on how to effectively combat the HIV/AIDS pandemic in Africa.

In response to the deepening AIDS crisis, the United Nations launched an International Partnership Against AIDS in Africa. This brought together the key stakeholders that is African governments, civil society, creditor governments, non-governmental organisations (NGOs), multilateral institutions, medical and scientific communities among others to mount intensified and sustained attack on the disease and to mobilise the human and material resources necessary.\textsuperscript{21}

Holsti (1995) described an international system as ‘any collection of independent political entities-tribes, city-states, nations or empires- that interact with considerable frequency and according to regularised processes’. According to him in any system, the whole is greater than the sum of the parts and result of interaction is a determining factor in the state of the system. The various units are interdependent in the sense that the parts are complexly interrelated through
the interactions among themselves and their commitment to specific roles in making sure that the end being pursued by the whole is fulfilled. Thus, the behaviour of each can be determined to an extent and a change in behaviour of one unit affects at least one other unit in the system.\textsuperscript{22}

For the purposes of this dissertation, the entire world community represents the international system; relations between state and non-state actors conducted under the auspices of the United Nations. These represent the system in its entirety, which is committed to the control of the AIDS pandemic in the world at large. In order for the efforts of the international community, however, to yield fruit, all the various members states of the United Nations will have to ensure that they remain committed to the specific roles assigned to them.

This study is therefore an attempt at examining the role being played by the United Nations agency (UNAIDS) at controlling the global spread of the AIDS pandemic and the constraints to attaining its set goals.

1.8 LITERATURE REVIEW

A number of people have written quite extensively on the HIV/AIDS disease. Indeed, the AIDS epidemic may be compared with any major visitations of pestilence ever to have struck humankind. To date it is estimated that almost 14 million people in sub-Saharan Africa have died from the disease, with a staggering 23 million African – 70 per cent of the world total currently infected. In most East and Southern African countries as many as one in four people tests
positive for the virus. Currently, AIDS is the number 4 killer in the world after Ischaemic heart disease, cerebrovascular disease, and acute lower respiratory infections. In Africa, it is now the number 1 killer disease.

Since the first cases of AIDS were reported in the United States in 1981, many AIDS cases have been recorded globally and in particular Africa, south of the Sahara where the disease has reached pandemic proportions. In December 1998, UNAIDS/WHO estimated that there were over 34.5 million people living with HIV/AIDS worldwide. AIDS related deaths totaled some 2.5 million in 1999. The UNAIDS and WHO now estimates that the number of people living with HIV or AIDS at the end of the 2000 stands at 36.1 million, with more than two-thirds of this number living in sub-Saharan Africa.

Although, AIDS is known to be transmitted through the transfusions of contaminated blood, the sharing of needles used for injections and could also be passed on by an infected woman to her child during pregnancy or delivery or while breast-feeding, heterosexual relations account for the wide spread of the disease. Its transmission is via body fluids that harbour the human immunodeficiency virus (HIV). According to Barnett et al (1992), in the early 1980s, doctors in the United States noticed increasing frequency of an unusual form of pneumonia called Pneumocystis pneumonia. The sudden appearance of many cases of this and also of a rare cancer—Kaposi’s sarcoma, indicated that something unusual was afoot. Patients were dying because their immune systems were unable to combat these and other more common illnesses. The
first victims were young homosexual men and early suggestions for a name, indicated the prejudices so easily associated with the disease. GRIDS- Gay Related Immune Deficiency Syndrome was the first attempt at naming the disease. However, cases were soon found in people other than homosexual men. In 1982, the United States Center for Diseases Control coined the name AIDS.26

Rowley et al (1990) have observed that HIV is a slow acting virus able to reproduce itself using genetic material from the cells of its host. As with many other viral disease agents, such as the common cold, it readily mutates, making the development of a vaccine or a treatment very difficult. According to them the virus can lie dormant for many years enabling infectious but asymptomatic people to appear healthy.27

The Human Immunodeficiency Virus destroys the body’s defence mechanisms. It does not kill people directly; rather it opens the way for other infections that do kill as the body as it becomes decreasingly able to muster its defences. Thus people die not directly from the HIV but from the effects of other, sometimes normally mild infections which abound in the environment and to which their compromised systems allow them to fall prey.28

Douglas (1966) states that HIV does not only affect the physical body but also affects the ‘social body’, the relationships between people. According to him as with any other illness, AIDS makes people dependent, less able to play their
part in their family or household. It may put them into a condition of socially defined 'impurity'.

Two observers Connor and Kingman (1988) have described AIDS as the disease of the devil and in Uganda the frightening and socially disruptive aspects of the disease are captured by some of the names by which people describe it—'the robber', 'the one that drains', 'the cheater', 'the incurable disease that imprisons us'.

Soon after a person is infected with HIV, the immune system produces antibodies in an attempt to neutralize the virus. As antibodies to HIV are far easier to detect than the virus itself, their presence or absence in the bloodstream is the basis for the most widely used test of HIV infection. A person whose blood contains HIV antibodies is said to be HIV-positive, or seropositive, meaning that he or she is infected with HIV.

In some people the period between infection with HIV and the development of AIDS may be a few years; in others it is 10 years or more. Intensive research is being conducted to find out the reasons for these variations. Scientists believe they could be due to differences in the aggressivity (virulence) of different HIV strains, or in individuals' genetic make-up or immune response; or to the presence of other diseases that might accelerate the infectious process. Disease progression is especially swift in infants and young
children: around four out of five become seriously ill or die before their fifth birthday.\textsuperscript{31}

Most HIV-infected people suffer intermittent bouts of illness that increase in severity as their immune systems collapse. Different disease causing microorganisms break through the immune system at different stages. According to Frank Cox (1997), there are at least two viruses that can cause AIDS, AIDS-related conditions, and cancers in human beings. HIV-1 is still the most common cause of AIDS worldwide, except in West Africa, where HIV-2 is relatively common.\textsuperscript{32}

According to the WHO (1994), the body cells that are the main targets of HIV are T-helper lymphocytes and the scavenger cells known as monocytes, which turn into macrophages when they leave the bloodstream to enter a body organ. In a healthy immune system, the monocytes/macrophages defend the body by seeking out and eliminating foreign particles and dead or infected cells. The body also defends itself by manufacturing special proteins called antibodies to render foreign bodies (known collectively as antigens) harmless. HIV infection interferes with both these processes, gradually weakening the immune system.

The course of HIV infection can be divided into several stages, the last of which is defined as AIDS. In the earliest stage, an HIV infected person may be asymptomatic except for the swollen lymph nodes in the neck, armpits and groin, which do not make the person, feel ill but may prompt a visit to the
doctor. People with a healthy immune system usually have more than 950 CD4+ cells in each microlitre of blood, although a few people never have more than 500 and remain healthy.\textsuperscript{33}

1.9 ORGANISATION OF THE STUDY

The study will be organized into 4 chapters. Chapter One will deal with the introduction, statement of the problem as well as the objectives that will guide the study. The chapter will further review the existing literature on the subject and justify the rationale for undertaking the study. The methodology to be employed in gathering the data will also be highlighted in this chapter.

Chapter Two will deal with the global HIV/AIDS situation. It will also discuss the role of the United Nations in combating the spread of the disease in sub-Saharan Africa.

Chapter Three, will discuss the spread of HIV/AIDS in Ghana and the role of UNAIDS in controlling the disease’s spread. The chapter will also examine the constraints encountered by UNAIDS in the performance of its functions. The socio-economic implications of HIV/AIDS to the development of Ghana will be highlighted.

Chapter Four will give the summary and conclusion. It will also suggest recommendations for addressing the HIV/AIDS situation in Ghana.
ENDNOTES

3 ibid.
4 http://www.uno.org/unaids.htm
5 ibid.
6 UN Secretary General’s Report to the 54th Session of the UN Security Council held in New York, 1999.
10 Disease Unit Control/MOH 2000.
13 ibid. p.2.
17 Archer, C., opcit.
CHAPTER TWO

2.0 INTRODUCTION

This chapter examines the global HIV/AIDS situation and the disease’s mode of transmission throughout the various world regions. It also sheds light on the activities of the United Nations to address the global AIDS problem.

2.1.0

GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC, DECEMBER 2000

People newly infected with HIV in 2000

<table>
<thead>
<tr>
<th>Total</th>
<th>5.3 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>4.7 million</td>
</tr>
<tr>
<td>Women</td>
<td>2.2 million</td>
</tr>
<tr>
<td>Children&lt;15 years</td>
<td>600 000</td>
</tr>
</tbody>
</table>

Number of people living with HIV/AIDS

<table>
<thead>
<tr>
<th>Total</th>
<th>36.1 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>34.7 million</td>
</tr>
<tr>
<td>Women</td>
<td>16.4 million</td>
</tr>
<tr>
<td>Children&lt;15 years</td>
<td>1.4 million</td>
</tr>
</tbody>
</table>

AIDS deaths in 2000

<table>
<thead>
<tr>
<th>Total</th>
<th>3.0 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>2.5 million</td>
</tr>
<tr>
<td>Women</td>
<td>1.3 million</td>
</tr>
<tr>
<td>Children&lt;15 years</td>
<td>500 000</td>
</tr>
</tbody>
</table>

Total number of AIDS deaths since the beginning of the epidemic

<table>
<thead>
<tr>
<th>Total</th>
<th>21.8 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>17.5 million</td>
</tr>
<tr>
<td>Women</td>
<td>9.0 million</td>
</tr>
<tr>
<td>Children&lt;15 years</td>
<td>4.3 million</td>
</tr>
</tbody>
</table>

Fig.1

SOURCE: UNAIDS: AIDS EPIDEMIC UPDATE, DECEMBER 2000

From Fig.1 above, it is evident that the human immunodeficiency virus (HIV) which causes AIDS has brought about a global epidemic far more extensive than what was predicted even a decade ago. The UNAIDS and WHO
estimates that the number of people living with HIV or AIDS worldwide as at the end of 2000 was at 36.1 million. This figure constitutes an increase of about 1.5 million new cases over the figures given in 1999. The number of adults living with HIV/AIDS at the end of 2000 was 34.7 million, including 16.4 million women. The number of children under the age of 15 living with HIV/AIDS was estimated at 1.4 million.

The UNAIDS has observed that the challenges posed by HIV vary enormously from place to place, depending on how far and fast the virus is spreading and on whether those infected have started to fall ill or die in large numbers. It points out that in all parts of the world except sub-Saharan Africa, there are more men infected with HIV and dying of AIDS than women. Altogether, an estimated 2.5 million men aged 15-49 became infected during the year 2000, bringing the number of adult males living with HIV or AIDS at year’s end to 18.2 million. Deaths from HIV/AIDS recorded at the end of the year 2000 was put at 3 million. A breakdown of this figure as shown in Fig.1 indicates that 83.3% of deaths recorded in 2000 were adults, whereas children under the age of 15 years constituted 1.7%. The total number of AIDS deaths since the beginning of the epidemic was estimated at 21.8 million.
2.2.0 REGIONAL DISTRIBUTION

Hung Fan, et al (2000) have observed that AIDS was first recognised as a disease in the United States. However, from the worldwide perspective, HIV infections in the United States and West Europe represent a small fraction of total cases. According to them estimates by public health officials indicated that in mid-1999, there were 34 million people in the world living with HIV infection and/or AIDS. From the beginning of the epidemic nearly 47 million people have been infected by HIV, with approximately 95 percent of HIV infected people currently living in developing countries and more than 90 percent living in sub-Saharan Africa or Southern and South East Asia alone. In Africa, HIV transmission predominantly results from heterosexual contact and other modes. Given the relatively poor medical support available in much of Africa, the number of infected people may increase significantly. In Table 2 below the regional HIV/AIDS distribution worldwide is given.
### Regional HIV/AIDS Statistics and Features, End of 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Epidemic started</th>
<th>Adults &amp; children living with HIV/AIDS</th>
<th>Adults &amp; children newly infected with HIV</th>
<th>Adult prevalence rate (%)</th>
<th>Percent of HIV-positive adults who are women</th>
<th>Main mode(s) of transmission(*) for adults living with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>Late '70s-early '80s</td>
<td>25.3 million</td>
<td>3.8 million</td>
<td>8.8%</td>
<td>55%</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>Late '80s</td>
<td>400 000</td>
<td>80 000</td>
<td>0.2%</td>
<td>40%</td>
<td>Heterosexual, IDU</td>
</tr>
<tr>
<td>South &amp; South-East Asia</td>
<td>Late '80s</td>
<td>5.8 million</td>
<td>780 000</td>
<td>0.56%</td>
<td>35%</td>
<td>Heterosexual, IDU</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>Late '80s</td>
<td>640 000</td>
<td>130 000</td>
<td>0.07%</td>
<td>13%</td>
<td>IDU, heterosexual, MSM</td>
</tr>
<tr>
<td>Latin America</td>
<td>Late '70s-early '80s</td>
<td>1.4 million</td>
<td>150 000</td>
<td>0.5%</td>
<td>25%</td>
<td>MSM, IDU, MSM</td>
</tr>
<tr>
<td>Caribbean</td>
<td>Late '70s-early '80s</td>
<td>390 000</td>
<td>60 000</td>
<td>2.3%</td>
<td>35%</td>
<td>Heterosexual, MSM</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>Early '90s</td>
<td>700 000</td>
<td>250 000</td>
<td>0.35%</td>
<td>25%</td>
<td>IDU</td>
</tr>
<tr>
<td>Western Europe</td>
<td>Late '70s-early '80s</td>
<td>540 000</td>
<td>30 000</td>
<td>0.24%</td>
<td>25%</td>
<td>MSM, IDU</td>
</tr>
<tr>
<td>North America</td>
<td>Late '70s-early '80s</td>
<td>920 000</td>
<td>45 000</td>
<td>0.6%</td>
<td>20%</td>
<td>MSM, IDU, heterosexual</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
<td>Late '70s-early '80s</td>
<td>15 000</td>
<td>500</td>
<td>0.13%</td>
<td>10%</td>
<td>MSM</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>36.1 million</strong></td>
<td><strong>5.3 million</strong></td>
<td><strong>1.1%</strong></td>
<td><strong>47%</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2**

**SOURCE: UNAIDS- AIDS EPIDEMIC UPDATE: DECEMBER 2000**

- The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2000 population numbers
- # Heterosexual transmission, IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).
2.2.1 AIDS IN SUB-SAHARAN AFRICA

Nowhere has the impact of HIV/AIDS been more severe than sub-Saharan Africa. All but unknown a generation ago, today it poses the foremost threat to development in the region. By any measure, and at all levels, its impact is simply staggering. At the regional level, more than 13 million Africans have already died since the disease was discovered in the late 70s and early 80s and 10 million more are expected to die within the next five years. During the year 2000 alone, 2.4 million deaths were recorded. It is estimated that as of end 2000, there were 25.3 million adults and children living with HIV/AIDS in sub-Saharan Africa, about two-thirds of the worldwide total. Indeed, deaths due to HIV/AIDS in Africa it is believed will soon surpass the 20 million Europeans killed in the plague epidemic of 1347-1351. At least 3.8 million Africans were newly infected with the virus in 2000. Again, Africa has an alarming 8.8% prevalence rate among adults aged 15-49.\(^4\)

Southern Africa is the part of the continent worst affected by HIV. In his article entitled 'Breaking the Silence', Tom Masland, observed that sub-Saharan Africa faces the worst AIDS plague on the planet, with the Republic of South Africa as one of the worst hit countries on the continent. He noted that some 4.2 million South Africans were living with AIDS, and that the overall HIV infection rate has jumped to nearly 20 per cent, from 13 per cent in 1998.\(^5\)

In Kenya, where one in seven people is HIV-positive, the list of dead grows 500 names longer every day. In Botswana, the rate of infection is one in
four people, while in Zimbabwe, it is heading toward one in three. Indeed, a child born in Zimbabwe is more likely than not to die of AIDS. The World Bank estimates that AIDS could shrink some African economies by up to over 25% over the next 15 years.⁶

In his address to the UN General Assembly's Special Session on AIDS held in New York from 25 to 27 June, 2001, the UN Secretary General observed that, in some African countries, the HIV virus has set back development by a decade or more, infecting the most productive workers. He therefore called for the setting up of a global fund to combat the killer disease.⁷

2.2.2 AIDS IN NORTH AFRICA AND THE MIDDLE EAST

As shown in fig 2 above, HIV/AIDS infection in this region is very low. Reasons for this may be attributed to the strict religious values which forbids extra marital sex or having multiples and the severe penalty meted out to offending culprits. According to UNAIDS because of insufficient data, few new country estimates were produced for the region between 1994 and 1999. Recent evidence however, suggests that new infections are on the rise. For example, localised studies in southern Algeria show rates of around 1% in pregnant women attending antenatal clinics, and surveillance sites in both northern and southern Sudan indicate that HIV is spreading among the general population. With an estimated 80 000 new infections in the region during the year 2000, the
number of adults and children living with HIV or AIDS had reached 400,000 by the end of 2000.  

2.2.3 SOUTH & SOUTH-EAST ASIA, EAST ASIA & PACIFIC

It is estimated that 700,000 adults have become infected in South and South-East Asia during the year 2000. According to UNAIDS these estimates are in line with known risk behaviour in this region, in which men not only form the majority of intravenous drug users but help drive the earliest wave of sexual HIV transmission, much of it through commercial sex and some through sex between men. Overall it was estimated in the year 2000, there were 5.8 million adults and children living with HIV or AIDS in the region, as compared with 1.3 million at the end of 1999. Estimated dead due to AIDS at the end of 2000 was 470,000.

In the region of East Asia and the Pacific on the other hand, some 640,000 adults and children had become infected by the end of the year 2000, representing just 0.07% of the region's adult population, as compared with the prevalence rate of 0.56% in South and South-East Asia. A number of reasons have been assigned for this growth among which include commercial sex and the extensive use of illicit drugs as well as migration and mobility within and across borders.

2.2.4 LATIN AMERICA AND THE CARIBBEAN

The HIV epidemic in Latin America and the Caribbean is a complex mosaic of transmission patterns in which HIV continues to spread through homosexuals, heterosexuals and intravenous drug users. In many Latin American countries,
thanks to antiretroviral therapy, HIV-people are living healthier lives. By the end of the year 2000, it was estimated that some 1.4 million people in the region were living with HIV or AIDS as compared with 1.3 million at the end of 1999.

The transmission patterns of HIV in the Caribbean, is the second highest after sub-Saharan Africa. Transmission in this region is mainly through heterosexual and homosexual behaviours. At the end of 2000, it was estimated that there were 390,000 people living with HIV/AIDS in the region. The prevalence rate among adults was 2.3%. For a region with small populations, this was considered as very high. Thus, in July 2000, the heads of the Caribbean Community (CARICOM) publicly admitted that the epidemic threatens to reverse the region's development achievements of the last three decades. 

2.2.5 NORTH AMERICA, WESTERN EUROPE, AUSTRALIA & NEW ZEALAND

Knowledge about HIV/AIDS in these regions came to the fore in the late 70’s and early 80’s. According to Peter O. Way and Karen A. Stanecki, in late 1992, the WHO estimated that over 1 million people were infected with the HIV virus in North America and 500,000 in Western Europe. By contrast, in these countries HIV is transmitted mainly through homosexual contact and the sharing of needles among intravenous drug users. Heterosexual relations account for only a small fraction of the spread of HIV in these regions although in recent times however, the number of infections seems to be increasing. According to UNAIDS, in the course of the year 2000, 30,000 adults and children were
estimated to have acquired HIV in Western Europe and 45 000 in North America. Overall HIV prevalence only rose slightly in these regions, mainly because anti-retroviral therapy is keeping HIV positive people alive longer.\textsuperscript{12} The UNAIDS attributes the increase in the prevalence rate in these regions to a growing complacency among people about the HIV risk and also about the fact that some mistakenly view anti-retroviral drugs as a cure for the disease.

2.3 AIDS AND THE UNITED NATIONS IN SUB-SAHARAN AFRICA

According to a UNAIDS/WHO report, at the end 1999, 33.6 million men, women and children were living with HIV or AIDS, and 16.3 million had already died from the disease. In 1999, there were 5.6 million new infections worldwide, of which 3.8 million were in sub-Saharan Africa, and 1.3 million in South and Southeast Asia. Some 15 million people in Africa have already died of AIDS. Nearly 25 million Africans are living with HIV/AIDS, the vast majority of them adults. Sub-Saharan Africa accounts for more than 70 per cent of all HIV/AIDS cases globally. There are several Africans greatly affected by the AIDS epidemic. The Namibian HIV/AIDS epidemic continues to rise to alarming levels. Together with Botswana, Zimbabwe and Swaziland, Namibia ranks as one of the four most affected countries in the world, with an overall prevalence of at least 20% among sexually active adults.\textsuperscript{13}

The United Nations has played and continues to play a crucial role in the battle against AIDS in Sub-Saharan Africa. UNAIDS' mission for instance is to serve as an advocate for global action on HIV/AIDS. In this regard, UNAIDS
leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV in sub-Saharan Africa. Also, UNAIDS provides care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. UNAIDS programmes such as WORLD AIDS CAMPAIGN 2000: Men Make a Difference- Engaging men as partners in fighting AIDS, is surest way to change the course of the epidemic. Through the World AIDS Campaign, UNAIDS and its partners worldwide will work with both women and men, with NGOs, governments, the United Nations system and the media to bring about a new, and much needed, focus on men. Also, the World Bank in September 12, 2000 approved a Multi-Country HIV/AIDS (MAP) for Africa, representing a region-wide commitment to strengthen the response to the epidemic. The Board agreed to commit an initial amount of US$500 million over the next three years, which will consist of several projects to fight the epidemic in sub-Saharan African countries.14

The Security Council has also played a role in eliminating AIDS throughout the global community. In January 2000, Secretary General Kofi Annan addressed the Security Council stating that the role of the Security Council with regards to AIDS should be to prevent conflict from contributing to the spread of AIDS, and from impeding the efforts that other partners are making to control it. According to the UN Secretary General, AIDS in Africa was no less destructive than warfare itself. By overwhelming the continent’s health services, by creating millions of orphans, and by decimating health workers and teachers, AIDS was causing
socio-economic crises which, in turn, threatened political stability. AIDS was thus not only an African problem, but a global one as well. Consequently, in July 2000, the UN Security Council adopted resolution 1308 which calls for pre-deployment testing and counselling for peacekeeping personnel. The resolution was sponsored by the United States and is the first Security Council resolution concerning a health issue. The resolution passed unanimously. The resolution recognises the potential damaging impact of AIDS on the health of peacekeepers and support staff, calls for member nations to strengthen their work with UNAIDS, and expresses interest in discussion between other UN bodies and other relevant organisations.15

Again, at the Abuja, summit on AIDS held in April 2001, the UN Secretary General Kofi Annan, proposed five key priorities for the global battle against HIV/AIDS. These include the under listed:

- **Preventing further spread of the epidemic**, especially by giving young people- those at greatest risk of infection - the knowledge and power to protect themselves. Large scale awareness campaigns must be mounted, and access provided to voluntary counselling, testing and, when appropriate, condoms.

- **Reducing HIV transmission from mother to child**.
  
  All mothers must be able to find out whether they are HIV-positive, and those who are must have access to short-term anti-retroviral therapy, which has been shown to reduce mother-to-child transmission by up to half.
- **Ensuring that care and treatment is within reach of all.**
  This includes access to affordable HIV-related drugs, as well as voluntary counselling and testing, home and community-based care, and simple treatments for opportunistic infections.

- **Delivering scientific breakthroughs.** Higher priority must be given in scientific budgets to finding both a cure for HIV/AIDS and, more importantly, a vaccine against the disease.

- **Protecting those made most vulnerable by the epidemic, especially orphans.**

  In achieving the aforementioned priorities, Secretary General Annan, proposed the launching of a Global Trust Fund to fight the disease. Mr. Annan intimated that the war against AIDS would not be won without a war chest, of a size far beyond what is available so far. He put global funding requirements for the fight against AIDS at $7-10 billion annually. According to him, although, the sum required is huge, the world should also be conscious of the magnitude of the problem at hand. He pointed out that currently there are 36 million infected people worldwide, with 70-80 per cent of them in Africa.
ENDNOTES

3 ibid. p.4.
9 ibid.
10 ibid. p.9.
14 opcit.
17 ibid. p.6.
CHAPTER THREE

HIV/AIDS IN GHANA

This chapter discusses the HIV/AIDS situation in Ghana and the efforts of the UNAIDS to curb the spread of the disease. It will also examine the constraints to the effectiveness of UNAIDS efforts in Ghana.

3.0 INTRODUCTION

The HIV/AIDS epidemic has become a serious health and development problem confronting many countries around the world. In Africa, the HIV/AIDS pandemic is frightening. The disease is taking a devastating toll in terms of human suffering especially in the sub-Saharan Region. According to a UNAIDS report released in December 2000, Africa accounted for more than 25 million of the world’s 36.1 million cases.¹

In Africa, the disease accounts for more than 80 per cent of the world’s AIDS related deaths. The death toll is about 2.4 million a year, a situation, which is creating more and more, AIDS orphans. Apart from the pain of losing their parents, these children are being traumatised due to the ordeal of living with such people who sometimes suffer a lot before their death. According to the UNAIDS, it is pathetic that in some countries today between 40 and 70 per cent of hospital beds are occupied by AIDS patients.²

A new United Nations statistical analysis about the HIV/AIDS disease released in June 2001, observed that in five African countries namely Botswana, Lesotho, Swaziland, Zambia and Zimbabwe, at least 20 per cent of the
population or one out every five adults is infected with the killer disease. The hardest hit in this group is Botswana where people are dying at an average of 23 years earlier - at 44 years of age rather than 68 - than they would have done without AIDS.3

3.1 HIV/AIDS SITUATION IN GHANA

When the AIDS was first reported in Ghana in the mid 1980s, it was thought to be a disease for prostitutes and people with history of travel abroad. Over a decade later, the number of reported AIDS cases had risen to nearly 30,000 and it is currently estimated that about 200 Ghanaians are being infected with the AIDS disease daily. Even though at current levels, the HIV prevalence rate in Ghana is relatively low compared to most Southern African countries it is the rate at which the disease is increasing which is of particular concern.4

The Ghana National AIDS Control Programme has observed that, the virus that causes AIDS has already infected and is infecting many Ghanaians. It notes that between four and five per cent of the entire adult population of the country is HIV infected and yet most of these people do not even know that they carry the virus. In 1998, about 356,000 adults and 24,000 children were already infected. Also, since the beginning of the epidemic in the mid-1980s and the end of 1998, more than 114,000 persons may have already developed AIDS, although not all of these have been officially recorded.5 With no cure available, the disease is becoming one of the most serious development issues in the country.
Based on the sentinel surveillance system set up by the Ministry of Health, it is estimated that HIV has already infected about 4.6 per cent of the adult population of Ghana. At least about 600,000 Ghanaians are estimated to be living with HIV today. At the current HIV prevalence rate of 4.6 per cent, Ghana is likely to exceed the 5 per cent threshold seen by experts as marking the beginning of an AIDS explosion. Beyond the year 2000, the average prevalence is expected to increase to 6.4% by 2004, 8.2% by 2009 and 9.5% by the year 2014. The reported cumulative AIDS cases in Ghana from 1986 to December 2000 was 43, 587 cases as shown in Table 1. below. Out of this about 89% were between the ages 15-49 years. Females formed 62.1%.

Table 1. REPORTED CUMULATIVE AIDS CASES IN GHANA BY AGE AND SEX FROM 1986- DECEMBER 2000

<table>
<thead>
<tr>
<th>AGE GROUP (YEARS)</th>
<th>FEMALE</th>
<th>MALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>PER CENT</td>
<td>NO</td>
</tr>
<tr>
<td>0-4</td>
<td>377</td>
<td>1.4</td>
<td>370</td>
</tr>
<tr>
<td>5-9</td>
<td>96</td>
<td>0.4</td>
<td>93</td>
</tr>
<tr>
<td>10-14</td>
<td>74</td>
<td>0.3</td>
<td>49</td>
</tr>
<tr>
<td>15-19</td>
<td>706</td>
<td>2.6</td>
<td>120</td>
</tr>
<tr>
<td>20-24</td>
<td>3850</td>
<td>14.2</td>
<td>758</td>
</tr>
<tr>
<td>25-29</td>
<td>6240</td>
<td>23.0</td>
<td>2476</td>
</tr>
<tr>
<td>30-34</td>
<td>5601</td>
<td>20.7</td>
<td>3694</td>
</tr>
<tr>
<td>35-39</td>
<td>4138</td>
<td>15.3</td>
<td>3533</td>
</tr>
<tr>
<td>40-44</td>
<td>2422</td>
<td>8.6</td>
<td>2200</td>
</tr>
<tr>
<td>45-49</td>
<td>1511</td>
<td>5.6</td>
<td>1577</td>
</tr>
<tr>
<td>50-54</td>
<td>982</td>
<td>3.6</td>
<td>793</td>
</tr>
<tr>
<td>55-59</td>
<td>432</td>
<td>1.6</td>
<td>392</td>
</tr>
<tr>
<td>60+</td>
<td>483</td>
<td>1.8</td>
<td>376</td>
</tr>
<tr>
<td>NOT STATED</td>
<td>161</td>
<td>0.6</td>
<td>83</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27073</td>
<td>100.0</td>
<td>16514</td>
</tr>
</tbody>
</table>

Source: Disease Control Unit/ MOH 2000
Although, many people in Ghana are now known to have died of HIV-related illnesses and AIDS, the numbers are very difficult to verify. At current rate of infection, it is estimated that by the year 2005, one million two hundred thousand (1,200, 000) people will be living with HIV.\(^8\)

The most disturbing feature of the statistics perhaps is the fact that most of the people who have developed HIV/AIDS in Ghana are young people. Peak ages for AIDS cases are 25-29 for females and 30-34 for males. It is worth noting that 3% of the reported cases of AIDS among females are in the age range 15-19.\(^9\)

### 3.2 TRANSMISSION MECHANISMS

HIV is transmitted primarily by three methods: sexual intercourse; intravenous exposure to HIV infected blood through transmission, donated organs, and drug use; and vertical transmission from mother to child. In Ghana, as in the rest of Africa, sexual intercourse is the predominant mode of transmission. It is estimated that 80% of all infections in Ghana occur through heterosexual relationships, while 15% and 5% have been due to mother-to-transmission and blood products respectively.\(^{10}\) Prevalence of HIV among blood donors has increased from 2.2 per cent in 1995 to 3.2 per cent in 1998, while prevalence in STD patients has ranged between 9.5 per cent and 15 per cent during the same period (Agyei-Mensah, S., 2000).
3.3 SEX AND AGE DIFFERENCES

Agyei-Mensah\textsuperscript{11} observes one interesting feature of the HIV/AIDS pandemic in Ghana in terms of the percentage of females who are infected with the virus as compared to males. According to him, Ghana is one of the few countries with higher HIV prevalence rate among women than among men. He notes that sixty-three per cent of cumulative reported AIDS cases between 1986 and 1998 have occurred in women. During the initial stages of the epidemic, the ratio of infected females was quite high. These were women who had been involved in the commercial sex trade in neighbouring countries and had returned home upon contracting the disease. As can be seen from Fig 1, the percentage of females infected was about 83 per cent as compared to a male percentage of 17 in 1986. This pattern began to change in 1991, with the female percentage going down to 67 per cent as compared to male percentage of 33. In 1998 the percentages for females were 58 and 42 for males. Thus from the initial female-male ratio of 5:1 in 1986, the sex ratio of AIDS patients may be gradually converging toward a 1:1 female sex ratio. This stands in sharp contrast to the situation in Uganda, Zaire and Rwanda in the early stages of the epidemic where the disease was equally spread between both males and females.
An analysis of the age-sex distribution of reported AIDS cases through 2000 shows that more than 90 per cent of AIDS cases are found among persons between the ages of 15 and 49. Since this is the most economically productive
part of the population, illnesses and deaths in this age group constitute an important economic burden. Many productive years and much investment in education and training will be lost. These deaths also have important family consequences since most people in this group are raising young children\textsuperscript{12}.

The peak ages for AIDS are 25-34 for females and 30-39 for males. The number of reported AIDS cases for females in the 15-24 age group is much higher than for males in the same age group. This is due to earlier sexual activity by young females and the fact that they often have older partners. The low number of cases in the 5-14 year old age group indicates that HIV infection is not transmitted by mosquitoes or casual contact. Children between the ages of 5-14 may be special “Window of Hope”. If these children can be taught to protect themselves from HIV infection before they become sexually active, they can remain free of HIV for their entire lives\textsuperscript{13}.

3.4 GEOGRAPHICAL PATTERNS

A geographical analysis of HIV/AIDS in Ghana shows a stark regional disparity in terms of distribution. A cursory study of the table provided in Table 2 shows that over 65\% of all reported cases come from just three regions namely Ashanti, Eastern and Greater Accra.
Table 2.

REPORTED CUMULATIVE AIDS CASES IN GHANA BY REGION FROM 1986-2000

<table>
<thead>
<tr>
<th>REGION</th>
<th>CASES</th>
<th>PER CENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASHANTI</td>
<td>13023</td>
<td>29.9</td>
</tr>
<tr>
<td>BRONG AHAFO</td>
<td>3540</td>
<td>8.1</td>
</tr>
<tr>
<td>CENTRAL</td>
<td>3061</td>
<td>7.0</td>
</tr>
<tr>
<td>EASTERN</td>
<td>6939</td>
<td>15.9</td>
</tr>
<tr>
<td>GT.ACCRA</td>
<td>6416</td>
<td>14.7</td>
</tr>
<tr>
<td>NORTHERN</td>
<td>1889</td>
<td>4.3</td>
</tr>
<tr>
<td>UPPER EAST</td>
<td>2247</td>
<td>5.2</td>
</tr>
<tr>
<td>UPPER WEST</td>
<td>719</td>
<td>1.6</td>
</tr>
<tr>
<td>VOLTA</td>
<td>1698</td>
<td>3.9</td>
</tr>
<tr>
<td>WESTERN</td>
<td>3969</td>
<td>9.1</td>
</tr>
<tr>
<td>UNSTATED</td>
<td>86</td>
<td>0.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>43587</td>
<td>100.0</td>
</tr>
</tbody>
</table>

SOURCE: DISEASE CONTROL UNIT, MOH/NACP

Ashanti region emerged as the region with the highest cumulative reported cases with 13023 cases, representing about 30 per cent of all cases. It was followed by the Eastern region with a total number of 6939 cumulative reported cases.
representing (18%) and Greater Accra with 4585 (16%) reported cases. The Upper West region had the lowest number of reported cases with a cumulative total of 719 (2%) cases. In recent years, the percentage of reported AIDS cases in the Northern and Upper East regions has risen significantly. This is interesting given the fact that up to 1986 there were virtually no reported HIV cases in these two regions.

According to Agyei-Mensah, the increased number of AIDS cases in the Ashanti region in the 1990s could well be understood within the framework of migrational patterns of the Ashantis in the 1970s and the uniqueness of the region within Ghana’s geographical space. Unlike the first wave of migration of women from the Eastern region into neighbouring countries especially Cote d’Ivoire, the second wave was mostly from women in the Ashanti region migrating to Cote d’Ivoire and Nigeria, a situation precipitated by depressed local economic conditions and the booming of economic activities in these neighbouring countries.

He explained that the low prevalence rate of the disease in the Greater Accra region clearly dismissed the notion that urbanisation was responsible for the spread of the disease. The relatively low number of cases reported in the Greater Accra region was not due to under-reporting but could be attributed to the relatively high education among the residents which made them more likely to perceive the risks of the disease and therefore take the precautionary
measures. Thus, people in the Greater Accra region were more likely to practice safer sex compared to the other regions.

Regarding the spread of the disease in the Northern parts of the country, Agyei-Mensah argued that the relatively low number of cases reported in the three Northern regions in the past, could be attributed to such cultural factors as the Islamic religion and its abhorrence for infidelity, as well as the greater distance of the area from the initial source region. However, with the increase in cross border movements by women in particular, into the neighbouring countries of Cote d’Ivoire, Burkina Faso and Togo to engage in prostitution, the area has witnessed in recent time an increase in the number of reported AIDS cases.

3.5 SOCIO-ECONOMIC IMPACTS OF AIDS IN GHANA

HIV/AIDS represents a dual challenge in as much as it is a terminal health problem and an economic one. Although the full extent of the economic impact is not as yet known in Ghana, it is estimated that the natural population increase without HIV/AIDS would grow to 21.1 million persons in 2004 and to 26.7 million persons by 2014. However, with AIDS causing increased deaths, the population would drop to 20.6 million persons in 2004 and to 25.1 million in 2014. This reduction in population will occur in the most productive segment of society and will contribute to a spiralling decline in savings, investment, productivity and earnings for Ghana’s economy. A recent study based on AIDSCAP model showed that at the current prevalence rate of 3%, a typical company was expected to incur an average annual HIV/AIDS costs of US$10,264 and an average cost per
employee of US$38 for 1997. At future prevalence rate of say 20%, these costs are estimated to rise dramatically to US$48,700 and US$179 respectively, a five-fold increase.\textsuperscript{15}

The impact of HIV/AIDS on agriculture cannot be overemphasised especially as sixty per cent of the Ghanaian labour force is engaged mostly in subsistence agriculture. As mortality increases as a result of HIV/AIDS, labour in agriculture becomes scarce and more expensive, thereby reducing the acreage under cultivation and increasing poor land and water management. This impacts more negatively upon the rural poor.

HIV/AIDS also undermines private sector development as the costs for employee/family care to companies escalates annually contributing to an overall rise in the cost of labour. As the average annual cost to companies from a national workforce having a 5% HIV prevalence rate is estimated at US$66 million, long-term damage to the national economy will be extensive.\textsuperscript{16}

3.5.1. Social Impact of HIV/AIDS in Ghana

The first social impact of HIV will be felt in the education sector. Human resources for education will slowly be eroded and this undoubtedly will undermine the government’s free, compulsory, universal basic education (FCUBE) programme. The spread of the epidemic amongst teachers will produce acute shortages in the already understaffed school system. Children who remain home to care for sick family members, or are forced to leave school because
there is no household income to support them, create a lost generation receiving no benefit from formal education and training.

Healthwise, AIDS treatment and associated costs will continue to escalate and put additional pressure on scarce resources to be funneled away from rural health centers to urban hospitals. According to the African Development Forum 2000 Report, the average annual cost of treating an AIDS patient in Ghana, is approximately US$130 (based on 1999 research data from three health care institutions). The report observed that if 80% of AIDS patients received health care, costs would rise to nearly US$9-10 million by 2009 and over US$12-13 million by 2014. The increasing need for funds to expend on AIDS care threatens to divert spending from other important health care needs, or to leave many AIDS patients with inadequate care. If funding is diverted from other health needs, then mortality and sickness not related to HIV is likely to increase as well, adding to the overall impact of the epidemic.

Another social effect of HIV/AIDS is that it leads to increased poverty. With approximately one-third of Ghana’s population currently living in poverty, the spread of the epidemic is further expected to decrease incomes thereby plunging even more families below the US$240 a year poverty line. It will exacerbate the already low utilisation of health care facilities in the country, contributing to rising levels of ill-health, and increase levels of illiteracy and insecurity with entire communities unable to withstand future economic shocks.
As the epidemic claims increasing numbers of productive adults, it reduces households to children and the elderly.

According to the Ghana’s National AIDS Control Programme, the number of maternal and double orphans would rise rapidly from 126,000 in 1999 to 252,000 in 2004 and to more than 603,000 in 2014, thereby putting a tremendous strain on the social systems to cope with such a large number of orphans and to provide them with needed care and supervision. Consequently, the number of street children will rise, and child labour will become more common as orphans look for ways to survive.19

Again AIDS has a very serious impact on the lives of women when it strikes a family member. In many parts of Ghana, women do not have a secure occupation that can provide a steady and adequate income. Thus, if the husband dies, the surviving wife and children become particularly vulnerable. Some women may be exploited or may have to resort to commercial sex to provide cash income for their sustenance. Again, research has shown that women are two to four times more vulnerable to HIV infection than men during unprotected sexual intercourse because of the larger surface areas exposed to contact. This would increase considerably the number of women exposed to further risk of HIV/AIDS.

Furthermore, a woman may be at risk even if she is monogamous and her partner has other sexual partners. She may have little or no control over her
husband’s actions and no ability to protect herself by insisting on the use of condoms by her husband.20

HIV/AIDS has recently been declared by the international community as a global security issue, especially in Africa. In Ghana, the security crisis resulting from the spread of the disease will impact negatively on the individual and his or her human rights. Experience elsewhere has shown the breakdown of overall social and cultural norms as the epidemic disrupts more lives and livelihoods.

3.5.2 NATIONAL RESPONSE TO THE HIV/AIDS CRISIS

The Government of Ghana in the early 1980s responded quickly to the emerging HIV/AIDS epidemic by establishing the National AIDS/STD Control Programme (NACP) within the Disease Control Unit of the Ministry of Health in 1987, to coordinate the national response to the epidemic. NACP led in the development of a Short Term Plan (STP) for the prevention and control of HIV/AIDS that ran during 1987 and 1988. Subsequently, NACP developed the first Medium Term Plan (MTP-1) that guided HIV/AIDS prevention and control efforts over the period 1989-1993. A second Medium Term Plan (MTP-2) also aimed at HIV/AIDS prevention and control covered the 1996-2000 period.21

As was typical in African countries, the Ministry of Health was primarily responsible for implementing the early programmes on HIV/AIDS control. Over time, however, other public sector ministries, the private sector, non-governmental organisations (NGOs) and people living with HIV/AIDS (PLWHA) became more involved in programme implementation. A recent review of the
national response to the HIV/AIDS epidemic stressed the importance of expanding a multi-sectoral approach to the epidemic.

In 1997, NACP led the drafting of a Policy Document on HIV/AIDS. The purpose of the policy was to create a favourable environment for all HIV/AIDS control and prevention programmes, and to mitigate the social and personal consequences of HIV infection on those persons living with the virus and on those persons who have already developed AIDS.

The objectives of the draft policy are to

- reduce the impact of morbidity and mortality as a result of HIV/AIDS in the general population;
- ensure that the basic human rights of persons infected with HIV and persons with AIDS are protected and upheld;
- ensure that HIV infected persons and persons with AIDS are provided with adequate medical and social care, including counselling;
- ensure that access to social and economic opportunities remain open to HIV infected persons and persons with AIDS;
- ensure that adequate attention is paid to groups such as women who have been found to be vulnerable to HIV;
- ensure that there is a consistent programme of information and education about HIV/AIDS among the general population, especially among the youth, and that this increased knowledge is translated into an increase in attitudinal and behavioural change;
• decrease vulnerability to infection, reduce stigmatization and discrimination, and minimise the socio-economic impact of the epidemic.

The draft policy emphasises information and education leading to behavioural change, especially among the youth, and the widespread availability and promotion of condoms as keys to limiting the spread of the virus. It also places emphasis on counselling and support for HIV/AIDS patients. A counselling system has been put in place at both the regional and district levels to provide psycho-social support to people living with HIV/AIDS (PLWHAs) and their families and the National AIDS Control Programme (NACP) has developed Counselling and Home-based Care manuals for capacity building purposes. Furthermore, the draft policy has incorporated into it the District Response Initiative (DRI). This initiative aims at the decentralisation and expansion of a multisectoral HIV/AIDS response at the district level. Following a study of the HIV/AIDS response in 10 selected districts, the then Ministry of Employment and Social Welfare decided to work along with the District Assemblies to establish a district level HIV/AIDS programme. The DRI has since been introduced into 31 districts, which are all at different stages of implementation. All the districts have a 6-person district management team, responsible for the coordination of the district HIV/AIDS programme. Activities include the development of a District Strategic Plan and Action plan, and the implementation and monitoring of the action plans. For instance, at the district levels in the Brong Ahafo region, the German Technical Cooperation (GTZ) is working towards integrating HIV/AIDS into primary health
care (PHC) programmes. It is further providing support to inter-country initiatives in the areas of migration, prostitution, youth, PLWA and African networks ethnic, law and HIV.

3.6 BACKGROUND TO THE GHANA AIDS COMMISSION

In April 1998, a joint team of Government, Bilateral and UN Agencies reviewed the national response to the HIV/AIDS epidemic to date in Ghana. One of the key recommendations resulting from the review was the need to establish a National Advisory Co-ordination Body to advise Government on policy and to coordinate activities of all stakeholders.

The decision to establish the Ghana AIDS Commission (GAC) was taken at a cabinet meeting on May 2000 following key recommendations made by the International Partnership Against AIDS (IPAA) Team in October 1999. The National AIDS Commission was launched at a Cabinet Retreat in Akosombo in September 2000. The ceremony was attended by members of the Commission which included Government ministers, Heads of Ministries, Departments and Agencies (MDAs), traditional leaders, representatives of religious bodies, civil society, community based organisations, the private sector and people living with HIV/AIDS. In a communique issued on the occasion of the launch, the Ghana AIDS Commission (GAC) acknowledged that HIV/AIDS had reached epidemic levels and could erode the economic gains made, if left unchecked. The Commission resolved to:

- intensify advocacy and public education at all levels;
• promote programmes to reduce mother-to-child transmission;
• promote the reduction of new infection amongst all age groups through the adoption of “safer sex practices” especially among the 15-49 age group;
• target commercial sex workers, migrant workers, disabled persons, uniformed service personnel and other groups at risk;
• organise social groups to help people living with HIV/AIDS to come “into the open” and involve family and community units in the management of the epidemic;
• establish an HIV/AIDS budget line in every ministry.²³

As the highest policy-making body on AIDS, the Ghana AIDS Commission provides effective leadership in coordination of all programmes and activities of all stakeholders namely MDAs, Private Sector, Development partners and Civil Society in the fight against HIV/AIDS through advocacy, joint planning, monitoring and evaluation for the eventual elimination of the disease. The President of the Republic of Ghana chairs the Commission which is made up 35 members.

3.6.1 FUNCTIONS OF THE COMMISSION

The functions of the Commission among other things include the following:

❖ to formulate comprehensive national policies and strategies and establish programme priorities relating to HIV/AIDS;
❖ to provide high level advocacy for HIV/AIDS prevention and control;
❖ to provide effective leadership in the national planning and support supervision;
❖ to expand and coordinate the total national response to HIV/AIDS;
❖ to mobilise, control and manage resources and monitor their allocation and utilisation;
❖ to foster linkages among all stakeholders;
❖ to promote research, information and documentation on HIV/AIDS;
❖ to monitor and evaluate all on-going HIV activities.

In the performance of its functions, the Commission will have a full time Secretariat, Regional and District HIV/AIDS committees and will relate to the following bodies: -

➢ The Expanded Theme Group

UN Agencies

- Multi and Bilateral Agencies
- Other Development Partners
- Government

➢ Public/Private Sector Agencies

The British Department for International Development is supporting the Government of Ghana in its fight against HIV/AIDS through a grant of 25 million Pounds Sterling (£25 million), to cover support to the Ghana AIDS Commission (GAC) and UNAIDS, surveillance and control, condom procurement and promotion, the District Response Initiative (DRI) and mainstreaming activities.
3.6.2 OTHER PARTNERS IN THE NATIONAL RESPONSE

I NON HEALTH SECTORS

(a) **Sectoral Workplans:** Following the completion of the National Strategic Framework, Government supported selected sectors with the development of costed implementation plans by mainstreaming HIV/AIDS in the different sectors. These plans should facilitate programme implementation by the public and private sectors. As the sectoral plans are costed, they can be used for resource mobilisation purposes. The Government sectors include the Ministry of Roads and Highways, Local Government and Rural Development, Defence, Manpower Development and Employment, Education, Health, Youth and Sports, Tourism, Transport and Communication, Food and Agriculture, Interior, the Office of the Head of Civil Service and Judicial Service.

(b) **Ministry of Education:** This sector has integrated Population and Family Life Education (POP/FLE) topics into existing curricula in four career subjects at each level of the school programme (Primary School Classes 4 to 6, JSS, SSS, Teacher Training Colleges and University level). POP/FLE includes STD/HIV/AIDS issues. The sector also developed a Strategic Plan and an Action plan covering the next five years.

(c) **Ministry of Manpower, Development and Employment:** This has been the lead sector responsible for the coordination of the District Response Initiative (DRI). The sector is supported by a DRI Committee
whose membership includes the Ministry of Local Government and Rural Development, Department of Community Development, Ministry of Manpower Development and Employment, Ministry of Agriculture, GTZ, some UN Agencies and private consultants.

(d) **Ministry of Food and Agriculture:** The Ministry has started building capacity among the agricultural extension workers to enable them protect themselves and provide HIV/AIDS education to farming communities. FAO will be providing technical assistance to the sector.

II **NON-GOVERNMENTAL ORGANISATIONS**

(a) **ACTIONAID:** ACTIONAID Ghana programmes have centred on peer education for the youth and adults in 14 districts of the country. In both the Northern and Upper East Regions, its work in peer education has been in collaboration with partners including the Ministry of Health and Education at the district level. ACTIONAID advocacy work also includes cross-border research on AIDS and Migration, promoting Stepping Stones (a participatory approach to HIV/AIDS education at the community level), and lobbying for the inclusion of such innovative education programmes within the formal sector, particularly for secondary school students.

(b) **African Commission on Health and Human Rights Promoters:** The Commission aims at reducing the levels of discrimination and stigmatisation against PLWHA in Ghana. To achieve this, the Commission has started capacity building in human rights issues and has plans to
convene a series of capacity building workshops on human rights in different parts of the country. It also provides counselling services to PLWHA whose rights have been violated. The Commissions work include collaboration with the Commission on Human Rights and Administrative Justice (CHRAJ).

(c) Care International: This NGO has been implementing STI/AIDS prevention projects in mining areas in the Wassa West District of the Western Region (since 1996-SAPIMA and WWRH projects) and in the Adansi West district of the Ashanti Region, (since 1998-ARCH project). Both projects aim at safer sex practices using societal and service based approaches and supporting partner institutions.

(d) Centre for Development of People (CEDEP): CEDEP provides guidance to people living with HIV/AIDS (PLWHA) in the establishment of Support Groups. It also advises the Groups on income generating activities and facilitates capacity building workshops for PLWHA.

(e) Christian Health Association of Ghana (CHAG): Membership of CHAG includes the Catholic Mission, Salvation Army, Presbyterian Church, Church of Christ, Siloam Mission, Anglican Church, Assemblies of God, Methodist Church, Church of Pentecost, Seventh Day Adventist and Baptist Church. Christian health facilities are all working in the area of Care and Support. CHAG receives support from UNAIDS/UNDP to mobilise community members in high prevalence areas. The National Catholic
Secretariat (CAS) has 27 mission hospitals and 59 clinics. CHAG has also built capacity in home-based care among AIDS coordinators in mission hospitals, who in turn train volunteers to provide care and support to PLWHA and AIDS education to family and community members.

(f) Ghana HIV/AIDS Network (GHANET):- GHANET is an umbrella organisation for all stakeholders working to prevent STI/HIV/AIDS in Ghana. Most GHANET members are involved in HIV/AIDS information dissemination and in the care and support of persons living with AIDS (PLWHA).

(g) Ghana Red Cross Society:– The Ghana Red Cross Society (GRCS) implements HIV/AIDS education through its First Aid Training and Health Education Programmes. Also, the Society’s youth-targeted HIV/AIDS prevention projects- “Action for Youth AIDS Projects” are being implemented in the Upper East, Western and Northern Regions as well as the Kumasi Metropolitan Area of the Ashanti Region. Trained Youth Peer Educators are used to educate their peers on HIV/AIDS prevention, reproductive health and correct condom use.

(h) Ghana Social Marketing Foundation (GSMF):-

GSMF is involved in the following ongoing programmes:

(i) Commercial Drivers HIV/AIDS Programme: As part of the “Stop AIDS-Love Life campaign and fitting in the 2001 theme of “Men as Partners”, GSMF is working with commercial drivers in six transport hubs in five
regions across the country. 189 peer educators have been trained reaching out to about 11,000 people a week. Also, condom sales in drinking bars, chop bars and kiosks have improved condom accessibility in the hubs.

(ii). Rural Communication: GSMF is involved in HIV/AIDS prevention programmes in rural communities. These programmes are jointly carried with parliamentarians. Volunteers were recruited and trained as volunteer community based agents to continue the education after the GSMF team had left. In carrying out the education programmes audio-visual equipment was employed. One of such programmes organised in Nkoranza recorded an increase in condom prevalence from 19% to 52% over a period of eight months. Using 20 audio-visual vans and 50 information officers, GSMF reached 3,150 communities, villages and towns with HIV messages in year 2000.

(i) Wisdom Association:- This association is a Support Group for PLWHA in Greater Accra with a membership of about 150 to 200 people. Some of the members have been trained as counsellors and provide counselling services to their peers.26

III BILATERAL- MULTILATERAL DONORS:- The under listed bilateral and multilateral donors are involved in HIV/AIDS prevention projects in Ghana.

(a) Canadian AIDS/STD Project Intervention:- The CIDA AIDS/STD Project operates in the Greater Accra Region, Manya Krobo District in the
Eastern Region and Kumasi in the Ashanti Region. Activities include STD clinics in five regions, capacity building for MOH personnel, STD management and STD Surveillance. CIDA Canada is also involved in community mobilisation and sensitisation of NGOs, home based care programmes for PLWHA in Odumase, income generating activities for Commercial Sex Workers in Accra and Kumasi, and providing support for PLWHA at the Battor Hospital in the Volta Region. CIDA AIDS/STD Project is also involved in the development of an STD Management Bulletin with the Ghana Pharmaceutical Society.

(b) Danish International Development Assistance (DANIDA):

DANIDA gives high priority to preventing and curbing the impact of HIV/AIDS in both bilateral and multilateral development cooperation. In this regard, DANIDA offers support in the following areas-

(i) Incorporation of HIV/AIDS prevention in ongoing bilateral development cooperation between Denmark and Ghana, with respect to country strategies, annual reviews and negotiation.

(ii) Integration of HIV/AIDS specific interventions into Sector Programme Support in Water, Transport, Health and Energy through the involvement of Line Ministries, Private Sector, NGOs and relevant Target Populations.

(iii) NGO/CBO projects for HIV/AIDS prevention in areas of information and outreach work with special emphasis on Youth, Street Children, Women,
PLWHA's, Human Rights and Poverty Reduction initiatives among rural poor.

(iv) Multilateral assistance through special HIV/AIDS allocations for initiatives instituted by multilateral organisations and support to UNAIDS.

(c) Department for International Development (DFID):-
DFID offer support to HIV/AIDS activities both internationally and at the country level. In Ghana, DFID continues to be involved in the fight against HIV/AIDS by offering both financial and technical assistance. For instance, DFID provided £20 million to Ghana through the GAC for anti HIV/AIDS activities in the Ghana AIDS Partnership Programme (GAPP). It has also funded several pieces of work in the fight against HIV/AIDS and co-financed with UNAIDS the development of the National Strategic Framework, the sectoral implementation plans, the study tour to Uganda by Ministers of State and others and support to the Ghana AIDS Commission.

(d) European Union (EU):- The EU offers support through MOH/NACP for the appropriate management of STD patients in all public health facilities in Ghana by ensuring the availability of logistical support and IEC to encourage clients to seek early treatment for STDs, through the European Development Fund (EDF). It also supports the NACP in STD and HIV/AIDS control activities. EDF funds are managed directly by the NACP for the implementation of project activities in the following areas: AIDS/STD
education, training, support for STD patient management and logistic support to the NACP management. Training and supervision of health care staff at the regional and district level are important elements of EDF assistance, while limited support is also provided to NGO initiatives.

(e) **German Technical Cooperation/Regional AIDS Programme (GTZ):** GTZ has provided funds to Wenchi district in the Brong Ahafo Region to facilitate integration of HIV/AIDS into its primary health care (PHC) programmes. It also provides support to inter-country initiatives in the area of migration, prostitution, youth, PLWHA and networks, African Network on Ethics, Law and HIV. The GTZ which has the best HIV/AIDS documentation Centre in the country is already liaising with UNAIDS/ICT with regards to collaborating with other regional centers supported by UNAIDS.

(f) **United States of America Agency for International Development (USAID/GHANA):** The USAID strategic plan for HIV/AIDS/STD prevention is primarily carried out through the Family Health International (FHI) Impact activity which has four major components. These are:

- changing behaviour in high risk target groups;
- training of health workers in improved detection and treatment of STDs;
- strengthening laboratory support and surveillance; and
- active promotion of appropriate condom use.
FHI/IMPACT currently provides technical assistance and training to strengthen and support the National AIDS/STD Control Program (NACP), the Ghana Police Service and the Public Health Reference Laboratory (PHRL) in implementing activities aimed at preventing HIV/AIDS in Ghana. The distribution and promotion of condoms is carried out through a cooperative agreement with the Ghana Social Marketing Foundation.

3.7 UNITED NATIONS SYSTEM IN GHANA

(i) UNICEF:-
- Since 1998, UNICEF has been supporting a youth-to-youth peer education projects in the Upper East and Northern regions of Ghana which targets In-school and Out-of school youth. Major partners of UNICEF in this project are ACTIONAID-Ghana and the Ghana Red Cross Society.
- UNICEF also has an HIV/AIDS prevention programme with young people and street children in Accra. This targets In-school and Out-of school youth in the Ga Mashie area of Accra. Major partners include RESPONSE, CAS (all NGOs), Accra Metropolitan Assembly (AMA), Department of Sociology of the University of Ghana, Ministry of Health (MOH) and the Ministry of Manpower Development and Employment (MMDE).
- UNICEF also has ongoing projects in the Obuasi District of the Ashanti region aimed at enhancing the negotiating skills and opportunities to engage in safer sex among commercial sex workers. Activities undertaken
include training, material development, STD services, support for PLWHA and Income Generation/Credit Activities.

(ii) **UNDP:**

- UNDP is providing support for the CHAG community mobilisation programme, which includes capacity building for health workers and volunteers in Care and Support for PLWHA.

- UNDP is also providing technical assistance in the area of financial management for the newly created Ghana AIDS Commission.

(iii) **UNFPA:**

In addition to joint support of UNAIDS with other co-sponsoring agencies, UNFPA assistance is largely mainstreamed into ongoing programmes and projects and include:

- support to the national HIV/AIDS and STDs programme, and improved management of STDs through integration of Reproductive Tract Infections (RTIs) into the Reproduction Health (RH) programme of the Ministry of Health. Specifically, HIV/AIDS prevention activities have been mainstreamed into the Safe Motherhood and Adolescent Reproductive Health components of MOH’s programme.

- supporting the integration of Population and Family Life Education (POP/FLE) with underlying gender issues including HIV/AIDS, STDs and other Reproductive Tract Infections (RTIs) by Ministry of education at
various levels of schools, colleges and university curricula and programmes.

- providing support for the incorporation of HIV/AIDS prevention and control activities into community based and literacy programmes.

- providing support for capacity building and training for health programmes and resource personnel on management of HIV/AIDS programmes and projects.

- providing support for peer education for youth on HIV/AIDS prevention and control activities including counselling, through the activities of various religious bodies and NGOs.

- provision of logistic support, that is, IEC materials and equipment, contraceptive supplies and transport equipment to facilitate and encourage more responsible and safer sexual behaviours.

- providing support for policy formulation and implementation and advocacy at all levels including civil society organisations on HIV/AIDS and STDs.

UNFPA also provides technical assistance for HIV/AIDS workplace activities.

(iv) UNESCO:

- UNESCO has helped with the creation of an HIV/AIDS Task force in the Ministry of education and is supporting the preparation of the Education Sector Strategic Plan on HIV/AIDS. In March 2001, UNESCO convened a Regional HIV/Education Conference.
- **UNESCO** is also involved in the organisation of youth programmes to sensitise the youth about HIV/AIDS.

**(v)** **WORLD HEALTH ORGANISATION (WHO):**

- This Agency is involved in disease surveillance and monitoring of the HIV/AIDS epidemic, training for management of Sexually Transmitted Diseases (STDs), capacity building for initiatives on home-based care and NACP management and coordination.

- WHO also coordinates support for local research into HIV/AIDS transmission and management and PMTCT activities.

**(vi)** **WORLD BANK (WB):**

- The World Bank has approved a US$25 million credit to support the implementation of the Government’s efforts to reduce the spread of HIV/AIDS and reduce the impact on those already infected and affected, as articulated in the “Strategic Framework for HIV/AIDS in Ghana” document. This support is called the Ghana HIV/AIDS Response Fund (GARFUND) and is expected to finance activities conducted by civil society organisations, including NGOs, CBOs, trade and professional associations, associations of PLWHAs and MDAs.

**(vii)** **FOOD AND AGRICULTURAL ORGANISATION (FAO):**

FAO provides technical assistance to the Ministry of Agriculture in the planning and implementation of HIV/AIDS-related plans.
(viii) WORLD FOOD PROGRAMME (WFP):-

WFP involved in providing food rations to 100 PLWHA participating in a study titled "Efficacy of herbal preparations in the treatment of opportunistic infections", being undertaken by the MOH in collaboration with Noguchi and Mampong Centre for Scientific and Medicinal Research.

3.8 BACKGROUND TO UNAIDS

When HIV/AIDS caught international attention in the late 1970s and mid-1980s, the responsibility of setting up the much-needed national AIDS programmes was entrusted to the World Health Organisation. By the mid-1990s, it became clear however, that the relentless spread of HIV, and the epidemic's devastating impact on all aspects of human lives and on social and economic development, were creating an emergency that would require a greatly expanded United Nations effort. It was felt that no single United Nations organisation could provide the coordinated level of assistance needed to address the many factors driving the HIV epidemic, or help countries deal with the impact of HIV/AIDS on households, communities and local economies. Greater coordination was therefore needed to maximize the impact of UN efforts.27

In addressing these challenges head-on, the United Nations in 1996, took an innovative approach drawing six organisations together in a joint and cosponsored programme- the Joint United Nations Programme on HIV/AIDS (UNAIDS). The six original co-sponsors of UNAIDS, that is, UNICEF, UNDP, UNFPA, UNESCO, WHO, and the World Bank, were joined in April 1999 by the
UNDCP. Working together through UNAIDS, the Cosponsors expand their outreach through strategic alliances with other United Nations agencies, national governments, corporations, media, religious organisations, community-based groups, regional and country networks of people living with HIV/AIDS, and other non-governmental organisations.28

As the leading advocate for worldwide action against HIV/AIDS, the global mission of UNAIDS is to lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the socioeconomic and human impact of the epidemic.

With an annual budget of US$60 million and a staff of 129 professionals, UNAIDS is a modest-sized programme with substantial impact. The UNAIDS Secretariat operates as a catalyst and coordinator of action on AIDS, rather than as a direct funding or implementing agency.

The largest donors to UNAIDS in 1998 were the United States Government, which contributed US$15 million, followed by the Governments of the Netherlands, the United Kingdom, Sweden, Norway and Denmark. UNAIDS also receives funds from non-traditional donors such as China, Thailand and South Africa.

UNAIDS is guided by a Programme Coordinating with representatives of 22 governments from all parts of the world, representatives of the 7 UNAIDS Cosponsors, and 5 representatives of non-governmental organisations (NGOs),
including associations of people living with HIV/AIDS. UNAIDS is the first United Nations programme to include NGOs in its governing body. The Cosponsors and Secretariat also meet several times a year as the Committee of Cosponsoring Organisations (CCO).

The Secretariat of UNAIDS is based in Geneva, Switzerland. Current priority areas for the Secretariat include:

- young people
- highly vulnerable populations
- prevention of mother-to child HIV transmission
- developing and implementing community standards of AIDS care
- vaccine development
- special initiatives for hard-hit regions, including sub-Saharan Africa.

In developing countries, UNAIDS operates mainly through the country based staff of its seven Cosponsors. Meeting as the host country’s United Nations Theme Group on HIV/AIDS, representatives of the Cosponsoring organisations share information, plan and monitor coordinated action between themselves and with other partners, and decide on joint financing of major AIDS activities in support of the country’s government and other national partners. The principal objective of the Theme Group is to support the host country’s efforts to mount an effective and comprehensive response to HIV/AIDS. In most cases, the host government is invited to be part of the Theme Group. Increasingly, other
partners such as representatives of other United Nations agencies and bilateral organisations working in the country are also included.

In priority countries the Theme Group has the support of a UNAIDS staff member, called a Country Programme Adviser (CPA). Elsewhere, a staff member of one of the seven Cosponsors serves as the UNAIDS focal point for the country. In addition to supporting the UN system, these staff endeavour to build national commitment to AIDS action and provide information and guidance to a range of host country partners, including government departments and groups and organisations from civil society, such as people living with HIV/AIDS.

The UNAIDS Secretariat makes catalytic funding available for selected AIDS initiatives. Between January 1998 and May 1999, proposals were received and approved for projects in a total of 87 countries. As of April 1999, the UNAIDS Cosponsors had established 132 United Nations Theme Groups on HIV/AIDS covering 155 countries. For their day-to-day operations, most Theme Groups have set up special working that involve donors, NGOs and groups of people living with HIV/AIDS.²⁹

3.8.1 UNAIDS IN GHANA

In Ghana, the UNAIDS office supports the UN Theme Group on HIV/AIDS in coordinating the UN response to HIV/AIDS through regular meetings of the Expanded Theme Group and the Technical Working Group on HIV/AIDS. UNAIDS facilitated the development of the National Strategic Framework, the development of the Sectoral Implementation Plans and the establishment of the
Ghana AIDS Commission and several thematic sub-groups to support Government HIV/AIDS prevention and control efforts. Examples include sub-committees on MTCT and VCT, STD and Commercial Sex Workers, Female Condom, Advocacy and Media. UNAIDS works in close partnership with all stakeholders in HIV/AIDS.

Though not a funding programme, UNAIDS Headquarters has provided support through its Programme Acceleration Funds to UNFPA for AIDS in the workplace activities, to WHO for blood safety and care and support, to UNDP for Strategic Planning and Mainstreaming HIV/AIDS, District Response Initiative and MTCT/VCT, to FAO for capacity building in HIV/AIDS for agricultural extension workers and farmers. It also provides funds and support to UNICEF in its MTCT prevention programmes as well as to UNESCO in support of AIDS education programmes through drama.

UNAIDS further provides technical and financial support to NGOs to facilitate the implementation of HIV/AIDS-related programmes for selected target groups. Approximately 10 NGOs including Society for Women Against AIDS in Africa (SWAA-Ghana) have been provided support for capacity building in the promotion of the female condoms or implementation of IEC materials related to the World AIDS Campaign Theme, “Men Make A Difference”.

Partnership funds have also been channelled to John Hopkins University for capacity building of NGOs in HIV/AIDS “Journey of Hope” and the “Stop
AIDS-Love Life” campaign and to the Ministry of Health for development of female condom training materials and training.

UNAIDS has in addition recruited technical assistance for development of proposals and work plans in Care and Support, MTCT, Strategic planning, research into Human Rights as they affect PLWHA and study of medical and health personnel.30

3.8.2 CONSTRAINTS TO UNAIDS ACTIVITIES IN GHANA

In their six years of operation in Ghana, different types of constraints have been identified. Initially, these constraints were of a rather general nature and had to do with the fact that the UNAIDS was a new entity. In many countries, the UN agencies, governments as well as donors, had to familiarize themselves with UNAIDS and its mandate, and commitment had to develop, also on the financial side. Also, UNAIDS as a program of different cosponsors, was still developing itself and the core areas of policies and intervention.

Another early years constraint may have been the fact that HIV/AIDS was perceived as a health problem only, and that commitments and activities were somewhat limited to this sector. Now it is fully recognised that the HIV/AIDS epidemic is a developmental problem that is affecting economies and societies at large. Ghana has fully acknowledged this, as can be illustrated by the government’s response in setting up the of the multi-sectoral Ghana AIDS Commission.
At present, UNAIDS is fully established and working closely with the co-sponsors and other UN agencies as well as the government counterparts and the donors, while also linking with local NGO’s, networks and associations of PLWHA.

A major constraint which the UNAIDS Country Adviser in Ghana acknowledges is that of understaffing of the UNAIDS office due to lack of funds. This situation, according to her, makes it impossible for the staff available to effectively support the government in monitoring and evaluation of ongoing programmes and activities as not enough time is available for review of submitted proposals and capacity building.

Again on the financial side, the UNAIDS office has insufficient funds available to assist all those involved in HIV/AIDS, and can therefore not support many small projects and programmes. This means that some programmes that have proven to be effective and successful cannot be scaled-up or repeated elsewhere due to lack of funds.

At a more general level, the enormous number of NGO’s and organizations that have sprung up nation and region wide, all trying to deal with HIV/AIDS, constitute a major constraint. In itself, this development is of course commendable and positive. However, if there is no or little coordination of all the various activities, a lot of overlap could take place and result in moneys being spent in a less than efficient manner.

Overall, funding remains a major constraint, not just for UNAIDS but in the fight against HIV/AIDS in general. Prevention remains an important area of
concern, but it is a reality that people already infected will be in need of medical care and attention as their illness develops, while they are not or less able to work. This calls for funding in the areas of care and support, medical requirements and income generation. A specific group that will always be in need of assistance is children orphaned by the loss of their parents due to HIV/AIDS. Although money will always remain a problem, it is promising to note that at the recently held UN General Assembly Special Session on HIV/AIDS, a new Global Fund was set up to mobilise funds to fight the HIV/AIDS pandemic.31

In spite, of the numerous constraints to its work, it is significant to note that the UNAIDS and its cosponsors have performed creditably in the fight against the disease in Ghana. First, through the activities of UNAIDS and the cosponsors, many Ghanaians both at the workplace and at the community level are now aware of HIV/AIDS. According to the 1998 Ghana Demographic and Health Survey, about 97% of women and 99% of men have heard of AIDS. Information is mostly obtained from the radio, workplace and television through programmes such as “Stop AIDS-Love Life” campaign and the institution of HIV/AIDS committees in MDAs.32

UNAIDS has also been pursuing quiet diplomacy with pharmaceutical companies trying to convince them to produce cheaper antiretroviral HIV/AIDS drugs for poor people in developing countries. A US-based pharmaceutical company with manufacturing facilities in Ghana, Phyto-Riker, has promised to set in motion the first effective programme to provide free of charge, the most
advanced drugs and diagnostic equipment to HIV-positive individuals throughout sub-Saharan Africa. In this regard, the company has signed a Memorandum of Understanding with the Minister of Health to support their strategy to make the drugs available at no cost to those infected with HIV/AIDS. The company has also established distribution channels in 18 African countries.

A multisectoral female condom committee comprising representatives from the Maternal and Child Health Unit (MCH) of the Ministry of Health, Ghana Social Marketing Foundation (GSMF), UNFPA, CIDA/Canada Society for Women Against AIDS in Africa- Ghana Branch (SWAA-Ghana) and UNAIDS developed a plan of action to facilitate the introduction of the female condom in Ghana. The condom was officially launched in May 2000. The stakeholders collectively built a capacity of over 10,000 health workers, pharmacists, SWAA members, professional sex workers and chemical sellers in the promotion and use of the female condom. Since May 2000, a total of 2,000,000 female condoms have been supplied to the Ministry of Health.

Finally, UNAIDS was instrumental in the drafting of the National Strategic Framework on HIV/AIDS which culminated in the formation of the Ghana AIDS Commission which has the responsibility of coordinating, monitoring and evaluating multisectoral HIV/AIDS in the country.

In summary, it is worth mentioning that the little successes chalked by UNAIDS would not have been possible without the necessary technical and financial support it received from its cosponsors and partners. Table 3 below
shows the support Ghana received from her international partners in the fight against HIV/AIDS.
<table>
<thead>
<tr>
<th>FUNDING AGENCY</th>
<th>CURRENCY</th>
<th>AMOUNT</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA</td>
<td>US$</td>
<td>1,693,730</td>
<td>HIV/AIDS-Related Activities</td>
</tr>
<tr>
<td></td>
<td>US$</td>
<td>20,000</td>
<td>Administrative Support to UNAIDS Office</td>
</tr>
<tr>
<td>WHO</td>
<td>US$</td>
<td>1,240,000</td>
<td>HIV/AIDS-Related Activities</td>
</tr>
<tr>
<td></td>
<td>US$</td>
<td>6,000</td>
<td>Admin. Support UNAIDS Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GARFUND Channelled Thro. GAC</td>
</tr>
<tr>
<td>WORLD BANK</td>
<td>US$</td>
<td>25,000,000</td>
<td>GARFUND channelled through GAC</td>
</tr>
<tr>
<td>UNICEF</td>
<td>US$</td>
<td>232,000</td>
<td>Care and Support, MTCT</td>
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<tr>
<td>UNDP</td>
<td>US$</td>
<td>100,000</td>
<td>Support to Ghana AIDS Commission (GAC)</td>
</tr>
<tr>
<td>EU</td>
<td>EURO</td>
<td>379,400</td>
<td>STD and HIV/AIDS Control Activities</td>
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<tr>
<td>FHI</td>
<td>US$</td>
<td>872,568</td>
<td>NGO Programme and Armed Forces/Police</td>
</tr>
<tr>
<td>DFID</td>
<td>US$</td>
<td>31,000</td>
<td>HIV/AIDS Response Analysis, HIV/AIDS Agriculture, Conference, Ministerial visit to Uganda</td>
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<tr>
<td></td>
<td>£</td>
<td>20,000,000</td>
<td>Through GAC for AIDS-related activities</td>
</tr>
<tr>
<td>CIDA/CANADA</td>
<td>US$</td>
<td>500,000</td>
<td>Sex workers intervention project</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>US$</td>
<td>1,464,000</td>
<td>DRI, MTCT, VCT, Care and Support, Capacity building, blood safety, Strategic Planning</td>
</tr>
<tr>
<td>USAID</td>
<td>US$</td>
<td>1,000,000</td>
<td>Lab. Services Infrastructure and IEC</td>
</tr>
</tbody>
</table>

ENDNOTES

2 opcit.
3 Daily Graphic, June 9, 2001 p.5.
7 Ghana National AIDS Control Programme, MOH 2000.
9 opcit.
13 opcit.
14 ibid. p.30.
16 opcit.
17 opcit.
18 HIV/AIDS in Ghana: Background Projections Impacts Intervention, MOH/NACP 1999 p.32.
20 ibid. p.36.
21 ibid. p.46.
22 ibid. p.46-47.
26 ibid. p.11-14.
27 http://www.unaids.org
28 opcit.
29 ibid. p.3.
31 Interview with UNAIDS Country Adviser.
CHAPTER FOUR

4.0 SUMMARY, RECOMMENDATION AND CONCLUSION

4.1 SUMMARY

This research study set out to examine the global role of the United Nations in the fight against the HIV/AIDS pandemic, stressing on the activities of UNAIDS in Ghana.

The study revealed the leadership role assumed by the United Nations and its agencies in the prevention and management of HIV/AIDS as well as finding a cure for the disease through their numerous activities. Through its collaborative efforts with stakeholders and pharmaceutical companies, the study observed the remarkable successes chalked in laboratory services for screening of blood sample of HIV infected persons, the introduction of the female condoms, and the production of cheaper anti-retroviral drugs that could prolong the life span of HIV infected persons.

The study also revealed the numerous financial and technical support offered by the United Nations and its agencies to all stakeholders in HIV/AIDS prevention and control. As the leading advocate for worldwide action against HIV/AIDS, UNAIDS for instance, facilitated the development of the National Strategic Framework, the development of the Sectoral Implementation Plans and the establishment of the Ghana AIDS Commission and several thematic sub-groups to support Government HIV/AIDS prevention and control efforts.
The study revealed the UNAIDS involvement in providing capacity building in the form of training of health personnel, NGOs and civil society for the fight against the HIV/AIDS pandemic. UNAIDS was also involved in providing support for people living with HIV/AIDS as well as providing commercial sex workers with alternative, safer and more honourable income generating activities. Again, through the activities of the United Nations system, awareness about the disease has become very high.

The personal crusade by the UN Secretary General Kofi Annan against the disease is mentioned. Following the Secretary General’s personal involvement in the fight against the disease, a Global AIDS and Health Fund to increase funding for AIDS, malaria and tuberculosis programmes in developing countries from its current level of under US$2 billion annually to the US$7-10 billion has been established. The UN Secretary General has also held meetings with the top executives from six leading multinational pharmaceutical companies to discuss further steps to be taken by these companies to make care and treatment more accessible for people living with HIV/AIDS in developing countries.

In spite of the numerous efforts of the United Nations and its agencies in controlling the global spread of HIV/AIDS, the disease seems to be getting out of hand with sub-Saharan Africa being the worst affected continent. A UNAIDS Report states that, in the year 2000, 3.8 million people became infected with HIV in sub-Saharan Africa bringing the total number of people living with HIV or AIDS in the region to 25.3 million, up nearly a million from 1999’s figure. At the same
time, 2.4 million people died in Africa of AIDS in 2000, as against 2.2 million in 1999.\textsuperscript{3} The HIV/AIDS pandemic has been described as the worst human disaster to have hit the world since the plagues of the 14\textsuperscript{th} century. Speaking at the African Summit on HIV/AIDS held in April 2000, in Abuja, Nigeria, former US President Bill Clinton observed that AIDS now kills more people in Africa than all the armed conflicts on the continent combined.\textsuperscript{4} Also, the US Secretary of State Colin Powell at the recent UN General Assembly Special Session on AIDS held in New York, in June 2001, declared that “no war on the face of the world is more destructive than the AIDS pandemic stressing that as a soldier once, he knew of no enemy in war more insidious or vicious than AIDS, a disease that poses a clear and present danger to the world”. He reiterated that the US would continue to lead the way in financing research for a cure. He stressed that from this moment on the US response to AIDS would be no less comprehensive, no less relentless and no less swift than the pandemic itself.\textsuperscript{5}

The global HIV/AIDS situation especially in sub-Saharan Africa remains a source of major concern and efforts are being made to arrest the situation worldwide. In Ghana, the UNAIDS office mentions the problem of understaffing, insufficient funds to assist all those involved in HIV/AIDS, the enormous number of NGO’s that have suddenly sprung up nation and region wide and all trying to deal with HIV/AIDS, and overall funding for its activities as some of the major constraints to the effective implementation of its programmes.
4.2 RECOMMENDATIONS

In the light of the foregoing constraints identified by the UNAIDS office as impeding the successful implementation of its activities in Ghana, I wish to make the following recommendations:

☑ Improve the staffing situation in the UNAIDS office to enable it support the government in monitoring and evaluation of ongoing programmes and activities. Also, improving the staffing situation will afford the UNAIDS ample time to review submitted proposals and its capacity building programmes.

According to the UNAIDS Country Adviser, Mrs. Cynthia Eledu, hopefully this shortcoming is to be resolved in the near future, as funds have now being made available from UNAIDS Headquarters for the recruitment of additional staff members.

☑ UNAIDS will have to eliminate an overlap in HIV/AIDS activities as well as prevent moneys being used in less efficient manner, by the numerous NGO’s and organizations that have sprung up nation and region wide. In this regard, it is expected that the new Ghana AIDS Commission will play an important role in coordinating the country response at different levels.

☑ Since funding remains a major problem for UNAIDS and the United Nations System in general in carrying out their respective activities, there is the need for the international community to support the effort in the fight against the HIV/AIDS disease. It is therefore reassuring to note that at the recent UN General Assembly Special Session on HIV/AIDS in New York held in June
2001, a new Global HIV/AIDS and Health Fund to mobilise between US$7-US$10 billion annually to fight the disease and other opportunistic infections was launched by the UN Secretary General. It is hoped that with funds made available through this new Global Fund, the UNAIDS office will have sufficient funds to assist all those involved in HIV/AIDS prevention activities as well as offer support many small projects and programmes.

4.3 CONCLUSION

Compared to other countries within sub-Saharan Africa, the current prevalence rate of 4.6% HIV/AIDS infection in Ghana may not be considered as serious. This should not however, lead to complacency in curbing the disease. It is in this regard that the UNAIDS and its cosponsors have been at the forefront in the fight against the spread of HIV/AIDS albeit with little success so far. It is significant to mention however, that in the field of capacity building, production of cheaper drugs and vaccines, improvement in care and support for PLWHAs, promotion of safe sex through use of condoms as well as youth-to-youth education about the disease, considerable successes have been made in Ghana. It must be borne in mind, though, that UNAIDS itself is not a funding agency, but a coordinating program that has its focus on the Cosponsored and the assistance of government in their response to the crisis.
ENDNOTES

BIBLIOGRAPHY

BOOKS

ARTICLES, PAPERS, REPORTS AND MAGAZINES


5. *Data on HIV/AIDS cases in Ghana from 1986-2000*, Disease Control Unit, MOH/NACP.


NEWSPAPERS AND INTERNET MATERIALS


3. *Ghanaian Times*, January 24, 2001


7. [http://www.unaids.org](http://www.unaids.org)

End-2000 global estimates children and adults

- People living with HIV/AIDS: 36.1 million
- New HIV infections in 2000: 5.3 million
- Deaths due to HIV/AIDS in 2000: 3.0 million
- Cumulative number of deaths due to HIV/AIDS: 21.8 million
APPENDIX II

Adults and children estimated to be living with HIV/AIDS as of end 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>920,000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>390,000</td>
</tr>
<tr>
<td>Latin America</td>
<td>1.4 million</td>
</tr>
<tr>
<td>Western Europe</td>
<td>540,000</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>700,000</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>640,000</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>400,000</td>
</tr>
<tr>
<td>South &amp; South-East Asia</td>
<td>5.8 million</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>25.3 million</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
<td>15,000</td>
</tr>
</tbody>
</table>

Total: 36.1 million
Estimated number of adults and children newly infected with HIV during 2000

- North America: 45,000
- Caribbean: 60,000
- Latin America: 150,000
- Western Europe: 30,000
- North Africa & Middle East: 80,000
- Sub-Saharan Africa: 3.8 million
- Eastern Europe & Central Asia: 250,000
- East Asia & Pacific: 130,000
- South & South East Asia: 780,000
- Australia & New Zealand: 500

Total: 5.3 million

World Health Organization
Estimated adult and child deaths due to HIV/AIDS during 2000

- North America: 20,000
- Caribbean: 32,000
- Latin America: 50,000
- Western Europe: 7,000
- Eastern Europe & Central Asia: 14,000
- East Asia & Pacific: 25,000
- North Africa & Middle East: 24,000
- Sub-Saharan Africa: 2.4 million
- South & South-East Asia: 470,000
- Australia & New Zealand: < 500

Total: 3.0 million