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HIV/AIDS Intervention in Ghana: A Constructivist Approach to Understanding AIDS Policy

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HIV/AIDS Intervention in Ghana: A Constructivist Approach to Understanding AIDS
Policy

Nat Papa Kobina Markin

Dissertation submitted to the
Eberly College of Arts and Sciences
at West Virginia University
in partial Fulfillment of the requirements
for the degree of

Doctor of Philosophy
in
Political Science

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Abstract

HIV/AIDS Intervention in Ghana: A Constructivist Approach to Understanding AIDS Policy

Nat Papa Kobina Markin

This study is about how donor policy, NGO policy and public policy work together in Ghana's national strategic response to HIV and AIDS. The dissertation touches on two areas of public policy - development policy and health policy specifically relating to HIV/AIDS to determine congruity of the policy approaches of the three groups. Based on a survey done in Accra, Ghana in summer 2010 and on documentary sources of data collection, the study captures areas of agreement and disagreement of the three groups and discusses their effects on policy implementation. In broader terms, it analyzes assistance for HIV/AIDS in the context of international development aid and how current economic realities make such assistance unsustainable in the long term. It concludes by developing a prescriptive model of HIV policy intervention in Ghana with proposed revisions to the current policy model.

For Genevieve and our children - Margaret, Jodie, Nathan and Kaitlyn

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ACRONYMS

ACF	Advocacy Coalition Framework
ACP	African, Caribbean and Pacific Countries
AIDS	Acquired Immune Deficiency Syndrome
ALCO	Abijan-Lagos Corridor Organization
ART	Anti-retroviral Therapies
ARV	Anti-Retroviral
AU	African Union
CBO	Community Based Organization
CCM	Country Coordination Mechanism (Global Fund)
CDC	Centers for Disease Control and Prevention
CD4	Cluster of Differentiation 4
CEPEHRG	Centre for Popular Education and Human Rights in Ghana
CYIB-CM	Children and Youth in Broadcasting – Curious Minds
DACF	District Assemblies Common Fund
DANIDA	Danish International Development Agency
DfID	Department for International Development (United Kingdom)
DRI	District Response Initiative
EKN	Embassy of the Kingdom of the Netherlands
EU	European Union
FHI	Family Health International
FSW	Female Sex Workers
GAC	Ghana AIDS Commission
GARFUND	Ghana AIDS Response Fund
GBC	Ghana Broadcasting Corporation
GBCA	Ghana Business Coalition Against HIV/AIDS
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHANET	Ghana Network of People Living with HIV/AIDS
GHS	Ghana Health Service

GPA	Global Program on AIDS
GPRS	Ghana Poverty Reduction Strategy
GTZ	German Technical Company
HFFG	Hope for Future Generations
HIV	Human Immunodeficiency Syndrome
IDA	International Development Assistance (World Bank)
ILO	International Labor Organization
IV	Intravenous (drugs)
JICA	Japanese International Cooperation Agency
JUTA	Joint UN Team
MARPS	Most At-Risk Populations
MDA	Millennium Development Account (UN)
MDG	Millennium Development Goals (UN)
MoH	Ministry of Health
MSHAP	Multi-Sectoral HIV/AIDS Programme
MSM	Men Who Have Sex with Men
MSW	Male Sex Workers
NACP	National AIDS/STI Control Program
NAP+	Network of African People Living with HIV
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NSF	National Strategic Framework (For HIV/AIDS)
OAU	Organization of African Unity
OVC	Orphans and Vulnerable Children
SWAA	Society for Women and AIDS in Africa
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

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Chapter 1: Introduction

When people started dying of AIDS it was considered one of the most devastating crises of the modern era. The world responded with an aggressive program to combat the disease. In countries like Ghana it meant the creation of new institutions and new policies in line with the global effort. HIV/AIDS opened up a new front in development aid to Africa.

In the western world the disease initially spread among a small number of people within 'politically unfavorable' minority groups namely homosexuals and intravenous drug (IV) users. That demographic became the lens through which the earliest studies saw the disease. In the 1970s and 1980s, when the disease first appeared, the political climate in the US was gaining a distinctively conservative flavor with emphasis on religion and family values. As one would expect from that political climate, initial calls for policy action to combat the disease were met with indifference. (Ostergard, 2002)

Since then, policy makers (and international financial and development agencies) have caught up with the disease and in many countries concrete action is being taken to deal with prevention and treatment of the HIV and AIDS. Once considered a fatal illness for those who contracted it, HIV infection is now a chronic manageable condition for victims with access to new antiretroviral therapies (ART). In parts of Africa however, HIV/AIDS is a growing problem. Enormous progress made, internationally, in understanding the molecular biology of the virus and how it affects humans has not mitigated the spread of the disease. Africa accounts for two-thirds of worldwide cases of HIV infection. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), sub-Saharan Africa remains the area worse affected by HIV accounting for 67% of all infected persons worldwide and 72% of AIDS deaths worldwide in 2007 (UNAIDS, 2008).

The initial spread of HIV in Africa not only affected a larger number of people but it also happened in the immediate post-cold war era when the Soviet Union had collapsed and the United States had begun what has been termed a diplomatic departure from the continent. Initial apathy towards the African HIV/AIDS experience was concomitant to the epidemic being filtered through the lens of perception of the disease in the west¹ as confined to members of male homosexual and IV drug using communities.

When eventually, the magnitude of the epidemic in Africa became apparent and scholars began to study the African case in its uniqueness, traces of this early filtration nevertheless remained. Epidemiological profiling based on western understanding of the disease was accompanied by efforts to explicate the particular social context of its evolution on the continent by identifying endogenous social factors that facilitate transmission. Several African "specificities" arguments emerged based on cultural factors as principal explanations for the high rates of HIV/AIDS in Africa (Nguyen and Stovel, 2004). This line of inquiry yielded important insight into the evolution of the problem, but recent research

¹ This is the case despite the fact that unlike the rest of the world, initial transmission of the virus in African countries occurred almost exclusively through heterosexual relationships (Caldwell, 2000).

has shifted the focus to economic and political factors such as weak state capacity and poverty.

Today ART drugs are available in many parts of Africa but are not affordable to many of the people that need them. HIV/AIDS has had devastating impact on Africans in terms of worsening trends in quality-of-life and generally in socio-economic development. In one sense it reflects the stark reality that even in the second decade of the 21st century, there still exists a very wide gap in health between populations in Africa and those in the advanced western democracies. There is widespread acknowledgment today that HIV/AIDS in Africa is not just a medical problem. It touches many aspects of life and of public policy. Even disease transmission is shaped by social dynamics and all indications suggest that there are socio-political, cultural and economic factors that play a role in its evolution and the institutional responses to it.

Academics from different disciplines recognize a need for responses to HIV/AIDS beyond mere medical treatment to encompass cultural understanding as well as a political will to address social aspects the problem within a broader context of achieving development goals. Along with this line of thinking, it has been suggested that the disease threatens to undermine achievement of the United Nations Millennium Development Goals (MDG). Those goals include poverty reduction (by half), provision of universal primary education, removing gender discrimination in primary and secondary education, reduction of child (under five) mortality by two-thirds and arresting and turning around the spread of diseases including HIV and malaria (Whiteside, 2002).

1.1 Objectives

This study is both descriptive and normative. It describes the real world situation of HIV intervention in Ghana - how ideas and perspectives affect HIV policy in Ghana and its implementation so that it is possible to compare intervention approaches along this dimension. Based on the descriptive model I outline a normative model of AIDS intervention in Ghana that proposes ways to improve the existing policy model to advance its ability to produce more optimal results. It is a response to the need for a more comprehensive approach for dealing with HIV/AIDS in Ghana. I outline the framework for a more holistic approach to dealing with the problem of AIDS within the context of international development assistance. The goal is to develop a better understanding into responses of the formal and informal domestic policy apparatus to international intervention initiatives by outlining an accurate model of the current intervention structure. Good prescription depends on satisfactory description because it is important to identify the nature of the problem prior to any attempt to correct it. Prescription is normative (valuative) in character because it involves choosing among competing values or favoring particular courses of action over others. My prescriptive model rests on a subscription to decision alternatives and subjective probabilities that are valued and preferred and considered necessary to achieve established policy objectives.

1.2 Research Question\Problem

HIV/AIDS affects different levels of policy at both the policy output and operational levels. As in all countries affected by HIV/AIDS, Ghana has several groups working in the intervention to address the problem. The government policy apparatus is supported by bilateral and multilateral international organizations, as well as by informal local networks often, but not always, dependent on state patronage. This complex policy environment is characterized by the pursuit of varied interests and the existence of diverse institutional procedures. Policy outcomes are therefore dependent upon how effectively the various organizations work together and how well they coordinate their activities. To achieve effective coordination and cooperation, it is vital to reconcile the interests and values of the various organizations.

This research is an effort to study complexities of interfacing formal and informal, domestic and international policy initiatives in HIV/AIDS program in Ghana. Since policy fields are interlinked and interdependent, I studied relationships of policy actors to determine if there is a policy/perception gap between the various organizations working in the HIV/AIDS field in Ghana. And if so, to try to understand how that affects responses to the epidemic on the ground. More specifically, I studied political, moral, socio-economic and cultural factors at play in the interface between local (public policy/NGO) and international (donor/NGO) intervention programs. Studying interface situations implies an attempt to elucidate discontinuities that may exist and the dynamic nature of encounters and interactions showing how goals, values, interests and perceptions influence those situations and shape their outcomes.

This study uses a qualitative design based upon inductive logic along the lines described by Creswell (1994). The full research protocol combines data obtained from a survey conducted in Accra, Ghana between April and May 2010 with analysis of policy documents to study frames of reference used by the major players in the field and tries to understand how those framing strategies affect HIV/AIDS policy and its implementation. The concept *frame of reference* is used in this study to denote processes of thought and problem solving which represent forms of information processing by groups and individuals.

In this study the dependent variable is Ghana's HIV/AIDS intervention program, sometimes referred to as the National Strategy Framework for HIV/AIDS (NSF). The independent variables are the individual policies of the three groups studied in the survey – donor organizations, NGOs and the Government of Ghana. NSF I (2001-2005) was primarily funded with a World Bank credit of US\$25m (UNAIDS, 2009:5) and transitioned to NSF II to reflect new requirements for a Multi-Sectoral HIV/AIDS Programme (MSHAP) (GAC, 2004a:48).

1.3 Approach

This study draws on constructivist theory in IR and policy literature to help evaluate the policy intervention in the HIV/AIDS field in Ghana. Constructivism is a theory that emphasizes the construction of knowledge rather than mere reception of it. It sees all knowledge as “constructed” and thus amenable to transformation through human practice. I am sug-

gesting that social construction of HIV/AIDS is produced and negotiated through policy and the medium of discourse. I am therefore thinking of policy as a discourse both in terms of articulation and implementation. Discourse theory is useful for study for HIV interventions because of the emphasis on power. Power struggles and political conflicts shape the discourse in both policy formulation and implementation. This framework will be used to provide a literary orientation for this study as a theory in development rather than a theory to be tested. This approach is consistent with the qualitative design of the study and is premised on the idea that “reality is socially constructed through individual or collective definitions of the situation.” (Creswell: 44)

1.4 Justification for Selection of Ghana

There are several reasons for selecting Ghana for this study. The first is that there is a relative paucity of literature on HIV/AIDS in West Africa compared to the so-called AIDS belt in Central Africa and also to Southern Africa. Also, Ghana is a donor favorite because of long standing relations with bi-lateral and multi-lateral donors from the developed world. As well, relative political stability in Ghana over the past few decades makes it attractive to donors. And, despite low general rates in Ghana, HIV infection has been on the rise within particular demographics. For instance, prevalence in the 15-24 age groups rose from 1.9% to 2.5 between 2005 and 2006 (NACP, 2007:1). HIV “prevalence rates are most pronounced among the youth, urban dwellers and high risk groups – sex workers, MSM [men who have sex with men]” and people infected with other sexually transmitted diseases (NACP 2007:1). Also, general infection rates have risen from 1.5% in 1986 to a current rate of 3.6 showing a worsening trend across the country. Furthermore, sub-populations in Ghana with higher prevalence than the national average are a reservoir sustaining the epidemic (NACP/GHS/MoH, 2010a:11). In spite of a comparatively low infection rate, Ghana is a good example of donor/government/NGO involvement in the HIV/AIDS area with the potential to offer new theoretical insights into intervention.

The paper is structured as follows. Chapter two provides a background of HIV/AIDS in Ghana and the West African sub-region and discusses how the current policy evolved. Chapter three examines the history of policy making in Ghana in the pre-colonial, colonial and post-colonial periods and discusses Ghanaian society and culture and the development and characteristics of the civil service. Chapter four, which is devoted to the literature review, straddles two bodies of literature; HIV/AIDS literature in political science and development and development aid literature. In chapter five, I describe the research design and method and lay out the framework of my inductive reflective model for policy making, using that model to describe the structure of current HIV policy system in Ghana. The survey findings and framing strategies of stakeholders are the subjects of chapter six. I also use a prescriptive version of the inductive reflexive model to expose weaknesses of the current approach based on the survey and literary data and outline proposals for improvement of the policy model. Finally, in chapter seven I present my conclusions.

Chapter 2: Background of HIV/AIDS in Ghana and the Sub-Region

2.1 HIV/AIDS and Development Aid

The current paradigm of health sector support for poor countries has been in existence since the 1990s evolving out of international health policies as part and parcel of the architecture of international development assistance. However, HIV/AIDS engendered new global health partnerships and models of financing with far-reaching consequences on the health sectors of recipient countries. The *Paris declaration on Aid Effectiveness*, the *Accra Agenda for Action* and the *UN Millennium Declaration* redefined standards and models of donor cooperation with recipient countries and set new targets (DANIDA, 2009:Introduction).

2.2 HIV in Ghana and the West African Sub-Region

Ghana falls outside what in the 1980s was called the AIDS belt in Central Africa and included countries like Zaire, Kenya, Zambia and Uganda. While heterosexual sex is the dominant mode of transmission in sub-Saharan Africa, some key populations, especially MSM, have a higher risk of exposure but are often overlooked by policy makers (UNAIDS, 2009:9). In the 1990s a southward and westward trend was observed in the spread of HIV in Africa. Southern African states affected were Botswana, Malawi, South Africa, Zambia and Zimbabwe. And in West Africa Nigeria, Ghana, La Côte d'Ivoire, Burkina Faso, Togo and Liberia were the most significantly affected (Adjei-Mensah, 2001). Ten million sub-Saharan Africans had died by the end of 1997 and another 20 million were infected (Caldwell, 2000: 129). The US Agency for International Development estimates that by the end of 2004, 404,000 Ghanaians were infected out of a population of twenty one million (USAID, 2004). The early response treated HIV as a medical problem and focused on surveillance, blood screening, safe medical practices and research². That approach was soon found to be inadequate and the focus was expanded to include prevention including social-based approaches like promotion of condom use, peer counseling and media campaigns. HIV has now been broadly re-defined as a socio-economic issue (GAC, 2004b:9).

Ghana has a population growth rate of 1.25%, a total fertility rate of 4.5 children per woman, a life expectancy of 55 years for males and 56 for females and a literacy rate of 74.8% (82% of males and 67% of females). In 2008 the total Ghanaian population was 23,404,686 with a total fertility rate of 4.0. The population is composed of 50 ethnic groups or tribes. One third of Ghana's population is reported to be living below the poverty line. 46% of the population is under the age of 15 and 5% is aged 65 years and above. Citizens in the 10-24 years age range make up more than one third of the population making a large portion of the populace potentially vulnerable to the risks of HIV/AIDS and other sexually transmitted infection (STI). Maternal mortality rate is 214 per 100,000 live births and infant mortality is 64 per 1000 live births. Poor environmental sanitation, poverty, limited access to healthcare, low education standards and poor utilization of services account for the prevalence of preventable disease including malaria and respiratory tract infections which are the most prevalent. (Ghana Health Service /Ministry of Health 2006:14-15)

²This approach was consistent with the first medium term plan of the WHO's Global Programme on AIDS (GAC, 2004b:9).

2.2.1 Early Response

Since the first case of HIV/AIDS in Ghana was recorded in 1986, infection rates have been relatively low compared with other sub-Saharan countries. Some experts believe male circumcision to be a major factor in containing the spread of HIV in Ghana³ (UNAIDS, 2009:vi). Not all cases of HIV infection are reported however, so the low prevalence figures are conservative at best. Victims may not report their infection for various reasons including preference for traditional health remedies, for prayer over hospitals and fear of discrimination and victimization.

The early policy framework established by the government of Ghana was said to be premised on Ghana's 1992 Constitution, the Ghana government's medium term strategy document, Ghana Poverty Reduction Strategy (GPRS), the Revised Population policy (1994) and the UN's Millennium Development Goals (GAC, 2004b:4). The National AIDS/STI Control Programme (NACP) was created after the first reported case in 1986 initially as the National Technical Committee on AIDS. It was renamed the National Advisory Council on HIV in 1987 and eventually became NACP. Since 1987 the NACP had led the health sector's response to HIV/AIDS (NACP/GHS, 2008a:7).

2.2.2 Multi-Sectoral Approach

In 2007 HIV prevalence declined slightly lower than it was in 2005 to 2.6% (Ghana National AIDS Spending Assessment Study, 2007:8). For close to two decades, the HIV Sentinel Survey has been the primary measuring tool for HIV trends in Ghana (NACP/GHS/MOH, 2009:49). Prevalence data from sentinel surveillance has remained fairly stable in Ghana at around 3% since 1992 (UNAIDS, 2009:vi). It is a national survey based on targeting pregnant women attending antenatal clinics. Together with other GHS data and programme data it is used to estimate prevalence rates for Ghana. Prevalence among pregnant women is considered “a good proxy indicator of the spread of the infection among the populace.” (NACP/GHS/MOH, 2010a:9)

In 2000 Ghana adopted the multi-sectoral approach to address HIV/AIDS. The Ghana AIDS Commission (GAC) a 48 member multi-sectoral body was set up by the government of Ghana in 2002⁴ with a broad-based mandate to provide leadership in the national response to HIV/AIDS and to coordinate the wide range of organizations and agencies involved in the program. The commission's work include policy formulation, prioritizing activities relating to the national response, advocating for HIV/AIDS prevention and control, mobilizing and managing resource for the response, promoting cooperation among stakeholders, monitoring and evaluating all activities relating to HIV/AIDS in the country and promoting research on and documentation of the epidemic in Ghana (GAC, 2004a:8).

³There is no evidence of reduction of “transmission to women, or among men who have sex with men” (UNAIDS, 2009).

⁴GAC was setup by an Act of Parliament. Act 613 gave GAC the mission to lead a multi-sectoral HIV/AIDS response (UNAIDS, 2009:5)

A parallel funding instrument GARFUND (Ghana AIDS Response Fund) was established by the government of Ghana with assistance from the World Bank as a funding instrument used by the commission in the execution of its functions. By 2004 the sources of funding for GARFUND were IDA – US\$25m, Government of Ghana - US\$2.7m of which a total of US\$9.173.091 was disbursed (GAC, 2004a:47). GAC developed annual programmes of work (POW) for 2006 and 2007 which defined strategic objectives, activities and expected results from the implementing partners (Ghana 2007 Progress Report on Universal Access:3) being mainly NGOs and CBOs (Community-Based Organizations). The POWs set the target⁵ of 70% Universal Access for those in need by 2010. In 2009 the focus GAC's POW drew on the aims of the Ghana Growth and Poverty Reduction Strategy 2006-2010, Universal Access to Prevention, treatment, Care and Support by 2010 and achievement of the Millennium Development Goals by 2015 (GAC, 2009:1).

2.2.3 Treatment/Anti-Retroviral Therapies (ART)⁶

Antiretroviral therapies (ART) are a combination of drugs that slows down the multiplication of the HIV virus and thereby reduces its ability to attack a person's immune system⁷. ART started in Ghana in 2001 in a USAID funded Family Health International (FHI) Support Treatment and Antiretroviral Therapy Programme (START) at two sites in the Eastern Region of Ghana (NACP, 2007:8). That same year the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) started supporting the Ghanaian response by providing funding to support the fight against HIV, Tuberculosis and Malaria (GHS/MOH, 2006:20). Round I, Phase I of the Global Fund support procured ART drugs for 2000 PLHIV (Persons Living with HIV/AIDS) over a two year period (NACP, 2007:9). The Global Fund has since become the main funding source for ART in Ghana.

The START programme was the basis of expansion of ART across the country. As at 2005 there were only 4 or 5 treatment centers. By 2007, 11% of children and 16% of adults that needed ART had been placed on the drug therapy - a total increase of 63.6% (Ghana 2007 Progress Report on Universal Access:2) The plan was to scale up ART service to all 138 districts in the country by 2010 (GHS/MoH, 2006:10). By June 2009 there were 110 ART service locations in 79 districts in Ghana with a total of 18,032 clients (GAC, 2009:13). Even though HIV service coverage more than doubled in that period, a 2008 report showed that it covered just over 50% of need (NACP/GHSa, 2008:6). Both inadequate access and low uptake of services are blamed for the low coverage (Ghana 2007 Progress Report on Universal Access:25)

⁵National targets for HIV/AIDS was developed by a team made up of representatives from GAC, NACP, WHO, DFID, NAP+, UNAIDS and GBCA) in 2006 (Ghana 2007 Progress Report on Universal Access:5)

⁶Antiretroviral therapies are drug cocktails that reduce HIV viral replication in patients and boost their CD4 cell count.

⁷The strengthened immune system is thereby better able to protect from opportunistic infections like tuberculosis (TB). Out of 11,500 new TB cases in Ghana in 2000, 14% are suspected to have resulted from HIV (Ghana AIDS Commission, 2004b:2)

UNAIDS estimates that 67% of the global total of HIV cases live in sub-Saharan Africa and almost one third of all new cases and AIDS-related deaths world-wide occur in the same region (UNAIDS, 2009:7). The same report shows that HIV is not homogenous in Africa. Initial skepticism that Africans may not be ready for ART because of the complexity of following the drug regimen have not materialized. Indeed the level of resistance to ART has been low. On the contrary, in places like Ghana, it has brought hope to thousands of persons infected with the virus. Some very sick people have had their fortunes reversed and been nursed back to health through the use of ART and this has been good promotion for treatment services. Currently, there is awareness among PLHIV in Ghana that if patients remain faithful to their ART prescriptions and observe some basic principles of personal care then they will be fine. The greatest challenge for scaling up ART services is in getting the needed finances and human capacity (Ghana National AIDS Spending Assessment Study, 2007).

Chapter 3: Background to the History of Public Policy in Ghana

3.1 Geography

By African standards Ghana is a small country located on the West Coast of Africa bordering three former French colonies: La Côte d'Ivoire to the west, Burkina Faso to the north and Togo to the east. She is bordered on the south by 544 kilometers of Atlantic coastline (The Gulf of Guinea). Ghana covers an area of 238, 538 square kilometers extending 675 kilometers inland from the coast between latitudes 11o11' North, longitudes 1o11' East and 3o15' West. As a result, she lies in close proximity to both the Greenwich Meridian, which passes through the country in the port city of Tema, and the Equator. This location has an important influence on Ghana's climate which is characterized by relatively high temperatures throughout the year. The mean monthly temperature is as high as 24.50 degrees Celsius.

3.2 Early History

Ghana's initial contact with the west may be attributed to the maritime revolution that made extensive sea travel possible, and the country's cache of gold that attracted one European country after another. Portuguese traders in 1482 initiated direct European trade with West Africa by sea. Discovery of the New World and the plantation system for sugar, cotton and tobacco created a high demand for labor and in the mid-1600s and 1700s. Ghana contributed around 10,000 slaves each year until her contribution eventually declined as the focus of the trade shifted further east of the continent. As a centre for the slave trade, Ghana changed hands repeatedly between the Dutch, English, French and Danes.

Ghana's economic history as a minerals exporter⁸ is reflected in her colonial name *The Gold Coast* which was changed to *Ghana* at independence in 1957. Presently, however the economy is dominated by the agricultural sector which employs 60% of the labor force. The industrial sector employs 15% and service sector employs 25%. Recent off-shore discovery of crude oil in Ghana has made the oil industry is one of the fastest growing in the country.

⁸The country has considerable mineral resources including of gold, diamonds, bauxite and manganese.

3.3 Pre-colonial Society

Pre-colonial social and economic formations are essential to an understanding of rural production in Ghana and the social stratifications and class relationships they gave rise to as they contrast sharply with the capitalist 'mode of production' and the use of rural (peasant) labor within that system.

Pre-capitalist African societies were essentially of a tribal or tribo-pariarchal type that exhibited tendencies towards development of a class society. In Ghana this was more evident in some tribes than in others. Villages were formed when the families of the first occupants of a piece of land began to levy tributes on incoming families and took up religious and other responsibilities. Even prisoners of war were incorporated into families. The system was more egalitarian as classes were not truly formed. But the seeds of a class system existed due to the extraction of levies and domination of other village communities through conquest. (Gakou, 1987:24.) This tribo-pariarchal system was dominant in all political formations of pre-colonial Ghana or the *Gold Coast and Ashanti* as the colony eventually became (Howard, 1980:63). The Ashanti nation in particular seems representative of this type of social organization.

For economic reasons and for reasons aligned with the West's own experience with an agrarian past, western colonizers looked upon African subsistence production as "backward" and "primitive" (Keesing, 1990, 65). The perception of traditional institutions and forms of organization as abstract entities rather than important social contexts in which people live and societies are organized is a prevalent feature of development scholarship. Also, subsistence production did not favor the colonial objective of economic exploitation so the British colonial system attempted to deconstruct the traditional production system and accompanying knowledge and value systems in Ghana. The colonial state heralded and took part in the destruction of the Ghana's pre-colonial natural economy.

3.4 The Colonial State

Full colonial status under Britain was established in 1874. Stubborn opposition to British domination put up, especially by the Ashanti⁹, gave strong impetus to the colonial desire to assimilate the country culturally, politically and economically. This desire was eventually manifested through the establishment of administrative machinery of control that facilitated colonial exploitation and prepared the country as a feed belt for the British economy. Export agriculture based primarily on the cocoa bean became an essential aspect of the colonial economy.

Direct colonial rule marked a 'qualitative historical leap' in the process of the penetration of commodity relations and the destruction of the natural economy. It was a question of how capital could exploit African land and labor which necessitated "breaking the reproduction cycle of various systems of natural economy". The break-up had two aspects namely the

⁹The Ashanti from the forest region of Ghana is made up of tribes sharing Akan language and religion. United in a powerful and militant confederacy they resisted the imposition of colonial rule throughout the nineteenth century and have since played an important role in Ghana's history.

withdrawal of labor from use value production as in agriculture, artisanship and animal husbandry and monetization of the production environment which 'forces' the transformation of rural producers into commodity producers (Bernstein, 1979:423-424).

Cash crop production had three interests operating in its supply, the colonial state which sought to increase its revenues and finance infrastructural costs and contribute to the imperial investments fund, metropolitan interest groups that consumed the product, and the large European trading companies that organized collection and export of crops. Skeptical of the reliability of peasants to ensure supply (quantitatively and qualitatively), they intervened in the conditions of production by establishing regulation about what is grown and how, as well as implement monopolistic pricing and management systems. The Gold Coast Government Board was prominent in the export of cocoa during the Second World War banking the proceeds in Britain.

Against these interests unorganized cocoa producing peasants seemed powerless to act. However cocoa production ultimately remained in local hands because after trying unsuccessfully to produce cocoa on a competitive basis with the Ghanaian cocoa farmers, British cocoa merchants retired to the coasts and left the Africans to clear, plant and pluck cocoa as well as to organize the marketing. Under the control of small-scale farmers, cocoa production shot up from 13 tons in 1895 40,000 tons by 1911 aided by the Cadbury Company's decision to buy cocoa from the Gold Coast.

The literature on social theory shows a divide between theorists who concentrate their analysis on structural issues and those who subscribe to human agency perspectives. The actor-oriented model belongs to the latter perspective. It emphasizes the creative ability of individuals and the differing contexts in which social action takes place, in contrast to the structuralist view which implies a commonality of the historical and contemporary contexts within which people labor (Drinkwater, 1992, 370).

Linked to the idea of social actor is the concept of *agency*, in which the individual actor is seen to possess social experience to cope cognitively and organizationally with life, in spite of uncertainty and constraint. Thus social actors are 'knowledgeable' and 'capable' (Long, 1992, 22). However, 'knowledgeability' and 'capability' are not universally determined but culturally specific, inevitably linked to the cultural makeup and rationality within which they develop. This kind of analysis is aimed at distinguishing strategies and rationales of different actors and characterizing their differing constructions of reality and their efficacy as problem solving mechanisms.

Responding to the challenge of production by focusing on the agency of local Ghanaian farmers as the basis of transformation implies recognition of the legitimacy of indigenous capacities and an acceptance that even externally planned interventions can involve initiation of change 'from below' through initiative from the grassroots. It also implies deconstruction of theoretical orthodoxies perceiving local cocoa farmers as backward. It is consistent with Long's actor approach which conceptualizes development on the basis of the eve-

ryday life experiences and of consciousness of ordinary people and emphasizes the strategies, rationalities and life worlds of various actors. It is recognition of the role of human agency and the existence of structural discontinuities in the 'critical points of intersection' or social interfaces where cultures intersect.

The concept of empowerment, having been associated with the neo-populist discourse favoring participatory approaches, has been stigmatized by notions of *more knowledgeable and powerful outsiders* intervening on behalf of *powerless locals*. The cocoa policy under the Gold Coast's colonial government shows that even in highly subordinated positions all actors exercise power which can be harnessed towards productive ends. That possibility emerges when actors operate in institutional structures and processes based on a prevailing policy discourse that is not restrictive of their social space for behavioral choice. It is, in a sense, a rejection of the conceptual polarization of traditional and modern methods of production. Rather than think of modern and traditional knowledge as ideal typical types they are conceptualized as mutually complementary. They are not pure and static forms because in real life they are processes that are in constant motion and converge quite frequently; in the same way that interface situations involve the intersection of opposing sets of values and interests that interact and negotiate to accommodate each other.

Rejecting of the polar treatment of modern and traditional knowledge is consistent with conceptualizing technology as a multi-dimension processes. In Ghanaian agriculture, methods derived from science-based knowledge are combined with more predominant techniques structured by practico-empirical experience. Both play a role in technical development of farming as they represent different sources of technology that may indeed have some common elements. The importance of deconstructing the terminological dichotomy in the policy framework is that it helps cultivate mutual respect and support as well as fruitful negotiation where there is an overlap of interpretative possibilities. Dichotomizing technologies implies isolating and ignoring some basic factors in many productive systems. In the developing world it often means allowing problem-solving to give way to highly abstract criteria for decision-making.

Purely technical models of technology transfer ignore the role of human agency and the different world views and resource utilization capacities. It is always problematic to determine the value of imported technologies relative to indigenous know-how. Often what may seem an advanced method, technique or tool may be destructive in ways not always easy to perceive. The trial and error and observation involved in traditional practices provide local farmers an opportunity to discover what is beneficial and harmful to them and to their livelihoods. New technologies may have eventual deleterious consequences especially where the context of innovation differs radically. What emerges from this perspective is the recognition of the value of 'cultural cross-breeding' by which different technologies are seen as the manifestation of specific values. Human consciousness and human agency then become focal points at which the materiality and ideality of technologies cross. Swantz (1989:121-2) suggests that the mental, material and institutional aspects of technology are all directly linked with society and imported technologies are accompanied by social carriers that

change the cultural mode of the host society and influence the process of adaptation. In transfer situations these different factors engender either a restructuring of society or cause conflict and distortions.

It has been said that the assumption by Marxist scholars that peasantries are reluctantly coerced into cash-based production for the world market is not borne out in the Ghanaian situation where “the consistent pattern was that entrepreneurial peasants were producing cash crops in response to world market demand before the colonial state” got involved in cash crop activity (Howard, 1980:69). But initial voluntary integration into the world market generates cash needs which then ‘coerce’ the peasant, by his integration, into a state of perpetual production of cash crops (Howard, 1980: 66).

The structure of the colonial economy did not attract capital necessary for the creation of processing industries, as raw material export was the norm. A more overt transfer of resource to Britain was represented in the activities of the marketing boards¹⁰ which accumulated proceeds from the export of commodities and sent off large portions of it to London to be held as sterling balances¹¹. Before 1958 Ghana was, among the colonies, the largest provider of capital to Britain except for Malaya (Fitch & Oppenheimer, 1966:43-45).¹²

Colonial economics thus had one characteristic feature; trading patterns and investment policies were directed to satisfying the economic demands of Great Britain for raw materials and opening up colonial markets to English manufactured goods. Even public enterprise investments were targeted at areas ancillary to the export sector.¹³

3.5 The Post-Colonial State

Ghana was not just the first black African country to attain independence from colonial rule, she was the most affluent and first to embark on an ambitious industrialization-based development programme. She was also among the first casualties of that kind of development

¹⁰The idea of marketing boards for raw material exports was meant to stabilize producer prices to counter instability in world market prices. In Ghana however they became a means of extracting a surplus from cocoa, and other raw material, production rather than a buffer against price fluctuations.

¹¹Sterling balances were long term investments in British government securities with very low interest rates (0.5% before 1950 and 2% to 4% after 1952). In the post-war period sterling balances accumulated from the colonies showed an upwards trend until after 1957 when Britain overcame her sterling crisis through reliance on United States loans (Fitch & Oppenheimer, 1966:44-45).

¹²The 1940s towards 1960s were periods of high economic dynamism for the colonies both in terms of their increasing sophistication as markets and their contribution to foreign capital flow. The granting of independence in this period is considered to have little to do with economic rationality or calculation. It is rather seen as based on the desire to avoid the diverse and growing responsibilities and liabilities (Fieldhouse, 1986:231-232).a

¹³“Thus pride of place was given to the development of a good railway system... [t]he other project which featured prominently in the plan was the development of harbours... railway development was concentrated in the cocoa growing areas of the Central Province. Without underrating the benefits of these plans to the Gold Coast, it must be admitted that they served the immediate interests of foreign commercial firms” (Armah, 1987:52).

strategy in Africa. Theoretically and practically, Ghana at independence had so much economic promise that she gained attention from internationally renowned economists some of whom served as advisors to Kwame Nkrumah, the country's first president, on the country's early development plans. Notable among them was W. A. Lewis whose *Report on the Industrialization of the Gold Coast* became the blueprint for development strategy in early years of independence. Unlike other developing states, Ghana had extensive cash reserves and high GDP and per capita income growth.

Different explanations have been advanced for Ghana's development failure despite the high early prospects. They include the inapplicability of the policy framework established by the Nkrumah regime, inefficiency of the system of governance and the development of vested interests that influence government policy. Some scholars extend the argument further by advancing a 'classes against masses' explanation that begins with the 'construction of revenue imperative' at independence by which the elite extracted resources from the only readily available source, agriculture to finance their proposed modern sectors (Fieldhouse, 1986:95).

The post-colonial state did not see the institutions left by the departing British as obstacles to national economic development. Rather there has been an attempt to stimulate growth within the old economic structures in the belief that to achieve growth, institutions established under colonialism needed only to be administered by Africans. The infrastructural base inherited at independence coincided with foreign-oriented needs. In the immediate post-independence period not only did the foreign trade structure by which raw materials were exported and manufactured goods imported persist but, as in colonial trade, profits were sent out of the country rather than reinvested locally. Also, the colonial educational system and civil service structure were largely maintained.

Moreover, since the early days of nationhood state institutions in Ghana have experienced a decline in administrative effectiveness and policy implementation due to inefficient and ineffective government and corruption exacerbated by inadequate technical know-how, shortage of capital and poor infrastructural development and maintenance. That state of affairs translates into gapping inequalities, regional disparities and the neglect of some sectors in favor of others. Administrative malfunction has been rampant and charges of corruption have been frequent. There has been such a high tendency for political functionaries in Ghana to seek the greatest financial self-aggrandizement possible. Indeed corruption has been offered as one explanation of Ghana's incapacitation.

3.6 Society and Politics in Ghana

Following independence from British colonial rule in 1957 Ghana became a republic in 1960 with Kwame Nkrumah as its first prime minister. Under Nkrumah's leadership Ghana spearheaded the movement for political liberation of other African countries still under colonial domination and championed the cause of advancement on the continent. That movement eventually led to the creation of the Organization of African Unity (OAU), predecessor of the present African Union (AU). Politically Ghana is one of the most

advanced countries in sub-Saharan African with a thriving democracy based on a multi-party system. The current governmental structure includes a president, elected in a general election which also selects representatives for a unicameral legislature (Parliament) and an independent judiciary headed by the Supreme Court.

The country is predominantly rural with an economy dominated by agriculture which employs around 60 percent of the working population. Rural farming communities in the country are generally based on traditional forms of organization that tend to emphasize community life, co-operation and solidarity among community members. The hard labor involved in rural life elevates solidarity to a moral status to emphasize unity in the face of the harsh realities of everyday life, and the weakness of isolated individuals. The basic social values are seen as life, survival and continuity. Productivity is a combination of cultural creativity and economic productivity which may have a familial, social, political or religious orientation.

For Ghanaians the destruction of the natural economy and its culture of production effected by the colonial state, the monetization of elements of production and the dependence on commodities marked a radical departure from the traditional production and exchange system. The market system was the principal means by which this transformation was made. The end result was the creation of a peripheral economy heavily dependent on the import-export trade through intensive production of cash crops and minerals for the international world market. (Howard, 1980:59).

Ghana's post-colonial economy is built on the foundation laid by colonial economy. The dependence on the raw material exports is compounded by growing levels of consumption and falling production levels. The growth rate of consumption since independence has been consistently greater than domestic production. In 1987 private consumption alone was 87 percent of GDP which was 10 percent higher than the regional average (Hodd, 1991:157).

Ghana is still a leading export of cocoa and an important export of gold and lumber. In 2010 she became Africa's newest oil exporter with production expected to rise to 500,000 barrels a day by 2015.

3.6.1 Superstition in Ghanaian Culture

Ghana's rural culture is based on a moral order that is rooted in custom and tradition that give meaning to various aspects of life according to norms and values. Ghanaians mark various occasions with rituals that reflect and emphasize such norms and values. With movement of populations to urban centers many beliefs and practices that may have been formed in the rural culture accompany migrants to towns and cities. Belief in deities and ancestors is widespread in both urban and rural communities of Ghana. Most Ghanaians believe that life generally, is influenced not only by natural but also supernatural factors some of which are beyond human control. As a result, many culturally defined rituals, reflecting promotional, protective and prohibitional values aim, at least in part, to appease local gods or deities and ancestors who are believed to have the power to influence the progress of people's

lives.

Belief in witchcraft and sorcery is not only central to the social fabric of many African societies but also in conceptions of disease causation and illness. It is a paradigm that feeds into the notion of HIV as the cause of supernatural forces beyond human control. It has been suggested that such local beliefs should be considered in the design of HIV intervention programmes. (Tenkorang et al, 2011:1002) Societies develop an internal logic for explaining events and through such beliefs and practices people develop a meaning of life befitting the universe within which they live. Witchcraft is an easy explanation especially for events deemed unexplainable, particularly when they involve misfortune. Ghanaians across different ethnic groups tend to think of disease and illness as the physical results of the work of witches in the spiritual realm. “With increasing modernization and the associated scientific breakthroughs in public health and medicine, one would think that the African's conception of disease causation may change, but recent evidence suggests that traditional beliefs and superstitions persist” (ibid).

Belief in witchcraft undermines the drive to promote AIDS prevention using behavior change communication and behavior change models. Belief in the supernatural causation of AIDS makes people less inclined to believe that they can influence their own destinies through the behavior choices they make. Tenkorang et al. found an association between belief that witches can cause HIV infection and risky behaviors among never-married Ghanaian men and women (ibid:1009). Since local beliefs vary from region to region, they argue in favor of a policy approach that not only pushes prevention programmes but also take into account those local beliefs that undermine prevention messages.

Increasing number of churches has not stemmed superstitious beliefs among their membership. It is common knowledge the many Ghanaian Christians practice the worship of deities and local gods on the side. In regards to HIV, pronouncements by both Christian and Muslim leaders seem to aggravate negative mind-set about the disease rather than promote attitudes more favorable to public policy aimed at addressing the problem.

3.6.2 Politics

Ghana went through a turbulent political history in the early stages of nationhood including six military regimes and four democratic experiments. Since the 1950s political parties have been an important part of the political landscape. Between 1954 and 1957 eight political parties were formed to take part in the independence struggle against British colonial rule. At the end of the military regime that overthrew Nkrumah's government, around 12 political parties joined the effort to restore democratic rule in the second republic (1969-1972). Eleven parties emerged in 1979 to participate once again in the restoration of democratic rule in the third republic but by 1981 that number had simmered down to 6 political parties (Ninsin, 2006:3). Two parties the National Patriotic Party (NPP), from what is known in Ghanaian politics as the Busia/Danquah political tradition and the National Democratic Congress (NDC) formed by the former (two-time) military leader Jerry

Rawlings have dominated elections since the 1980s. Governance has alternated between these two stable political parties over the past 30 years.

In 1960 the first post-independence republic was established as a presidential system. Dr Nkrumah's Convention People's Party (CPP) created a socialist single-party system and dominated the political scene. The main opposition party, the Ashanti-based United Party (UP), an amalgamation of several opposition parties, kicked hard against the CPP's single-party rule and other centralizing policies. In 1966 the first republican government was overthrown by a joint military and police coup which led to the creation of a National Liberation Council (NLC) led by Lt. General Joseph Ankrah. However, a palace coup in 1969 saw the removal of Ankrah from office and his replacement by Lt. General Akwasi Amankwa Afrifa as chairman of the NLC. The NLC leadership transitioned into a three-man Presidential Commission which paved the way for the second republic later in 1969 when the Progress Party (PP) led by Dr Kofi Abrefa Busia won general elections. The PP was generally perceived as a party dominated by people of the Akan ethnic group and made up of former officials of the opposition UP which was pushed underground by Nkrumah's single party system and Acts of parliament passed to ban political opposition in the first republic.

The second republic was an executive system with Busia as Prime Minister and Edward Akufo Addo as ceremonial president. Busia's government was short-lived because in 1972 the Ghana Armed Forces led by Colonel (later General) Ignatius Kutu Acheampong again seized power and formed a National Redemption Council (NRC) which later became the Supreme Military Council (SMC). Another palace coup in 1978 saw General Acheampong replaced by General F.W.K Akuffo.

On June 4th 1979 a mass revolt of junior military officers removed the SMC from power and established an Armed Forces Revolutionary Council (AFRC) chaired by Flight Lieutenant Jerry John Rawlings. The AFRC embarked on what it called a "house-cleaning exercise" against corruption ostensibly aimed at restoring morality and accountability in public life. After a mere three months in office the AFRC organized general elections which ushered in Ghana's third republic on 24th September 1979 and the civilian government of Dr Hilla Limann leader of the People's National Party (PNP). Limann's third republican government was a presidential system with an executive president.

Like the second republic, Ghana's third republic was also short-lived as Limann's government was overthrown on 31st December 1981 by a military takeover again led by Flight Lieutenant Jerry John Rawlings as Chairman of the Provisional National Defense Council (PNDC). Rawlings and the PNDC insisted that the "revolution" was the result of failed leadership from Limann and the PNP and collapse of the economy and state services. A "holy war" was declared on political institutions supposedly to streamline the political systems, revive the economy and establish genuine democracy based on Ghanaian ideals and traditions. A National Commission for Democracy (NCD) was set up and tasked to plan

the political future of Ghana. The PNDC also created District Assemblies of elected officials to decentralize government to the grassroots level.

Under a new democratic constitution which calls for an executive president chosen by universal adult suffrage, Ghana's fourth republic was ushered in by multi-party elections in 1992. The former military leader Jerry Rawlings (of the NDC) won and was re-elected in 1996 to a second four-year term. In 2000 John Agyekum Kufour of the opposition National Patriotic Party won election and became president. He was re-elected in 2004 to a second term which ended in 2008 when John Atta-Mills of the opposition NDC and a former vice-president under the Rawlings government won elections to become president.

The political history of Ghana's fourth republic shows that in the past 20 years presidential leadership has changed hands from incumbent to opposition party in three out of four very competitive elections with a smooth transition of government in all three cases. That is a sharp departure from what usually pertains in African countries which have acquired a reputation for electoral violence and rigged elections. It also reflects the domination of the political scene by two political traditions. On one hand the Busia-Danquah faction of the NPP which is the modern descendant of the Akan-based United Party (UP) of the Nkrumah era and the Progress Party of Dr Busia in the second republic, and on the other hand the NDC formed by the former military leader turned civilian Jerry Rawlings, who has been Ghana's longest serving leader counting eleven years of military rule and two four-year presidential terms. While the NPP is considered an Akan, especially Ashanti, party the NDC is widely perceived to be dominated by people of the Rawlings' ewe ethnic group from the Volta Region bordering Togo in the east of the country.

3.6.3 Ethnicity in Politics

In the African context, ethnicity is often discussed in conjunction with political conflicts often, but not always, involving violence. Arthur notes that prior to colonization Africans "belonged simultaneously to a multiplicity of social networks: nuclear and extended families, lineages, age sets, religious secret societies, village communities and chiefdoms. As a result, individuals' identities and loyalties were multiple, crosscutting, complex, malleable, and in some instances overlapping and complimentary. The consequence was that individuals did not consider themselves as belonging to a particular ethnic group." (Arthur, 2009:48) In the case of Ghana it is hard to gauge the effect of ethnicity on electoral outcomes. Arthur makes the case that the notion of ethnicity being a dominant influence in Ghana politics has been, at best, checkered and not been a subject of extensive scholarly inquiry since 1992. Despite a general perception that electoral outcomes in Ghana's Fourth Republic have been influenced by ethnic undercurrents, little comparative research has been done on voting patterns across different elections since 1992.

The British colonial policy of indirect rule developed in parts of Africa, including Ghana, entrusted the administration of particular localities to traditional leaders as a way to allow few British colonial officials the ability to oversee extensive territories and populations working through native leaders. This colonial policy destabilized social networks already in

existence through by creating new ethnic groups and delineating of new ethnic boundaries.¹⁴ The construction of African ethnicity was further promoted and aided by “Christian mission and mission education that created standardized print version of ‘tribal’ languages from related vernacular dialects, created a literature intelligentsia, and, with translations of the bible, provided them with potent literary sources for imagining of ethnic history and culture” (Arthur, 2009:48).

With independence and the introduction of electoral politics in Ghana, ethnic identity has become a vehicle for political elites to mobilize voters to their course. As a result of this trend parties became affiliated to particular regions of the country. The two dominant parties in the electoral system in the Fourth Republic are both associated with particular regional and ethnic identities. Regional categorization also has a basis in disparities among the regions. One important factor that underlines the influence of ethnicity in Ghana politics is the role that Northerners play in the political landscape. This factor is related to the level of under-development in the Northern regions compared to the south. Stark regional variations in the wealth and welfare of citizens between the northern and southern regions of Ghana are a colonial heritage.

The British colonial government produced an unequal system by which the northern regions lagged far behind the south in terms of development and economic and social well-being of citizens. This has translated into gapping inequality, regional disparity and the neglect of some sectors in favor of others. The northern regions (comprising Northern, Upper East and Upper West regions) are least developed both because of disparities in resource endowments, ecological conditions, a poor human resource base, a land-locked position and lack of policy initiative to promote development. Post-independence governments have all paid lip-service to development of the northern sector of the country but have done little in terms of deliberate effort and the north south gap has not been systematically addressed.

Due to the disadvantaged condition of northern regions, major political parties try to win votes in those regions by selecting vice-presidential candidates who hail from that part of the country. The majority of vice-presidential candidates of the major parties in the Fourth Republic have been natives from the Northern, Upper East or Upper West Regions. Nevertheless it is still problematic to read ethnicity into regional disparities since no one region in Ghana is ethnically homogenous even though individual ethnic groups may dominate particular administrative regions. The Akan people comprising a large range of ethnic groups (including Asante, Fanti, Brono, Akyem, Akwapim, Denkyira and Nzema) can be found in the Central, Eastern, Ashanti, Brong Ahafo and Western regions. Whereas the Mole-Dagbani (including Dagomba, Nanumba, Dagarti, Frafra and Mamprusi) are concentrated in Upper East, Upper West and Northern regions and the Eve live mostly in the Volta regions with pockets of them spread out through the rest of the country. (Arthur, 2009:51).

¹⁴ Where no traditional leaders/authorities could be found, the British simply elected one.

Also, Ghana's fourth republic constitution actually bars formation of ethnically based political parties. It requires that "every political party shall have a national character, and membership shall not be based on ethnic, religious, regional or other sectional divisions... [and] internal organization of a political party shall conform to democratic principle" (The Constitution of the Republic of Ghana Article 55 Chapter 7). Still the argument that Ghanaians tend to vote along ethnic lines is supported by results of presidential elections from 1992 to 2008 which show that the NPP draws most of its support from the Ashanti region while the NDC does very well in the Volta Region (Arthur, 2009:53). A common explanation of this voting trend is that post-colonial political leaders have exploited ethnic rivalries to advance their own interests. While there may be truth to that assertion, I am inclined to agree with Arthur's contention that while ethnic-based voting patterns are clearly in existence, several other variables interact to influence voting trends in Ghana including economic factors, effectiveness of political campaigns, and perceptions of corruption. (ibid:45) So, while ethnicity and tribalism are important factors in Ghanaian politics, it is easy to exaggerate their importance to electoral outcomes.

In HIV/AIDS literature ethnicity has been suggested as an important determinant of how governments respond to the disease. In his insightful book *Boundaries of Contagion: how ethnic politics have shaped government response to AIDS* Lieberman (2009) suggests that the nature of government response to the epidemic is dependent on the strength of ethnic boundaries within the country. He found that in countries with strong ethnic boundaries fragmenting society into groups, government response to the epidemic has been less aggressive. In this study I found no evidence to suggest that government response to AIDS in Ghana is mediated by the salience of ethnic boundaries. Rather disparity has followed the same lines as economic and social prosperity within the regions of the country. Those regions that have the best health care facilities have benefited the most because treatment of HIV/AIDS in Ghana has been mostly hospital-based. Perhaps this lends support to the argument that ethnic competition among Ghanaians is at best weak and the influence of ethnicity on politics and policymaking even weaker.

Beyond sheer tribalism, which derives essentially from ethnic rivalry, there has been a 'tug of war' of between populist and elitist strains of Ghanaian society. The rivalry between these two broad categories of social forces was born with the rivalry of political movements during the independence struggle and is a dominant theme of contemporary Ghanaian politics.

3.6.4 Elitism

While ethnic conflicts have at times characterized the Ghanaian political scene, in class terms, stratification is based more on economic position than on ethnic prerogative.¹⁵ If regional disparities in Ghana are a colonial heritage, the same cannot be said of class differentiation. Various pre-colonial Ghanaian ethnic groups displayed class structures. The Ashanti

¹⁵Fitch & Oppenheimer (1966:4) contend that western observers of Ghanaian politics tend to over emphasize the tribal factor and "conjure up pictures of political battles decided by painted warriors", while in reality over 85% of Ghanaian people are involved in the money economy.

nation for instance was led from village patriarchies into statehood by the emergence of privileged aristocracies.

At independence the professional-commercial strata that had operated in the orbit of the colonial state occupied all major economic positions. Since then there has been a perennial conflict between privileged and under-privileged sections of Ghanaian society. In the immediate independence period, clearly delineated networks of corporate groups, social formations and community-based structures crystallized and entrenched their positions. The conflicts that emerged were a recurring theme of Nkrumah's CPP administration (Pellow & Chazan, 1986:45).

The concepts of class and class struggle are rarely applied to African societies but this by no means implies social homogeneity of African populations. Since independence, Ghanaian politics has been dominated by elites comprised of well-off and highly educated business and professional people and senior military and police officers. It is the same class of elites that led the independence movement and were girded by their symbiotic relationship with the colonial administration and their conception of themselves as cultural mediators between the British and traditional rulers and as heirs-apparent to British colonial rule.

Economic class often correlates to education as education opens an avenue for highly paid European-type occupations that clearly delineate occupational lines of division. As one author notes, it is a continuation of the colonial system with elite Africans taking the place of the departed Europeans.

An enormous gap exists between the masses of low-paid workers and the elite stratum of politicians and senior civil servants. From 1968 to 1971, the differential between the highest- and lowest-paid employees in government service was in the proportion of 39:1. And the relative distribution of income has deteriorated badly; in 1965, the upper 6 percent of earners accounted for 12.9 percent of Ghana's total national income, whereas by 1968, the upper 4.6 percent accounted for 24.7 percent of the total... . The urban workers are physically segregated from those who control them-expatriates and Ghanaian professionals, politicians, business people, and the like, whose own surroundings present a stark contrast. Thus the colonial system is perpetuated (Pellow & Chazan, 1986:103-105).

Besides the commercial/professional class there is the class of the low-level employees in the civil and public services, urban dwellers, traders and middle school leavers, whose political support was obtained by the commercial/professional strata for the independence struggle. The nationalist movement brought these groups together despite latent contradictions among them. When the excitement of self-government receded and independence was taken for granted, various private, sectional, regional and tribal interests were reasserted.

The effect of that has been rising inequality due to the emergence of a class system based on inequity in the distribution and use of national resources. As in many African countries, the state in Ghana has become a symbol representing those narrow class interests. Ghana has however made progress in fighting poverty. The percentage of the population estimated to live below the poverty belt dropped from 51 percent in the 1990s to 28.5 percent in the mid

2000s.

3.7 The State Bureaucracy

Administrative ability is not a dominant feature of the post-colonial Ghanaian state bureaucracy and certainly that ineffectiveness seems to have been replicated at the lower levels of public administration. Also the interests of the ruling class do not often coincide with the needs of the most productive sectors of the economy so policies are often motivated by political rather than economic considerations.

The efficiency of the public service in Ghana is compromised by low supply of skilled labor that has been on the decline as the population has grown and the economic travail has engendered a massive brain drain. Rising levels of public employment in a state of falling output has caused a serious strain on government expenditure and resulted in a significant drop in productivity levels. Consequently the state has been unsuccessful in pushing for increased productivity and effective utilization of the work potential as unemployment and underemployment, especially in urban areas, has grown. Thus one of the paradoxes of the Ghanaian labor scene is that even in the face of severe labor shortages there is a high rate of unemployment.

Weak administrative effectiveness in policy implementation is exacerbated by inadequate technical know-how, shortage of capital, poor infrastructural development and maintenance. Significantly, the lowest levels of productivity have occurred in those sectors closely allied to the state nexus. Studies of labor productivity of state-owned establishments are not common in Ghana but one study in the period of high public sector employment in the first republic showed publicly owned industrial enterprises to have productivity levels well below their counterparts in the private sector (Fitch & Oppenheimer, 1966:118). Fiscal policy has been characterized by a trend of increasing government expenditure derived from rising demand for imported consumer goods and industrial material without a balancing increase in revenue. For many years government receipts relied heavily on cocoa and tended to rise or drop following the fortunes of cocoa on the world market. Low indigenous sources of capital leading to fluctuating revenues and coupled with heavy expenditures have resulted in budget deficits that have led to heavy borrowing.

Despite minor changes to the state bureaucracy at independence major national level institutions have maintained their original colonial structure including legislative and administrative agencies, the police service, the armed forces and public-funded universities. Price suggests that due to persistence of those colonial structures many national institutions of the post-colonial states can be considered as exogenous to those states rather than being institutions that have developed over lengthy periods of social change. "They are emulative of the organizations found in the highly industrial countries, and have been set up to fulfill similar functional needs" (Price, 1974:24). In areas like traditional Africa where "society is organized on the basis of corporate groups, social and political rights, obligations, and identities reside in the group, not, as in the contemporary West in the individual. Society is perceived by its members as a collectivity of groups; individuals are viewed as extensions

of the corporate groups – they have no autonomous existence and identity outside of their group membership.” (ibid:26)

The scale of the task of promoting social change at the end of colonial rule in Africa required complex governmental administrative institutions to steer states in the direction of economic progress so the fortunes of the state were tied to those institutions whose operations and effectiveness determine the ability of ex-colonies to “translate economic development goals into reality” (Price, 1975:2). In Ghana the early strategy of economic development made it necessary to rely on public bureaucracies for the management of state-owned and state-run enterprises, “but the coordination and control demanded by such a strategy never materialized. State-run corporations, plagued by corruption, mismanagement, and a shortage of raw materials and spare parts, operated at a fraction of capacity, failed to show a return on the public capital invested in them, and often required further government subsidies just to remain in operation” (ibid:5). Those early problems of public administration have endured over 55 years of self government.

Presidential leadership in Ghana’s first post-independence government routinized the charisma¹⁶ of the leader and moved towards centralization of the management of public affairs as part of the effort to “modernize” the country. The practical effect of charismatic leadership of the bureaucracy was that the personal power of Dr Nkrumah made the selection of public officials less based on actual competence than on their loyalty to the leader. This led to clashes within the bureaucracy pitting Nkrumah’s appointees against members of the professional civil service created under the British colonial system. “This strenuous relationship existed in Ghana with a variety of class and historical factors exacerbating the difficulties.” (Tiger, 1966:17)

Like Nkrumah’s regime, successive post-independence governments were confronted with the challenges of administering a modern nation in a tough political environment with inadequate institutional arrangement for modern government. If Nkrumah’s government dealt poorly with those challenges successive governments have fared no better. Bureaucratic weakness within state institutions, irrespective of the political ideology of the governing elite or institutional base, has had led to a lingering perception of the public-sector as inept.

The system of government offices made up of sector ministries and departments manage the cumbersome administrative machinery of the state and control national development efforts because the bulk of capital and aid is channeled through the state. The centralized structure of the public service has persisted despite prolonged efforts to decentralize the machinery of government. Decentralization efforts began in 1988 with a comprehensive policy to spread

¹⁶ Tiger uses the term charisma to refer to “a certain quality of an individual personality by virtue of he is set apart from ordinary men and treated as endowed with supernatural, superhuman, or at least specifically exceptional powers and qualities. These are such as are not accessible to the ordinary person, but are regarded as of divine origin or as exemplary, and on the basis of them the individual concerned is treated as a leader.” (1966:15)

out the system of government outside the capital, Accra, to regions and districts across the country. The process was driven by a conscious policy to “promote popular participation and ownership of the machinery of government by shifting the process of governance from command to consultative processes” (Koranteng and Larbi, 2008:213). But institutional and legal backing of these initiatives has not mitigated greater concentration of power and resources and a weakening of the decentralization process. (ibid)

There has been such a high tendency for political functionaries to seek the greatest financial self-aggrandizement possible that administrative malfunction and rampant charges of corruption plague the machinery of government in Ghana. To many observers, the activities of bureaucratic and military functionaries in amassing extra income through embezzlement and other corrupt practices have retarded the prospects of sustained development in Ghana.

For many post-independence years, political instability had a lot to do with administrative weakness in Ghana as it undermined opportunities to carry out policies to their completion and envision the results of strategies. The stable political environment of Ghana’s fourth Republic (1992 to present) gives reason for optimism. In the words of one observer, due to the “role played by institutions such as the Ghana Electoral Commission, the media, and civil society, signs of the consolidation of the democratic process in Ghana during the Fourth Republic, which began 1992, seem quite positive.” (Arthur, 2009:45)

Chapter 4: Literature Study

One of the earliest papers published on HIV/AIDS political science literature was an article published in *Political Science and Politics Journal* by Kenneth S. Sherrill et al. (1992). The title of the article, *What Political Science Is missing by Not Studying AIDS*, captures the ambivalence of the discipline to the then relatively new disease. Ostergard, (2002) has traced that initial hesitation of political scientists to take on the HIV/AIDS as a research interest to the fact that the disease was initially identified exclusively with a specific demographic – homosexuals and intravenous drug users (Ostergard, 2002). Sherrill et al took issue with political science professionals for lagging behind other social science disciplines and not making an effort to help society make sense of the new plague. They noted some important questions that the discipline could help answer including the question of “[t]o what degree might the study of AIDS test the breath of current explanatory theory? What testable hypotheses might be generated from studies of AIDS policies? What does AIDS tell us about processes of political mobilization, policymaking, the creation of political networks or alternative power maps?” (689)

With regards to AIDS in Africa, intellectual apathy coupled with political negligence to create a situation in which African governments got away with total inaction. There was no international pressure or domestic demands from citizens, even in the most stricken areas, to take action to deal with this disease. If this apathy, in the African case, is attributable to the early association of HIV with the gay community and intravenous drug users, it was completely misplaced. Behavioral research and parity in the infection rates between males and females in sub-Saharan Africa suggests the spread of the disease in the region was al-

most exclusively heterosexual, a finding that made it unique in the world (Caldwell, 2000:120-121).¹⁷ However recent data from Ghana suggest that 7.2 percent of all new infections was caused by men who have sex with men (MSM) even though they form only 0.25 percent of the population (UNAIDS, 2009:vi), a trend that indicates transmission both among and outward of that group.

Despite the *call to arms*, the bulk of the early work on HIV/AIDS in political science only began to appear in the early part of this century.¹⁸ One reason for the delay was the Reagan/Thatcher revolution and the rise of conservative principles with an attendant negative attitude towards the perceived early victims (homosexual men and intravenous drug users). The rise of positivism in political science in the 1990s reflected the influence of the Reagan political philosophy on intellectual activity within the period. Studies of Africa specifically were initially reactions to the ‘green monkey theory’ and discussions of the origins of the disease¹⁹. It was only when those debates were more or less exhausted, or became exhausting, that focus shifted to policy issues, treatment, poverty, aid and development among other things.

Generally, political science studies on HIV/AIDS have dealt with different analytically distinct but interconnected categories. However, three broad themes stand out in the literature relating to Africa namely *poverty/development*, *cooperation* and *globalization*. I discuss the literature within these themes in part because they encapsulate the bulk of the discussion about HIV/AIDS in Africa but also for the following reasons: 1. HIV/AIDS has important implications for already poor countries and has unmistakable consequences for development prospects. 2. HIV/AIDS policy has become an important aspect of the bilateral and multilateral development cooperation. 3. The disease is, by its very nature, a global phenomenon as its spread is not hampered by national boundaries and as efforts to deal with it are being championed internationally, thus the trajectory of policy interventions is being impacted by trends in globalization.

My literature study will not be restricted to public policy nor political science text. I also use other literary sources that deal with North/South development cooperation more broadly rather than specifically relating to HIV/AIDS.

¹⁷This makes the prevalence of an AIDS epidemic in Africa surprising in light of the fact that “HIV transmission rate during one vaginal intercourse between otherwise healthy persons is so low”. Caldwell identifies five factors responsible for the high transmission rate in Africa; a. high levels of sex outside marriage, b. high level of prostitution, c. a resulting high level of STDs d. untreated, uncured STD due to poverty, e. low level of condom use.

¹⁸Other disciplines were quicker to respond to HIV/AIDS. Herrell (1991) discusses scholarly HIV/AIDS research and collaboration among sociologists, anthropologists, psychologists, communications theorists, and language and literature specialists.

¹⁹ See Poku 2001:194

4.1 AIDS Poverty and Development in Africa

Ever since conventional wisdom began converging on the belief that AIDS has become the biggest single threat to human life in African countries there has been significant advances in political science literature relative to HIV/AIDS in Africa. It is now widely accepted that the disease undermines development not only by bloating health budgets but also by reducing life expectancy and drastically impacting productivity. 90% of infected persons worldwide live in poor countries with Africa accounting for 70% of that number. For a continent where 4 of every 10 people live in abject poverty, many consider the HIV/AIDS poverty link to be tenable.

High infection levels are compounded by inadequate social and economic “safety nets” and low access to care which worsens the impact for affected families (Poku 2001:191-192). The disease has engendered a downward trend in life expectancy as poor families lack the capacity to deal with morbidity and mortality or the “psychosocial and economic” effects of the disease (ibid. 196). AIDS’ impact has not been uniform across the continent. Rather, it has been more devastating among east and southern African states than among West and North African states. Also, women seem to more vulnerable to infection.²⁰ In sub-Saharan Africa 14 women are infected for every 10 men (UNAIDS, 2009:24). There are social-cultural and religious factors in Africa that also add to women’s vulnerability to HIV (GAC, 2004:28) including, culturally sanctioned, gender inequality and sexual subjugation.

Poku (2001) finds that irrespective of region, poverty heightens women’s exposure to infection. In West Africa, this is worse because women are more integrated into economic life than in other parts of the continent (197). Similar evidence linking HIV to poverty is reported by Whiteside (2002) who takes it a step further by suggesting a “poverty/epidemic cycle” at work. In his scheme, poverty boosts the spread of HIV whereas AIDS increases poverty at all levels from the household level to the global level (325). He does submit however that there is no single causal relationship between the epidemic and poverty (ibid. 317).

The disease differs from other epidemics in that it has two epidemic curves – the HIV curve and the AIDS curve. The infective curve (HIV) precedes the AIDS curve by 5 to 8 years (being the incubation period). The long incubation period causes the disease to spread silently infecting large numbers of people. Only after large numbers have been infected does death through AIDS and related effects begin to rise. Moreover, people do not leave the pool of infected people by getting better because there is no cure for the disease. Rather the pool of infected people increases as a result of anti-retroviral drugs where they are available (Whiteside, 2002:314).

Caldwell (2001, 128) reports that because 95% of infected victims in Africa are not aware of their HIV status until the symptomatic AIDS stage, the long latency period makes it harder for victims to associate the appearance of symptoms with a sexual act that may have taken place a decade earlier. The tendency for Africans to blame disease and death on

²⁰See Adjei-Mensah, 2001 Poku, 2001 Caldwell, 2000

witchcraft and other occult manifestations further hinders their comprehension of the disease.

Exploiting the link between HIV and development has been fruitful for some researchers. For example de Vaal (2002) and Whiteside (2002) find a strong relationship between the disease and economic growth and poverty respectively. One of the United Nations' Millennium Development Goals (MDG) is to half poverty by 2015 – this is also an objective of the New Partnership for Africa's Development (NEPAD). NEPAD is a socio-economic development framework established by the 37th summit of the erstwhile Organization of African Unity (OAU)²¹ whose prime objectives are to address poverty, promote sustainable growth and development, empower women and facilitate a positive outcome for Africa in the globalization process currently taking place. The spread of HIV/AIDS on the continent doubtlessly threatens one of the principal aims of NEPAD. The concern that the disease perpetuates poverty and under-development has spawned studies that locate the HIV/AIDS debate within the context of the MDG as enunciated by the United Nations.²²

Linking HIV/AIDS with MDG is seeking to put the fight against HIV/AIDS within the commitment of global poverty alleviation. Whiteside submits that because of its influence on development policies and goals, HIV/AIDS has become one of the most “profound development challenges faced in modern human history” (2002:325). Even though both economic growth and economic stagnation and decline cause changes that encourage the spread of HIV, he submits that conventional economics misses the complexity of HIV/AIDS – by implication development policies that are based essentially on economic theory miss the mark. Also, development targets based on conventional economic indicators fail to take full account of the implications of the HIV/AIDS situation (ibid, 323). de Waal, on the other hand sees evidence that beyond having the lowest life expectancy, Africa is actually experiencing declining longevity on account of the HIV/AIDS pandemic (2002:465).

The relationship between HIV/AIDS and security in Africa is equally important given the implications for food security, political stability, labor force issues and war but there has not been a great deal of attention paid to the security implications of HIV/AIDS in Africa. A notable exception is Ostergard's 2002 article *Politics in the hot zone: AIDS and national security in Africa*. In it he points to a general ethnocentric bias in the literature (especially during the Cold War) in which security studies tended to focus on US or European national security and security threats were gauged in military terms.

²¹The Organization of African Unity was formed in Addis Ababa, Ethiopia in 1963 to promote African cooperation and solidarity and to form a common front in the fight against colonialism and apartheid as well as be a force for the defense of human rights. The OAU was transformed in 2001 into the African Union (AU) modeled on the European Union (EU) with a transnational parliament and executive commission based in Addis Ababa.

²²NEPAD also framed its goals around the UN's Millennium Development Goals.

It was not until the 1970s and 1980s that a shift of focus occurred and scholars began to pay attention to other areas, such as economics, that could threaten security (Ostergard, 2002: 334). This period signaled the birth of international political economy (IPE) as a sub-discipline of political science, but the focus was still on those powers that have the clout to impact the international system not on peripheral areas like Africa. Ostergard believes while the categories are not independent, we dilute the importance of AIDS by defining it as a security threat. He advances the viewpoint that AIDS has security implications due to its effect on the political structure and the military and through illness/death of policy makers/military personnel and the threat this poses to political processes and stability. However the disease is still hard to conceptualize as a security threat because most people think of security threats as those posed by states or groups not viruses (Ostergard, 2002). If it is hard to conceptualize the AIDS virus as a security threat it is not as problematic to think of security as a factor in the spread of the disease. Adjei-Mensah (2001, 444) finds that ethnic conflicts and civil wars actually help spread HIV/AIDS in West Africa because of population movements that result from such disputes.

While we cannot speak of HIV/AIDS intervention in Africa without discussing the issue of international cooperation, some scholars question the ability of donor policy, as currently structured, to promote achievement of the eight MDG goals (see Jones, 2004). Among African governments NEPAD has become the new catch phrase for both intra-African cooperation and cooperation with Western donors. NEPAD advocates a model of enhanced partnership which “is a common commitment by African countries and donors to a set of development outcomes (defined by African countries), whereby donors pool funds, guarantee them for an extended period and channel them through budgetary processes, which are then jointly monitored on the basis of outcome.” (de Waal:466)

NEPAD thus represents a new African project with many constituent parts including trade, debt relief, aid, and conflict resolution all bound together by a ‘compact of partnership’. Maxwell and Christiansen (2002) use the concept of ‘matrix’ to describe that relationship. They suggest that whereas the individual elements of the matrix are widely discussed, the matrix that interlinks them is not (477). Based on this idea of interlinked elements there has been movement in the direction of dealing with multiple issues at various international meetings and conferences. While they acknowledge the fact that countries will deploy bargaining chips within and across meetings, Maxwell and Christiansen however disagree with this idea of combining issues at international conferences because of “unnecessary clutter”. Borren (2000), on the other hand argues that to be able to effectively interconnect local and global problems and the work of local and global interventionists it is essential to have clarity about the roles individual actors and agencies play. She uses the term “withdrawal” to represent the stage at which the international partner withdraws and the recipient country takes their destiny into their own hands and the concepts of ‘injustice’ and ‘exploitation’ to suggest consciousness at both cognitive and emotional levels of cooperation (408-413).

The cooperation framework outlined by Borren is quite radical compared against the majority of development cooperation models that have been in use in the decades following

independence in Africa. With a few exceptions cooperation has been based on a “developmentalist” paradigm that has been the principal framework for post-second world war development intervention. Developmentalism is based on neo-classical economic theories of development, a by-product of Keynesian economics that led to the construction of growth theory. This theory narrowly conceives development as economic growth called forth by the application of technical scientific knowledge of western economic experts. That perspective embodies a broad interpretative framework based on the concept of authoritative intervention (Preston, 1986:78). Rostow (1960) was one of the earliest supporters of the growth school. He analyzed development as an essentially endogenous process involving a progressive transition from traditional to modern society. Along these lines he elaborated a five-stage model of growth linking a stage of tradition to a stage of maturity as the route to be followed by developing countries to become modern. Despite a backlash against growth-based cooperation models, to date, they continue to be a popular prescription for development initiatives and models of cooperation. The same developmentalist mentality seems present within HIV/AIDS ‘project’ in Africa.

Jones (2004) asserts that it is important to think about how “the cartographic imagery of Africa and how representations of ‘crisis’ actually frame development interventions”. Through an “optic of developmentalism” certain metaphors have been used as the intellectual basis for providing development assistance. These range from “civilizing mission” to “management” and “intervention” upon which modern development is premised (387-393). His description of developmentalism captures the essence of its character and underlines its potential for hijacking the discourse relating to HIV/AIDS. He describes it as

a tendency to reduce the problems of improving life in poor countries to one of a compulsion to promote ‘development’ by looking at them and knowing them only through lens of ‘developmentalism’ and what they are not. Through this optical lens, the landscape of ‘Third World’ has been constructed as if ripe for the challenge of international development agency intervention. Not only has the term ‘Third World’ become a badly fitting categorization that inaccurately represents and homogenizes huge and diverse regions and populations. It is downright harmful – even lethal in the context of HIV/AIDS policy – because it subordinates these territories to the gaze of Western (and certain local) eyes, which legitimates particular types of intervention. (ibid)

To be fair, supporters of development aid have not disregarded extensive evidence of failure. Rather there have been efforts to revise the conceptual framework of aid around three basic ideas: a. failure is due to insufficiency as more not less aid is needed; b. there is less focus on aid but rather on poverty alleviation; c. sympathy of aid givers rather than proof of effectiveness is pushed as justification (Shleifer, 2009:386). In spite of this adjustment of the aid argument, growth maximizing criteria still dominates much of the discourse on development aid.

4.2 The Critique of Aid

Since the early 1960s when the ex-colonies emerged as newly independent states and development economics dominated policy making in those states, critics of aid have been vocal in their rejection of it as a solution to underdevelopment and poverty. Intellectual

support for aid was based on the idea that countries were caught in a vicious cycle of poverty due to a lack of income and savings needed to invest for economic growth. It was argued that foreign aid was necessary to generate the requisite capital which, coupled with economic planning and the development of new industries, would assist these countries to jump start economic growth (big push model). Then, like now, some of the most vocal critics of aid emerged from the discipline of economics. That critique focuses on five broad areas of policy; poverty, corruption, planning, accountability and markets.

Perhaps the best known early critic was the Hungarian-born development economist Peter Bauer who from as early as the 1950s argued that development aid perpetuated poverty by entrenching corrupt and autocratic governments in poor countries (Shikwati, 2002:13). Bauer was ostracized by his peers in the 1970s for his radical views on aid and his rejection of the big push model. The ideas of Bill Easterly, a more contemporary critic of aid can be traced back to Bauer. Like Bauer, Easterly rejects central planning of development as a pathway to ending poverty.

In recent times the call to cease development aid is coming also from African scholars. Dambisa Moyo has become prominent as a leading African voice among anti-aid scholars. Her book *Dead Aid* is dedicated to Bauer and is faithful to the intellectual tradition he championed. Moyo's main thesis is that non-emergency aid and grants have the same corrupting influence as natural resources and that aid has made the poor poorer and economic growth slower. Paul Collier, another modern critic of aid also rejects the idea of a "poverty trap" and all "one-size fits" all explanations.

Poverty

Bauer argued that inequality represented fair pay for output and that attempts to address income inequality infringed on individual liberties, thereby slowing down economic development. He also rejected the argument that poverty in the developing world resulted from colonial exploitation because, in his opinion, those countries are better off now than they were before the imposition of colonial rule (Economist 2002). In this view, development is still based on an external determinant which is engagement with the west. Easterly's model has a more internal focus. Reducing poverty and human suffering can only be achieved through "self-reliant efforts of the poor themselves in free markets." (Easterly, 2006: 29). Ending poverty depends on the efforts of economic and political "searchers" defined as actors who "find products and public services that satisfy customers and voters" including private firms and "democratically accountable politicians" (ibid 2-4). Collier, on the other hand, uses the idea of four distinct *traps* to explain the condition of countries populated by what he characterizes as the *bottom billion*. The four traps are the *conflict trap*, the *natural resources trap*, the *trap of being land-locked with bad neighbors*, and the *trap of bad governance*. The countries of the bottom billion share the common dilemma of being caught in one or more of these four traps. "Seventy percent of these people are in Africa and most Africans are living in countries that have been in one or another of the traps" (Collier, 2007:5).

Corruption

Moyo is most concerned with the corrupting influence of systematic aid²³ defined as “aid payments made directly to governments either through government-to-government transfers... or transferred by institutions such as the World Bank” (2009:7). This includes all bilateral and multilateral aid the bulk of which is composed of concessional loans²⁴ or grants. She states that aid encourages corruption by providing cash for free use which leads nations into a vicious cycle of aid causing governments to usurp the rule of law, civil institutions and civil liberties thus making those countries unattractive for investment thereby increasing poverty and prompting donors to give more aid (ibid.49). She equates aid dependence, (a commonality among African states despite all their differences) to a malignant disease. For her, aid is not “part of the solution, its part of the problem – in fact aid *is* the problem.” (ibid.47). Aid fuels corruption and corruption does not disqualify leaders from aid. Easterly speaks of the corruption of the aid effort in terms of the recycling of old ideas and a failure to learn. He suggests a more constructive approach that would “hold aid accountable for results and be more open to using diverse types of evidence” (2009, 438).

Lack of Accountability

There is strong theoretical support that “democratic and market accountability go with economic success.” (Easterly, 2006:3). Moyo laments the lack of accountability in aid, but unlike Easterly she does not focus on accountability of donor agencies but of African leadership to the citizenry. Since governments do not have to depend on tax revenues to finance their budgets, there is no accountability to citizens. The aid model therefore, in her view, introduces negative externalities and incentives in Africa. Like Bauer, Moyo is concerned that aid stifles the growth of capitalism in Africa because it “chokes of desperately needed investment, instills a culture of dependency, and facilitates rampant and systematic corruption, with all the deleterious consequences for growth.” (Moyo, 2009:49).

Planning

Both Bauer and Easterly take issue with the idea of planning development and therefore with the concept of “big push” which essentially implies authoritative intervention in poor country economies to stimulate investment and infrastructure. Contrary to that thinking, in Bauer’s framework the primary driver of development is not government plans or development aid but private profit. He posited that ignorance among aid providers of what a developing economy actually needs in terms of investment leads to money being poured into bad projects or ‘white elephants’ (Shleifer, 2009:381). For Easterly ‘planners’, unlike ‘searchers’, “raise expectations but take no responsibility for meeting them” and base their efforts on global blueprints, unlike searchers who seek to adapt to local conditions. He submits that to address poverty we must be “tough on the ideas of planners, even while we salute their goodwill.” (Easterly, 2006: 2-4).

²³ As opposed to humanitarian/emergency aid and charity-based aid.

²⁴ A concessional loan is “money lent at below market interest rates, and often for much longer periods than ordinary commercial markets.” (Moyo, 2009:8)

Market/Private Sector Initiatives

Being a fierce advocate of market forces even in subsistence economies Bauer believed in a limited role for government restricted to protecting property rights, keeping taxes low, minimizing inflation, enforcing contracts, and ensuring equality under the law (Economist 2002). The main problem and therefore the core challenge of development, as he saw it, is the failure of growth in these countries. For him, aid not only fails to speed up economic development but it actually hurts economic development (Shleifer, 2009). So by channeling money to governments rather than to business, aid increases patronage of governments as it stifles entrepreneurship and markets because rather than engage in productive activity interest groups become engaged in a struggle to control aid money.

Bauer's prescription for growth and development is total reliance on pro-market economic policies to foster economic development. Like Moyo, he sees little hope for better outcomes given the record of nations with abundant natural resource wealth. Easterly's preferred solution is akin to what has been defined in this study as capacity-building; "distilling practical knowledge on operating banking systems or stock markets, advice on good macro-economic management, simplifying business regulations, or piecemeal reforms that promote merit-based civil service." (2009:31). Elsewhere he advocates a marginal approach to replace the transformational approach by which smaller steps ("one small step at a time") will be used instead of the large scale societal transformation projects that have often been used in the development aid project (Easterly 2009). Moyo proposes a gradual reduction and eventual elimination of aid over five to ten years (2009:76) and a reversion to bond markets by African states as a *capital solution*, expansion of trade and towards non-traditional markets for African products like China. Collier's preferred solution runs counter to Moyo's argument in the sense that he is not opposed to budget support or to debt relief as he sees aid not as part of the problem but as part of the solution (Collier, 2007:123).

4.3 Supporters of aid

To supporters of international aid, globalization implies raising living standards while maintaining a sustainable environment. It pricks the conscience of some vested interests in the west that in this twenty first century world with all its material comforts there are still large areas human habitation characterized by abject poverty. Those interests emerged as a result of different factors: There are those who carry the post-colonial guilt there is faction that sees aid as serving national security interests. The George W. Bush administration identified the three pillars of national security as defence, diplomacy and development. The belief is that having a significant portion of the world living in poverty, disease and instability spells doom for those countries but also carries a risk for all nations (Sachs, 2005a:3-4).

Jeffery Sachs is currently the leading modern voice for continuation of development aid. In *The End of Poverty: Economic Possibilities of our Time* he speaks of an ascending ladder of economic progress for countries of the world ranging from the lowest rung where the bottom one sixth of the world's population live on less than one dollar a day, are destitute, ill and poor and unable to lift a foot to the first rung of the development ladder (similar to

Collier's bottom billion); followed by the next 1.5 billion people occupying a few rungs up the ladder who exist just above subsistence level but are the most privileged among low-income countries; next are the 2.5 billion city dwellers who live on the margin of prosperity in urban area but in poverty; and the top rung of the ladder is composed of the one sixth of the world representing the one billion inhabitants of the rich western developed countries. (Sachs, 2005b).

Sachs advances an argument based on structural deficiencies in the poor countries which can only be addressed with assistance from rich countries. The challenge of our generation, in Sachs' view, is to assist the extreme poor to escape misery and climb out of poverty up the ladder of economic development and also support others in poverty (moderate and relative) to afford opportunities to strive for higher economic attainment. Globalization can have a more positive outcome for poor countries if it, in the words of Sachs, "takes place in a sensible framework" (2005a:5). In his scheme the success of these initiatives depends on coordination between global governments, and international civil society groups and NGOs. His idea of a "Global Compact" (Sachs, 2005b:269) implies responsibility on the part of poor country governments in respect to good governance. The role of rich countries would be to "to help all poor countries where the collective will is present to be responsible partners in the endeavor."

4.4 HIV/AIDS in a Global Economy

Global action to deal with the HIV/AIDS is a relatively recent development. Growing awareness of the disease led to concern within the United Nations in the early 2000s to address the problem internationally. But that was only after two decades had passed with no international action in that area. The first significant global initiative to respond to HIV/AIDS was a 1986 Global Program on AIDS (GPA) established by the World Health Organization (WHO). WHO aimed to limit HIV infection and cooperate with governments as well as infected persons to deliver strategies to fight the spread of HIV (Poku, 2002:287). GPA was the first attempt to integrate various players in the HIV/AIDS field. That initiative highlights the importance of policy coordination and consistency that pools the efforts of governmental and non-governmental players in a global response. However lack of consistency and the spate of policy differences doomed this early policy initiative.

A significant portion of the political science literature on subsequent global trends relating to HIV/AIDS has been focused on the role of pharmaceutical companies in the fight against the disease. Thomas' (2002) article *Trade policy and the politics of access to drugs* captures this debate succinctly. She defines the problem of access to drugs as a "moral" problem regarding the role WTO rules and US trade policy seen within the context of health disparities between rich and poor countries. While anti-retroviral drugs (ART) are produced mainly in rich countries, the majority of HIV/AIDS sufferers are in the poor countries especially in Africa where neither the governments nor the victims can afford the drugs even at 'market' prices.

Since 2001 some transnational NGOs have highlighted issue of access to drugs on the global agenda to improve access of ART drugs to those less able to afford them. This effort has met resistance from the pharmaceutical industry, and the United States government (Thomas, 2002:251). As a result, breakthroughs made over the past decade in biomedical techniques that slow down the effects of HIV infection have become the monopoly of a few powerful pharmaceutical companies (Bristol-Meyer Squipp, Merck, Glaxo Wellcome, Hoffmann-La Roche and Boehringer Ingelheim) which use international copyright laws (patent protection) to keep others out of manufacture, pricing and distribution (Poku, 2001:201). Through setting the price of medications above production costs the drugs have become more expensive in the poor countries where they are most needed. This has created a situation of “two epidemics” one in the rich countries, where patients have access to the new techniques and drugs, and the other in the poor countries where there is a lack of treatment opportunities and HIV continues to be a “death sentence” (ibid 291-292). Patients in poor countries only have access to ART drugs when they are purchased with donor funds and distributed almost free of charge. This in effect means huge subsidies for drug companies instead of relaxing the rules on patents to allow poor countries to produce the drugs at home.

Under WTO international property rights established in 1994 at the Marrakesh Agreement with 100 countries as signatories, the Trade Related International Property Rights (TRIPS) agreement binds nations to accept western-style intellectual property rights across a range of areas including pharmaceuticals. “Under the agreement, foreign pharmaceutical companies can apply for patents on pharmaceuticals in individual countries and receive exclusive rights to produce the pharmaceutical product in that country.” This has created a monopoly situation for ARV drugs the prices of which are, as a result, not dictated by market conditions but are set by producers (Ostergard: 345). Resulting international disputes have pitted developed against underdeveloped nations and created ethical dilemmas in international trade policy. However, TRIPS does, in theory, provide for member nations protecting public health within their countries. Still few developing countries have the infrastructure to produce the ARV drugs themselves and also countries that have done this have received a heavy-handed response from the US government (Thomas: 255).

This review of the literature on HIV/AIDS shows that early political science studies debated the question of whether the subject of HIV/AIDS was even worth taking up. Since the initial reluctance, the body of literature that has developed provides important insight into the disease itself and efforts being made to mitigate its effects on African populations. It seems to me however that, to be able to effectively evaluate and document those structural interventions we need to adopt an interdisciplinary approach that will help us better understand the policies and institutional practices being employed to deal with this major challenge both domestically within states and internationally.

Chapter 5: Research Design

5.1 Theory

There has been growing interest in what has been called the ‘explanatory power of ideas’. Constructivist research has become popular in social science even though there has not been a uniform approach among those who subscribe to ideas-based (as opposed to interests-based) research. Strictly speaking, it is not a theory but an ontology or social theory which facilitates the development of theoretical propositions. In political science since the 1990s reliance on ideas, beliefs, narratives, meaning, and knowledge (“interpretive schemata”) marked a “cognitive turn” which has focused on areas hitherto neglected by approaches stuck on interests (Nullmeier, 2006). Legro offers the perspective that collective ideas are often incorporated in symbols, discourse and institutions and not in individual minds. A collective idea is not a “monolithic homogeneous entity” that all actors “internalize and advocate”... But “to act coherently groups require a dominant theme” (Legro, 2000:420). Through the theory that HIV/AIDS is socially constructed in different ways by different groups and the idea of policy as discourse, this study aims to transcend the rationalist, reductionist bias in mainstream HIV/AIDS literature by emphasizing the role of framing and discursive processes in the articulation and implementation of HIV/AIDS policy.

HIV/AIDS intervention programs represent an area of public policy, and also of international relations, where there are varied identities at stake. Ideals are often invoked due to the complex and challenging nature of the epidemic. Ideational concerns have traditionally been important to political scientists but were diluted at the advent of the behavioral revolution and the rise of microeconomics. Constructivists place a premium on ideas in their research agenda. A constructivist analysis of the HIV/AIDS epidemic could be useful in terms of identifying mechanisms that lead to the choice of specific policies and defining specific interests.

While the cognitive approach has been influential in the rational choice field it has had minimal effect there. Rather, it has been more instrumental in institutionalism within policy research starting with the proclamation of a “new institutionalism” by March and Olsen in 1984, and evolving into several institutionalisms (sociological, historical, economic) then culminating in recent years in “discursive institutionalism” and “constructivist institutionalism” (Nullmeier, 2006:2).

Schneider and Ingram (1993) say social construction of the targets of public policy not only influences the policy agenda but also determines the choice of policy tools and provides a rationale for policy choices. For that reason, social construction of target populations should be an important aspect of the study of public policy as it both shapes policy agenda and influences policy design (334). In their scheme, assignment of policy benefits derive as much from the social construction of such groups (by policy makers, media representatives and the general public) as from the group’s social power relative to other groups in society. Social construction is either positive or negative leading to allocation either of policy benefits for groups that carry positive constructions or punishment for groups that carry negative

constructions. Furthermore, such constructions may hold constant of a long period of time or evolve over time (ibid. 336).

Within international relations scholarship, Alexander Wendt has pioneered constructivist analysis. He presents his idea of constructivism as a conceptual alternative to what he calls “individualist and materialist” conceptions about the international system. In his scheme, material power and interests are not unimportant but their meaning and effects are dependent on the social structure and on the culture of anarchy. Ideas are treated either as intervening variables explaining some aspect of behavior, as independent variables or as constitutive of the interests, power and institutions (material forces). Wendt’s social constructivism conceptualizes ideas as constituting material causes. They are not more important than power and interest or autonomous from them. Rather “power and interest have the effects they do in virtue of the ideas that make them up.” (Wendt, 1998:135). As a result, the “distribution of ideas” in the system is critical and should be the focus of inquiry. There are three types of structures; material structure, ideational structures and a structure of interests all partially independent but also linked as a single whole and all necessary for explanation of social outcomes. “Without ideas there are no interests, without interests there are no meaningful material conditions, without material conditions there is no reality at all.” (ibid 139).

Along these lines Weldes (1998) advances an argument for use of critical social constructivism based on what he calls an “argumentative turn” in policy analysis with a basic premise that “language does not mirror the world, but instead constitutes the world as we know it and function in it.” In this sense language produces issues that policymakers deal with and the problems they confront. (217) This line of thought, he says, encourages us to focus attention not just on language (“Discourses encompass not only linguistic but also non-linguistic practices...”) and argument but also on discursive and representational practices which form the basis upon which policy issues are defined and policy is made (Weldes, 1998: 218).

Joseph Schneider (1985) discusses the sociological research tradition dealing with the sociology of social problems which he calls a “constructionist view”. This view considers all social problems as socially constructed and calls on sociologists to dig deeper into the processes by which social problems come to be recognized as such. Proponents have, since the 1970s, pushed for reconceptualization of social problems to project their perception as outcomes of a process of collective definition rather than objective conditions or social arrangements. This includes the view that a wide range of definitional activities take place even before bureaucrats, the media and other professionals become involved in an issue. To Schneider, much of the sociological work done in this area “reaffirms a major strength of labeling, namely, the independence of meaning from the objects to which it is or may be attached by sentient actors as they create, recreate and are created by social life.” (Schneider, 1985: 226).

The Advocacy Coalition Framework (ACF) is another ideas and belief systems-based approach that has been gaining currency within the field of policy research. It focuses on policy subsystems (coalition of actors from different institutions- including journalists, government personnel, researchers and policy analysts) that act in concert. ACF conceptualizes public policy in the same way as a belief system (sets of value priorities) “perceptions of important causal relationships and perceptions of the state of the world (including the magnitude of the problem), perceptions of the efficacy of policy instruments” (Jenkins-Smith and Sabatier, 1994:180). Rather than focus on short-term decision-making, ACF considers everyday knowledge and the combined effect of different studies as exerting the greatest influence on policy. ACF is presented as an alternative to the stages heuristic which is criticized for lacking causality and for dissolving the policy process into disjointed sub-processes. Belief systems are hierarchical in nature. A ‘deep core’ of shared belief systems which constitutes the highest level is composed of basic ontological and normative beliefs whereas a next level ‘policy core’ is made up of causal perceptions and normative commitments across a policy domain. Deep core beliefs are resistant to change whereas policy core beliefs are less rigid and may change over time, even though coalition members will generally resist information that invalidates their core and policy beliefs (Jenkins-Smith and Sabatier, 1994). The model has been used to study a wide variety of policy issues with mixed results²⁵.

Social constructivism calls attention to the importance of culture and context in understanding developments in society. People create knowledge in their interaction with others and with the environment they live and operate in. As knowledge is socially and culturally constructed this approach facilitates the assembly of knowledge based upon this understanding. This knowledge is not universally determined but culturally specific, inevitably linked to the cultural makeup and rationality within which it develops. Thinking of culture as the structure of ideas, Wendt (1998) distinguishes between “common” and “collective” knowledge. Culture is more than just shared ideas, it involves causal and constitutive effects. Culture thus gives equal weight to agency and structure. (197)

It is a proposition supported by Weeden who suggests that we move beyond the traditional understanding of political culture²⁶ and instead adopt a practice-oriented cultural approach. That is the anthropological conceptualization of culture as “semiotic practices” which “refers to the processes of meaning-making in which agents practices... interact with their language and other symbolic systems.” (Weeden, 2002:716) It implies a process by which people make sense of their worlds by jointly reproducing “conditions of intelligibility” and one which produces “observable political effects.” By “paying attention to the ways in which certain meanings become authoritative while others do not, political scientists can use this practice-oriented concept of culture to help explain why recognizable events or empirical regularities occur.” (ibid 713)

²⁵See for example Weible, 2005, Lertzman et al. 1996.

²⁶Mainstream thinking about culture in political science is traced to Geertz's idea of “culture as connoting group traits”.

Public policy includes the making of persuasive arguments by policy actors who do not always share a single frame of reference but rather have different belief systems that frame how they see the world and what they consider as relevant. This makes it important to study the underlying assumptions of belief systems and to understand which actors' powers are legitimized by particular frames of reference (Sabatier, 1995: 201). Framing is an important part of agenda setting through which "subjective interpretations" of perceived conditions are made (Jönsson and Söderholm, 1995:461). HIV/AIDS was initially framed as a health care issue (Poku 2002:284), but since then it has also been variously framed as a medical problem, as a human rights issue and as a socio-economic problem. The variety of ways that an issue is framed determines how resources are mobilized for addressing it and empowers some types of actors while disempowering others (ibid 461).

Framing is also essential for the possibility of partnership with donor organizations as it determines whether or not different players have compatible interests and shared ideals that allow for collaboration. The converse of that is a situation in which groups working in the same field pursue individual, possibly conflicting, interests through value-based donor action based on an organizational culture that is committed to a certain cause. In such a situation, sympathy and "wanting to act become negative forces when the problem (and therefore the solutions) are defined by those showing solidarity rather than by those suffering the particular condition... the 'helper' will then dominate those 'being helped', and so undermine their emancipation (Borren, 2000:409).

Through a discourse analysis of policy formulation and implementation this study will identify frames of reference used by various players in the HIV/AIDS field in Ghana. This approach is useful for analyzing different kinds of intervention because it drills into how issues are framed and the extent to which ingrained perceptions (Dark Continent, Primitive or Victim) of Africa influence intervention in HIV/AIDS. I would also consider the role of tradition and culture in this area of donor, public and NGO policy. Biomedical experts tend to consider anything affecting HIV/AIDS that is not bioscience within a residual category labeled "culture". Yet there is evidence that sensitivity to culture has positive implications for effective intervention (Herrell, 1991:202).

Ideas about HIV/AIDS in particular and disease generally among Africans tend to be filtered through religious beliefs. In a 2000 government census sixty nine percent of Ghanaians identified themselves as Christian, sixteen percent as Muslim and fifteen percent as believers in traditional religion or other belief systems (US State Dept).²⁷ Whether they are Christian, Muslim or followers of traditional African religion, Ghanaians have a propensity to apply a moral standard to attitudes about HIV/AIDS. Whether we call it religion or superstition, there is widespread belief about the role of supernatural forces as intermediary mechanisms in any predicament including death from AIDS even among people who recognize the role of infection and the HIV virus. Also, for a disease that is spread primarily through heterosexual relationships the issue is further complicated by traditionally long-held beliefs about sex and marriage that emphasize fertility rather than

²⁷International Religious Freedom Report, 2007 - <http://www.state.gov/g/drl/rls/irf/2007/90100.htm>

keeping sexual activity within the marriage (Caldwell, 2000). In this study I will try to understand the extent to which this framing of the disease as a moral issue filters into the policy discourse.

The encounter of differing forms of knowledge in social interactional processes can be analyzed with the concept of *interface* to distinguish strategies and rationales of different actors and characterize their differing constructions of reality and their efficacy as problem solving mechanisms. Intersection of different knowledge systems may be viewed as the interconnection of different worldviews through a discursive process. Discourse is achieved through dialogue, the essential element of which is language that serves as a bridge linking varying perceptions of reality held by different social groups. Discourse is thus, by definition, a social process influenced by social structures. According to Ricoeur (1997), "it is as discourse that language is either written or spoken... it is in discourse that the symbolic function of language is actualized... Discourse alone has... an other, an interlocutor to whom it is addressed". (317)

The recourse to language and language analysis in social science inquiry is the result of a realization that social action and reality will be impossible to grasp without being seen as intricately interwoven in linguistic practices. Wittgenstein's concept of language as a set of "language games" refers not just to speech but also to systematic response "in real action to real situations". (Winch, 1987:133) Social action is thus likened to games governed by rules that give action its meaning by establishing its relation to a social context. Language serves as a "shared pool of significations" by which we articulate the meaning of social action. (Dallmayr and McCarthy, 1977:7) This process is facilitated by the uniqueness of each society. Human society is not a homogenous entity but rather made up of contrasting and "competing ways of life, each offering a different account of the intelligibility of things". (ibid 8)

Using discursive analysis in policy research is a post-empiricist approach to public policy that is growing in popularity. The first real synthesis of this genre of policy scholarship is presented by Frank Fischer who incorporates the social construction of policy problems with dialectics of policy argumentation and the role of interpretation and narrative analysis in policy inquiry. In Fischer's (2003) scheme, public policy is a discursive construct that is amenable to multiple interpretations.

The object of my theoretical exercise is to be able to say something concrete about the kinds of ideas and discourses that influence the policies of various actors working in the HIV/AIDS field in Ghana. That is, as argued by King et al. (1994), to generate descriptive and explanatory inferences on the basis of investigation of interaction and communications between actors. The empirical study helped me determine if and how attitudes are influenced by 'pre-programmed' ideas of the epidemic based upon social patterns and rules of language use.

5.2 Inductive Reflexive Model – (Descriptive) Current HIV Policy

Fischer (2003:60) suggests that “[t]he essence of policy making... is the struggle over ideas and their meanings... a constant discursive struggle over the definitions of problems, the boundaries of categories used to describe them, the criteria for their classification and assessment, and the meanings of ideas that guide particular actions.” Based on that thinking the following *inductive reflexive model* of policy making escapes from the narrow focus on interests and instead seeks to describe and explain the social reality of HIV/AIDS in Ghana based on actor experience data gathered from the survey and literature study. “Discursively constructed, there can be no inherently unique decisions, institutions, or actors constituting a public policy that are only to be identified, uncovered, and explained. Public policy, as such, is an analytical category with a substantive content that cannot be simply researched; more fundamentally, it has to be interpreted.” (Fischer, 60)

Explanation is rarely ever a straight forward endeavor. White argues that traditional policy models constrain us by the limiting effects of viewing reality through theories. That approach may undermine a neutral and objective understanding of policy issues. Drawing inspiration from Kuhn’s idea that, as with other bodies of knowledge, policy arguments are theory laden but derive from a distinctive worldview she argues that “[r]eality is not “there” to be described; rather we “socially construct” it through webs of beliefs and values”. Multiple values and arguments may be applied to any policy issue (White, 1994:507).

This constructivist, post positivist or post empiricist approach builds upon the work of Habermas, Gadamer and Foucault. All three pondered the relation between subjective discourse and truth. Being a new theoretical orientation there are no firmly established principles for using this approach (Fischer, 2003:40). Studies of the social world can take lead us down different paths of legitimate inquiry. Often, if not always, “the form of explanation depends on the nature of the particular social reality to be explained.” (ibid. 22) Keeping with this tradition my inductive reflexive model can be thought of as a conceptual blank slate which is then filled out with the elements of the public policy it seeks to explain, analyze, describe or prescribe as the reality of the policy is uncovered.

The inductive reflexive model can be descriptive, explanatory or prescriptive. The model depicted in Figure 1 is descriptive and explanatory based on the context of HIV policy process in Ghana. Using data gathered both in the survey and literature study it describes and analyzes the policy structure currently in use.

Figure 1: Inductive reflexive model (Descriptive) HIV Policy in Ghana

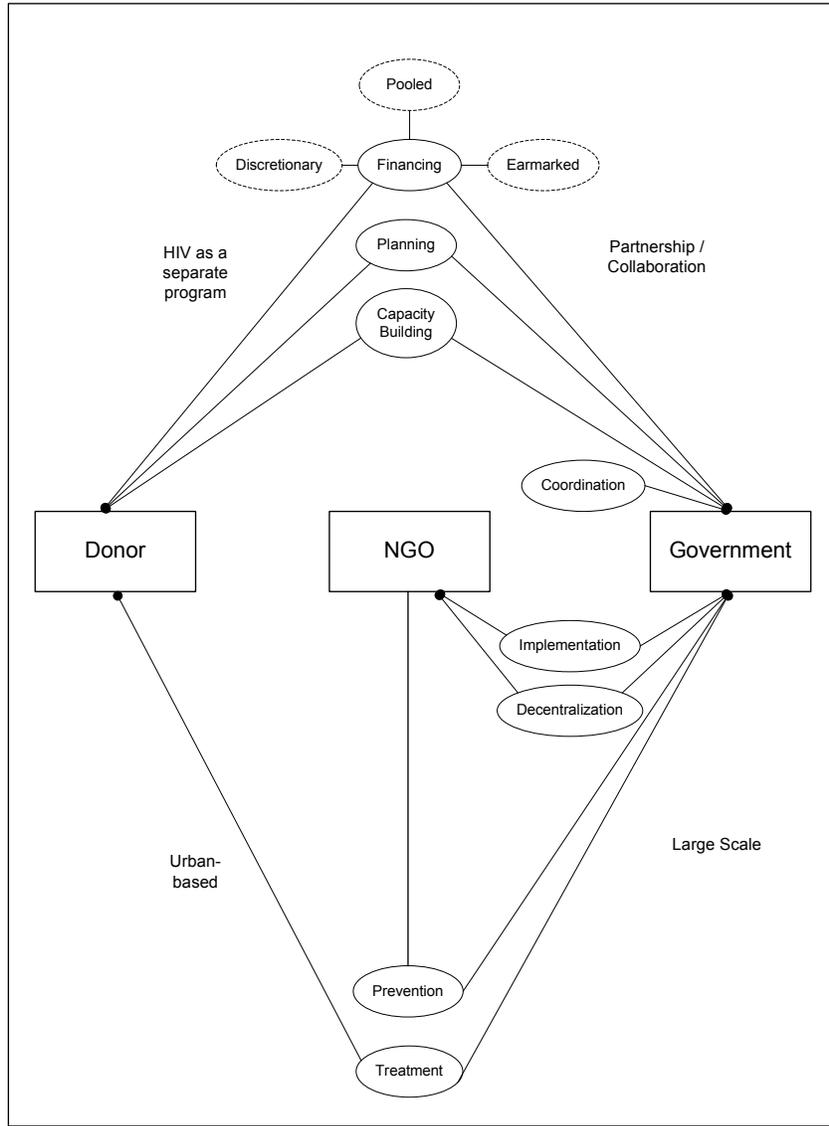


Figure 1 depicts the current policy model used to address HIV/AIDS in Ghana. The model has the following components:

Entities: The three entities are the three groups - Donors, NGOs and the Government of Ghana represented by public officials.

Activities: The three groups engage in various activities within the policy area. Figure 1 details the main activities in the HIV policy structure.

Properties: I use “properties” to describe the general characteristics of the policy structure. Four basic properties are shown in the diagram above; HIV/AIDS as a separate program in the health sector independent of other health delivery services; urban-based intervention, a top-down decision-making approach; large scale intervention and the partnership relationships that characterize the program.

Planning

Ghana's National Strategic Framework (NSF) for HIV/AIDS gives a vision of what the country must do over several years to address HIV/AIDS and identifies areas of priority. NSF is developed with assistance from donors and development partners and shows heavy influence of external players. As with many development-related policies in the Africa, HIV policy did not evolve from executive and/or legislative initiatives in the country. Rather it emerged from the work of a coalition of international actors working on behalf of the state of Ghana. Donors are actively involved in policy debates and help design policies and strategies at the national and international levels. For instance, WHO provides health policy guidelines for adaptation by the government.

Prevention

NSF I (2001-2005) made important progress in terms of creating awareness and expanding ART use. By the time of NSF II the environment had changed. Awareness (but not behavior change) was up. (GAC 2009:2) As the model shows, prevention is done mostly by government agencies and NGOs. The study results show that progress been made in promoting awareness has not translated into comprehensive knowledge among the population of Ghana. Comprehensive knowledge is what guides decision-making and help people make informed choices. One important aspect of prevention is behavior change. There is broad agreement among those working on HIV/AIDS in Ghana that behavior change policies have been mostly unsuccessful but there is disagreement between donors and local officials about the value of behavior change initiatives. Some donor agencies consider behavior change programs a waste of resources. NGO and public officials, on the other hand, favor more behavior change initiatives.

Treatment

Ghana's HIV policy is a treatment-based policy. Treatment with anti-retroviral (ART) drugs purchased with donor funds is the most defining activity in this policy. Treatment for HIV/AIDS is provided essentially by hospitals and health providers working for the government. The diagram shows a role for donors in the area of treatment because they provide most of the funding for treatment programs. Stakeholders agree on the value of increasing treatment levels they disagree on the degree of progress. Even though Ghana's ART supply management is considered to characterize best practice in terms of policy, management and legal frameworks (NACP, 2007:39), there is insufficient PMTCT and ART sites in some districts of the country especially in the Northern regions (NACP/GHS, 2010:5). Despite a scale-up of treatment services under NSF II, coverage is still just above 50% of all HIV/AIDS patients.

Capacity-building

Poor institutional and infrastructural support for delivery of AIDS drugs speaks to a larger capacity problem in the Ghana health system. The need for capacity-building shows up prominently in the survey data. Since the 1990s the term *capacity-building* has been used in UN circles to represent the processes of building technical and non-technical resource capabilities of local development partners at various levels of operation. It is often based upon

assessments of local contextual imperatives such as existing capacities, potential and weaknesses. In health care, the term has been used to represent “building of infrastructure (staff, skills, resources, structures) across health and other agencies to tackle particular health problems.” (Hawe et al.1998:285) Part of Ghana’s HIV program has focused on building capacity to redress weak institutions, lack of adequate technical capability in health delivery.

Decentralization

Decentralization in Ghana’s HIV policy framework follows a line of delegation of authority from national, through regional to district level administrators. The District Response Initiative (DRI) “was a Local Government led project to provide Improved capacity to plan and implement preventive, Care and Support intervention. It included the provision of technical support by the WHO for its execution” (Ministry of Local Government and Rural Development). The policy has the support of all three groups even though all recognize areas of weakness. NGO and donor officials think decentralized structure needs strengthening. Public officials are more concerned about the decentralized response getting the needed better political support to make it more effective.

Coordination

The Ghana AIDS Commission is the coordination agency. It is a 48-member board with members drawn from various ministries and departments of government and chaired by the president of the republic. GAC coordinates the work all organizations and agencies working in the area of HIV/AIDS in Ghana. That coordination includes mobilizing and managing and monitoring and evaluation of programs. Only 55% of survey respondents think the policy is well coordinated.

Implementation

NGOs play the role of implementers in the policy process but the government through the provision of treatment services can be considered as an implementer as well. As implementers of the policy NGOs are able to exercise power when they do not share the policy positions of government or of donor agencies. Through the use of media events NGOs are able to apply political power to gain access to the policy process and promote their own objectives.

Financing

For the past 10 years the program has relied heavily on external funding with some minimal funding coming from the government of Ghana. Funds are either pooled, earmarked or given directly to implementing partners. Most of the funding goes to Ghana AIDS Commission (GAC) which out sources implementation of individual projects to NGOs and other civil society groups. Between 2005 and 2010 there was an increase in funding for HIV/AIDS programs in Ghana. The Ghana National AIDS Spending Assessment Study, 2007 (23) shows that there was overspending by almost US\$9 million compared to the amount budgeted for that year

Survey findings in chapter 6 provide detail the data that leads me to this descriptive model and satiates elements of the model.

5.3 Method

The central concept being studied is the interface of different policy initiatives, clarity about which is essential to developing more sustainable solutions to the problem of HIV/AIDS. This study aims at determining how cultural and institutional frames of reference impact different forms and levels of policy whether or not they are directly and physically present.

The qualitative design involved a survey and literary investigations. The method is both exploratory and descriptive. The unit of analysis is the National Strategic Framework (NSF) for HIV/AIDS which is the official policy program of the HIV intervention. NSF I (2000-2005) was later found to have focused excessively on prevention to the detriment of other areas components. Based on that and other gaps²⁸ identified in the program, NSF II (2006-2010) aimed to address intervention areas including: creating an enabling environment; coordinating the response; mitigating various impacts; prevention; treatment; monitoring evaluation; and research and resource and funding mobilization (NACP 2007:2).

A key feature of HIV/AIDS in Ghana is the extent to which it impacts an already weak economy through increasing health care costs. The Global Fund for AIDS Tuberculosis and Malaria (GFATM I and V) is the main source of funding for national response. Other funding sources include the World Bank, Support to the International Partnership Against AIDS in Africa (SIPAA), M-SHAP (World Bank, DANIDA/DfID), UN agencies, international and local NGOs (NACP/GHS, 2008b:5).

Using a grounded theory approach this study scrutinizes the interface to gain insights into intervention processes. Understanding the interface is important because Ghana, like the rest of Africa, will have to deal with the challenges presented by AIDS for many years. This study is contextual but it does establish a domain in which useful theories could be derived from studies of HIV programs occurring in other contexts such as in other countries in sub-Saharan Africa and possibly developing countries in other parts of the world. Both the environment of the study and the size and varied nature of the sample²⁹ provide confidence to apply the findings to other situations. Also, the findings are generalizable because factors that are part of the theoretical model are present in HIV policy models used in several countries. Categories in my conceptual model are constructed from the data rather than any logically deduced hypothesis and therefore provide grounded understandings of HIV policy development and implementation that could possibly be adopted and used in other contexts due to the meaning and explanatory power that they hold. A case in point is the fact of the international HIV/AIDS programme being a common denominator in the HIV policies of many countries in the developing world. Other factors such as poverty, aid dependence,

²⁸GAC commissioned an “Assessment of the National Response to HIV” in 2004.

²⁹The sample is drawn of the leading government agencies and NGOs in the HIV field in Ghana and most of the major donor agencies dealing with HIV/AIDS at the international level.

poor health care infrastructure and centralized government are consistent across different contexts for which my prescriptive model fits.

The categories for the study (hypotheses) were not predetermined. Rather were derived from the study itself to allow information derived from the context of the study to be the basis for constructing a framework to enhance knowledge about the interface of donor, government and NGO activity. This is in keeping with the grounded theory approach to let themes emerge from data rather than identify ideas *a priori* based on existing theories.

Interface is a social science concept that represents areas in which social groups interact. Long defines social interface as “a critical point of intersection between different life worlds, social fields or levels of social organization, where social discontinuities based upon discrepancies in values, interests, knowledge and power, are most likely to be located.” (Long, 2001:243) Arce and Long explain that studies of interface encounters “aim to bring out the types of discontinuities that exist and the dynamic and emergent character of the struggles and interactions that take place, showing how actors' goals, perceptions, values, interests and relationships are reinforced and reshaped by this process” (1992, 214).

The reality of HIV/AIDS interventions is constantly being constructed by the individual and groups involved. I am conceptualizing HIV/AIDS on the basis of the everyday lives of people working in the field emphasizing their strategies, rationalities and life worlds. Like Long, I am linking the idea of interface with the *concept* of agency. Agency is not necessarily attributed to the individual actor but is constitutive of social relations. Effective agency is based on a definitive set of organizing principles and requires strategic negotiation at points of interaction. It is also linked to considerations of power, authority and legitimation that involve not just a consideration of social restraints and access to resources or hegemonic ideologies, but also to the perception of actors of their capability to influence the outcome of the interface and their ability to negotiate accordingly. Yet social processes, including intervention situations, involve complex negotiation that is not always amenable to easy manipulation through injection of power and authority.

Rather than presenting a theory to be tested and validated (or invalidated), I aimed to discover a theory from the data/information gathered in the study. This is consistent with the inductive model of thinking. As Creswell explains, grounded theory is theory derived “by using multiple stages of data collection and the refinement and interrelationships of categories of information... Two primary characteristics of the design are the constant comparison of data with emerging categories, and the theoretical sampling of different groups to maximize the similarities and the differences of information.” (1994:12)

I also agree with the proposition by King et al. (1994) that irrespective of design, it is useful at the onset to advance a tentative conceptual framework to be followed by a subsequent construction of an orienting framework as the study proceeds. Based on this thinking, although the bulk of my theoretical discussion will come late in the study, I will lay out a conceptual framework to provide the building blocks of the subsequent theoretical exercise.

My research strategy was practically oriented towards the research task. I conducted a semi-structured interview survey during my fieldwork in Ghana. The survey data is the principal source of information. It is supported by content analysis of literature to study the policies of the three target groups (donors, NGOs, government officials). Growing attention being paid to HIV/AIDS in West Africa is generating considerable recent data for a study like this one. There is also a growing body of national data on HIV/AIDS in Ghana which I tapped into.

As far as one can tell, this study breaks new ground in HIV/AIDS research in Africa in terms of the methodology used. Recently my attention has been drawn to the research of Jeremy Youde on HIV/AIDS in South Africa. In *AIDS, South Africa, and the Politics of Knowledge* he studies the emergence of epistemic and counter-epistemic communities offering competing analysis of dissenting views on AIDS that challenged the very basis of the international AIDS programme and the “mainstream scientific consensus” (Youde, 2007:2). His approach is similar in the sense that he studied the state of affairs in terms of knowledge. He focused on subjective opinions that rebelled against convention. He does an in-depth qualitative study of interaction between government officials and members of the international AIDS control community and identifies the emergence of epistemic mainstream experts but also of counter-epistemic communities of experts that rejected mainstream ideas on the problem of AIDS and what are thought to be the best policy responses to it. Methodologically, his approach is similar to mine in terms of his use of constructivism to explicate how epistemic communities frame issues which then influence their policy recommendations. Where Youde’s approach departs from mine is in his use of existing theory (Epistemic Communities theory) to analyze AIDS policy in South Africa while I use a grounded theory approach in search for a new theoretical perspective based on a constructivist model.

5.4 Sample

The sampling design used is a purposive non-probability sampling method because of the need for respondents to be individuals with intimate familiarity and insight into the HIV/AIDS national response in Ghana. This sampling method facilitated a more focused investigation of institutions and the individuals that operate within them.

My purposive sampling design also had a snowball component in that I used interview respondents to identify other respondents and useful sources of information. The objective was to find the people from whom the needed information can be obtained. Understanding the meanings people attach to policy processes required, in my scheme, an inductive mode of inquiry that would shed light on the multiple realities constructed daily by the social individuals engaged in that policy area.

Since this study examined multiple interventions working in the same field, the sample was drawn from a potential pool of qualified people based on carefully constructed selection procedures. The sample frame consisted of two lists, one representing domestic

governmental and non-governmental organizations and the other made up of bilateral and multi-lateral organizations. The finite number of groups and individuals working in Ghana's anti-HIV/AIDS program defined the boundaries of this case. The sources of data for the survey are listed in table 1 below.

Table 1: List of agencies/organizations in survey

<u>Government Agencies</u>	<u>Donor Agencies\Organizations (Multilateral)</u>
School of Public Health University of Ghana	The World Health Organization (WHO)
The Ghana Aids Commission (GAC)	UNFPA
The Ministry of Health (MOH)	UNAIDS
The National AIDS Control Program (NACP)	The World Bank
Fevers Unit Korle Bu Hospital	UNDP
<u>Non-governmental organizations (NGOs)</u>	<u>Donor Agencies\Organizations (bilateral)</u>
Ghana Business Coalition Against HIV/AIDS (GBCA)	Royal Danish Embassy
Ghana HIV/AIDS Network	U.S. Agency for International Development (USAID)
Ghana Network of People Living with HIV/AIDS (GHANET)	DANIDA
SURE Foundation	
Society for Women and AIDS in Africa (SWAA)	
Hope For Future Generations (HFFG)	
Children and Youth in Broadcasting – Curious Minds (CYIB-CM)	
Theater for a Change	
Centre for Popular Education and Human Rights in Ghana (CEPEHRG)	
Phoenix Foundation	
Human Compassion	
Wisdom Association	
Network of African People Living with HIV (NAP+) Ghana	

I collected data through face-to-face interviews of 50 respondents composed of three respondent groups; public officials (10), NGO officials (28) and donor officials (11). The survey administered a semi-structured instrument that solicited information for a comprehensive picture of the frames of reference of HIV/AIDS experts, activists and

policymakers. The interviews tapped into subjective influences such as thoughts and feelings of participants in the program as they relate to the HIV/AIDS policy in Ghana. The survey data is supplemented with secondary research based on a variety of publications including reports of the Ghana AIDS Commission, the National AIDS/STI Control Programme, and several other organizations and agencies working in the field to capture an objective snapshot of what is going on in the HIV/AIDS policy filed in Ghana today.

5.5 Donors Organizations Surveyed

World Health Organization (WHO)

The World Health Organization (WHO) is a specialized agency of the United Nations with a focus on international health issues. The constitution of WHO was ratified by 61 member nations in 1946. It coordinates health-related matters within the United Nations system including developing and articulating policy, monitoring health trends and providing technical support to member countries. WHO's current priorities include HIV/AIDS, tuberculosis malaria and sexual and reproductive health issues. Together with UNAIDS, WHO has, since 1996, been part of the Working Group on Global HIV/AIDS and STI Surveillance, a UN coordination and implementation mechanism responsible for strengthening national, regional and global structures for HIV/AIDS and STI monitoring and surveillance (WHO, 2008:2) The organization's main role in Ghana, in regards to HIV/AIDS, is to provide technical support for the Ministry of Health (MoH), and the Ghana AIDS Commission (GAC), to provide guidelines for adaptation by government and assist with health centers administering anti-retroviral drugs (ART) to HIV/AIDS patients.

United Nations Population Fund (UNFPA)

The United Nations Population Fund (UNFPA) is a UN organization under the authority of the General Assembly. Its main goals are to promote access to reproductive health services, universal primary education, reduction of maternal mortality, increase in life expectancy and decrease in HIV infection rates in over 150 member nations. UNFPA supports national development in member countries through the Country Programme Action Plan (CPAP) based on the United Nations Assistance Framework and Country Common Assessment. In Ghana, UNFPA works with the Government of Ghana and Civil Society Organizations at national, regional and district levels to implement annual Work Plans which are the local equivalent of (CPAP). UNFPA assistance in Ghana falls into three broad areas; Reproductive health (including HIV/AIDS), Population and development and Gender issues. On HIV, the organization's focus is to integrate STI/HIV prevention into family planning services and condom programming (UNFPA Mission Statement).

Joint United Nations Programme on HIV/AIDS (UNAIDS)

UNAIDS is the leading international organization pushing accelerated, coordinated and comprehensive intervention in HIV/AIDS. It unites the efforts of UN agencies, civil society groups, governments, global institutions, private sector organizations and people living with and affected by HIV/AIDS. The organization's main focus is to provide leadership and advocacy and to mobilize political, technical, scientific and financial resources to address the disease. UNAIDS is sponsored by the World Bank and various UN agencies including

The Office of the UN High Commissioner of Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), International Labor Organization (ILO), UNFPA and the World Health Organization (WHO). The UNAIDS office in Ghana facilitates the HIV/AIDS work of the agency in all the areas mentioned above by principally providing technical support to the Government of Ghana, building partnerships with civil society organizations to strengthen their participation in the national response to HIV/AIDS, supporting the government's decentralized response and working with other UN agencies to promote a more harmonized response to the disease.

The World Bank

The World Bank is the world largest financial institution dedicated to providing loans to developing countries. It is actually comprised of two institutions the International Bank for Reconstruction and Development (IBRD) and the International Development Agency (IDA). While the World Bank represents 186 countries, its management is dominated by the United States and European states which provide the bulk of the bank's funding. The organization has a principal objective to reduce poverty in poor countries through the promotion of foreign investment, capital investment and international trade. The World Bank prepares a Country Assistance Strategy (CAS) for all borrowers accessing funds from the International Development Association (IDA) and the International Bank for Reconstruction and Development (IBRD). The CAS for Ghana, endorsed by the Bank's board in 2007, lays out the World Bank's development priorities and details the type and level of assistance the Bank will provide. That assistance aims to support Ghana's Growth and Poverty Reduction Strategy (GPRS II) to promote attainment of the Millennium Development Goals (MDG) and achievement of a middle-income status. The basic objectives of the Bank are to support economic growth, reduce poverty and reduce inequalities. HIV/AIDS falls under the health portfolio as part of this general strategy. According to its website since 2000 the Bank has provided \$24billion for health and multi-sectoral programs to assist developing countries promote the health of their populations.

United Nations Development Programme (UNDP)

UNDP is the UN's primary development agency supporting national development programs in 177 countries. It is funded entirely through voluntary contributions from member nations. Its principal role is to coordinate global and national efforts to achieve the Millennium Development Goals with an active focus on helping countries attract and use aid effectively. To achieve that goal UNDP links global efforts to national efforts of host countries by focusing on five primary areas; democratic governance, poverty reduction, environment and energy, HIV/AIDS and crisis prevention and management. In Ghana UNDP is the coordinating agency for all UN agencies and that includes supporting the UN Strategic Implementation Plan for HIV/AIDS in which several agencies work together to support prevention and control of the disease. UNDP advocates integration of HIV/AIDS into national development planning and as part of that promotes human rights and gender equality.

Royal Danish Embassy/DANIDA

DANIDA was established in 1962 as the principal Danish agency for international development cooperation and assistance. In the 1990s DANIDA was transformed from an independent unit into a service of the Danish Ministry of Foreign Service. Since then, it has played an active role in poverty reduction and development initiative around the world. As part of supporting Ghana's development objectives DANIDA provides budgetary support for the health sector to Ghana's Ministry of Finance and provides earmarked funds to the Ghana AIDS Commission as part of the public finance of the HIV/AIDS policy. In this role DANIDA is also involved in the policy debates in the health sector and plays a technical advisory role. DANIDA also supports several private sector initiatives and private sector organizations (like the Christian Health Association of Ghana) working in the area of HIV/AIDS. According to the website of the Embassy of Denmark in Ghana, under the fourth phase of Danish support to Ghana's Health sector (2008-2011) a budget of DKK425 was dispensed, an increase of 25% over the previous phase.

U.S. Agency for International Development (USAID)

USAID is an agency of the United States federal government tasked with managing and delivering non-military foreign aid. The agency's activities are based on foreign policy initiatives of the President, Secretary of State and the National Security Council. Funding for USAID comes from annual appropriations from Congress. The stated goals of the agency are to support economic development and provide humanitarian assistance around world as well as to promote the foreign policy goals of the United States. Ghana has long standing relations with the US aid industry dating from the early days of independence in 1957 when a cooperation agreement was signed for technical cooperation and other arrangements in support of Ghana's development. Areas of cooperation have ranged from agriculture to infrastructure to health, education and democratic government. In all these areas, USAID assistance is delivered through multi-year programs working with implementing partners in various policy stages including training, infrastructure development, capacity-building and commodity delivery. In the area of HIV/AIDS specifically, USAID cooperates with the Government of Ghana to address the problem through policy-reform, service delivery and financial commitments.

5.6 Survey

The fieldwork started with identification knowledgeable local and international officials with expertise in the national response for interviews accomplished through personal contacts and interaction within the HIV/AIDS policy community. Respondent selection was oriented towards finding experts and policy makers willing and able to articulate the culture within which they operate.

The next step involved interviewing key people – people with knowledge and understanding of Ghana's HIV/AIDS program. These interviews had both open-ended descriptive questions and more detailed questions. A predetermined open-ended set of questions preceded the more structured questions because respondents generally tend to be less relaxed in the beginning of interviews than they are towards the end. Open-ended

questions may undermine flexibility for the researcher but provide advantages for improved comparability and straight-forward analysis especially in a context in which the researcher wishes to maximize common features among study groups while remaining sensitive to cultural differences (Ulin et al, 2004 :61).

The semi-structures survey instrument allowed me to solicit information used to build a comprehensive picture of the frames of reference of respondents and develop an understanding of how they interpret the world they operate in. I employed a fairly open framework to facilitate focused, two-way communication using, in part, open-ended exploratory questions to capture respondent experience and perceptions of the program. Following open-ended questions, probes were used to obtain more detail and amplification of gray areas. Also, there were a number of standardized questions that were asked of each respondent to identify themes that occur regularly.

I collected information to identify factors that impact the interaction of the domestic public policy apparatus with international aid organizations and their representatives, and with NGOs. My interest was to identify social, cultural, environmental and psychological constructs associated with working within the anti-HIV/AIDS campaign in Ghana. Since the field is composed of multiple institutions, stakeholders and complex policy objectives that correspond to multiple indicators, my interviews focused on assessments of program accomplishments and shortcomings as well as on interpretations of program mission by officials in connected and unconnected institutions.

The survey data was used to create a qualitative database using a software program developed by the Centers for Disease Control and Prevention (CDC) of the US Department of Health and Human Services. Using the EZ-Text³⁰ program, the survey data was subjected to integrated content analysis to help systematically examine the data to find patterns and dominant themes in the responses of the three respondent groups for comparative purposes.

EZ-Text allows a researcher to create a series of data entry templates customized for his/her questionnaire. The user is able to enter open-ended responses to questions directly into the templates either verbatim or as a summary generated from interview notes. The program has functionality that enables users to create online-code books that apply to specific response passages once the data has been entered into the program. This allows for case study development and execution of database queries to classify text passages based on user-specified conditions. Additionally, the program enables data export in several different for-

³⁰The software application is specifically designed to assist researchers to analyze structured and semi-structured questionnaires administered in face-to-face interviews. It is available at <http://www.cdc.gov/hiv/topics/surveillance/resources/software/ez-text/index.htm>

mats for further analyses with related or un-related qualitative data or statistical analysis programs³¹.

Using the EZ-Text software package I defined a set of codes which denote frequently cited ideas and concepts relevant to the HIV and AIDS programme in Ghana. Those codes were then linked to segments of text that represented open-ended responses to survey questions. I was then able to run queries that generated simple frequency counts that allowed me to identify dominate themes in the survey data.

Chapter 6: Survey Findings

This is how the survey supports my model. The National Strategic Framework (or NSF) is the Ghana government policy for addressing HIV/AIDS in Ghana. The government works with several financial and technical partners to implement the National Strategic Framework for HIV/AIDS (Ghana 2007 Progress Report on Universal Access: 3). All respondents surveyed for this study work in some official capacity in HIV/AIDS program. This chapter presents findings from the survey of public officials, donors and NGO representatives working on the program. The survey was conducted during the implementation period of NSF II so survey responses apply to NSF II as well as to its predecessor NSF I. NSF II has the following basic goals: reduction of new infections among vulnerable groups and the general population, fighting the impact of the epidemic on health and socio-economic systems and on infected and affected persons, encouraging healthy lifestyles, especially in regards to sexual and reproductive health (GAC 2009:2). The survey was conducted in April and May of 2010 in Accra the capital of Ghana.

6.1 Public Official Component

Three agencies employ all respondents interviewed in the public official component of the survey: The Ministry of Health (NACP/Fevers Clinic), the Ghana AIDS Commission and the School of Public Health of the University of Ghana. Interviews took place at respondents' places of work. A total of 11 interviews were completed with public officials through electronic recording and handwritten transcripts. The data reported here is an aggregate of responses from public officials as a group of policy actors in the public health system in Ghana.

Interviews were conducted between April and May 2010 at respondents' places of work. A total of 11 interviews were completed with public officials through electronic recording and handwritten transcripts. The data reported here is an aggregate of responses from public officials as a single group.

The interviews were designed to identify and elicit information on:

1. Perceptions of the policy process/output

³¹AnSWR is another software program from CDC designed for use with more complex qualitative projects. Other resources for software selection for qualitative data analysis are available at <http://www.car.ua.edu> and at <http://caqdas.soc.surrey.ac.uk/>

2. Ideas about partnerships
3. Divergence with the other groups in the survey
4. Commonly repeated themes and points of view

Table 2: Breakdown of public official interviews by site

Agency	Location	Respondents
Fevers Clinic, Korle Bu Teaching Hospital, Ministry of Health	Korle Bu Hospital	1
National AIDS/STI Control Program (NACP)	Korle Bu	4
Ghana AIDS Commission	Accra	2
Sch. Of Public Health, University of Ghana	Univ. Of Ghana	4
Total		11

6.1.1 Summary of key findings

- Most public officials in the survey believed HIV is a development issue that undermines financial viability of families, subverts national development, affects poverty and may in turn be affected by poverty.
- Officials saw the scaling up of treatment services (essentially ART drugs) as a positive outcome that has been very successful in reducing cases of full-blown AIDS in Ghana.
- Officials had a perception of capacity-building as fundamental factor to effective intervention at all levels that needs to be pursued aggressively.
- Officials viewed collaboration with donor agencies as critical to the program and more donor funding as needed to expand treatment services.
- Respondents were concerned about failure of behavior change (prevention) programs and favored a change in strategy to promote behavior change among the population.

6.1.2 Views on National Response to HIV/AIDS - Public Officials

Access to care is a constitutional right linked to the right to health enshrined in the Ghana constitution from which both the Ghana AIDS Commission (GAC) and the National AIDS/STI Control Program (NACP) derive their mandates. Many public officials reported

the constitution of Ghana³² as providing the guiding principles for their work. The survey showed a wide recognition among public officials working on HIV/AIDS that scaling up treatment and support to the districts of Ghana has been relatively effective.

6.1.2.1 Impact of HIV/AIDS

Public official respondents universally agreed with the official Ghana government view that HIV is a development issue. According to the NACP “Ghana is faced with the threat of the socio-economic impact of HIV...” (Ghana 2007 Progress Report on Universal Access:1). Respondents said the Ghanaian workforce is getting sick due to HIV eroding productive capacity when victims cannot work. Also the siphoning away of national resources to deal with HIV has a negative effect on development projects and poverty alleviation. While acknowledging that HIV/AIDS affects poverty, some respondents suggested the reverse to be also true in the sense of poverty worsening the impact of HIV/AIDS.

One sentiment reported frequently by respondents is the effect of HIV/AIDS on patients and their families. The severest impact identified is financial hardship. People who previously depended on the now infected person, entire families and society as a whole are adversely affected. That hardship is exacerbated by a 5 Ghana Cedis³³ co pay required for procurement of anti-retroviral drugs. While it is a small amount by North American standards, for a poor Ghanaian family burdened with HIV it can be a huge burden. When patients are unable to come up with the co pay, they get the drugs free of charge. But due to a culture of pride some patients refuse to show up at health centers if they do not have the money for the co pay because of the fear of being looked down upon by health workers. Concern among public officials about HIV/AIDS' effect on children focused on two things:

- 1 The likelihood of children becoming wayward when parent(s) die from AIDS and the poverty conditions the disease engenders which causes children to drop out of school.
- 2 The need for communities and traditional leaders (particularly queen-mothers³⁴) to support orphans and vulnerable children. There was evidence that such support does exist in parts of the country. For example researchers of The School of Public Health of the University of Ghana collaborated with traditional leaders in Manya Krobo³⁵ in the Eastern Region of Ghana to implement HIV-related activities targeting children.

³²Specifically, respondents cited the constitutional provisions on the right information and the right to health.

³³The Cedi is the official currency of Ghana. The name of the currency is derived from the Akan word for cowry shells once used as a form of currency in Ghana. (1 New Ghana = 60Cents US Nov 25 2011 conversion rate)

³⁴Queen mother in the Ghanaian chieftaincy system is not necessarily the chief's (King's) mother but a paramount queen or sub-queen whose role is to work to foster favorable social conditions within the traditional area. Her power and prestige may equal or exceed that of a reigning chief.

³⁵The Manya Krobo district in the Eastern Region of Ghana has the highest HIV/AIDS prevalence in the country. Agomanya, a community within the district reported prevalence rates of 8.4, 8.9 and 8.0 respectively in 2006, 2007 and 2008 (NACP/GHS/MoH, 2009)

6.1.2.2 Results of the National Strategic Framework (NSF)

Public officials generally acknowledged the importance of coordination work being done by the Ghana AIDS Commission but believed that there is room for improvement. 91% of public official respondents reported knowledge of formal or informal coordination of the various groups working on HIV/AIDS, but only 55% thought the program was well coordinated.

Strengths

Respondents perceived the establishment of centers for administration of anti-retroviral drugs (ART) as a positive outcome of the intervention. But those centers are not available in all districts in Ghana because the treatment is hospital-based and some districts do not have hospitals. HIV/AIDS patients in those districts go to centers in other districts or in the cities. This partly explains why coverage of the treatment program only reaches around 50% of all patients. In some cases patients with advanced AIDS were relocated from remote villages to more urban areas with the necessary facilities (like the Fevers Clinic in Accra) and survived as a result of that intervention. Universally, respondents agreed that there aren't as many full-blown AIDS cases in Ghana today because of the combined effects of ART drugs and education.

Weaknesses

The Ghana government's early response to HIV included an extensive media campaign to sensitize the public about the dangerous nature of the disease. That campaign used a scare tactics approach by using skeletons and other scary images to draw attention to the problem. Some public officials expressed the opinion that the campaign was ineffective because of the negative terms in which it portrayed the problem. Some thought information programs for diabetes, hypertension and other terminal diseases provided a good template for HIV information campaigns without the negative connotations. Perhaps due to the drawbacks of that initial campaign, several public official respondents spoke boldly about the limits of government effectiveness. For instance, only 27% believed that government was best equipped (compared to NGOs and donor agencies) to deal with the question of HIV/AIDS and sexuality.

Behavior change or modification emerged an important concern for public officials. The popular view expressed was that despite all that is being done, Ghanaians are not refraining from high-risk behavior. Officials admitted that while basic knowledge of HIV/AIDS is extensive, there is not a lot of comprehensive knowledge that would make people to objectively assess the risks of engaging in certain types of behavior. Some respondents believed more has to be done in terms of using an interpersonal approach to engage a public that may be getting fatigued by information overload on HIV.

Still most public official respondents were satisfied that current efforts in the public sector were adequate to address the problem of HIV/AIDS. The exception is with the attitude of health workers towards HIV/AIDS patients which was cited as one area where progress has been slow. The popular solution for this problem seems to be better in-service training to reduce stigmatization among health workers. This was seen essential to improve the quality

of service provided to persons living with HIV/AIDS (PLHIV). That responsibility falls to the National AIDS/STI Control Programme (NACP) which works in collaboration with other stakeholders to fight stigma (Ghana 2007 Progress Report on Universal Access:17). Public official respondents stressed the importance of addressing stigma within the public health service at the frontline of providing treatment.

Prevalence

Respondents expressed frustration that low national prevalence rates in Ghana are undermined by high prevalence among certain vulnerable groups such as men who have sex with men (MSM), female sex workers (FSW) and male sex workers (MSW). But public officials, unlike donor officials, did not speak of these groups in the terms of human rights. Prevalence among those population groups is much higher than it is among the general population. Respondents said existing laws in Ghana that criminalize both homosexuality and prostitution inhibited the ability of public officials to deal with those high-risk groups. Under Ghana law homosexuality and prostitution are illegal. Section 104 of Ghana's Criminal Code prohibits what it describes as "unnatural carnal knowledge" which many people interpret as implying homosexual behavior. Respondents generally felt that addressing HIV among the general population but neglecting to do the same within those high-risk groups weakens the effectiveness of the national program.

Conflict and Infighting

Infighting among stakeholders emerged as another shortcoming in the national response. Most frequently mentioned was squabbling among NGOs and other support groups over money. Another was disagreements between the Ghana AIDS Commission (GAC) and certain donor agencies (such as USAID) over the definition of the epidemic. The issue of disagreement is the definition of Ghana's HIV epidemic as a "general epidemic" or as a "concentrated epidemic". Agencies that subscribe to the "concentrated epidemic" definition tend to focus their attention and resources primarily on high-risk groups as a way to deal with the problem. That approach conflicts with the Ghana AIDS Commission's definition of the epidemic as a general epidemic that needs to be addressed in a generic way.

Religion

Public official respondents universally identified religion as an obstacle to addressing HIV/AIDS. Accounts narrated to illustrate this problem included citizens' refusal to test for HIV because their religion forbids drawing blood even by pricking a finger; patients abandoning treatment they were already receiving because pastors offered to pray for them to be cured of HIV; patients refusing medications for religious reasons preferring to drink what they call "holy water" or "consecrated water" in the belief that it would cure them; the use of prayer and incantations as a means to get rid of the virus.

While asserting the negative effects of religion on the national response to HIV, several public officials are deeply religious themselves (even superstitious). When asked a majority of officials did not rule out the possibility of HIV being transmitted by supernatural means (witchcraft or black magic). In answer to a the question "What do you think of the idea that

disease and death often have their sources in witchcraft or other forms of black magic?”, fewer than half of public official (45%) “strongly disagreed”. 45% “somewhat agreed” or said they were “unsure” whereas only 9% “somewhat disagreed”. One respondent said that even though it is widely believed that HIV has a spiritual dimension, she counsels her patients to deal with the physical aspects of the disease with drugs and other medical treatment and then address the spiritual aspect spiritually. She said in several years of experience working in hospital wards she can say with authority that some conditions are not amenable to hospital treatment. That view, she said, is shared by some doctors in the hospitals she has worked in.

6.1.2.3 Essential Features of Ghana’s HIV/AIDS policy

Partnership

Public officials widely recognized collaboration with other stakeholders as important for better targeting and for avoidance of duplication and waste. Several examples of collaboration were mentioned to illustrate this. They include: collaboration between WHO and NACP which resulted in transfer of skilled personnel to the NACP; collaboration between NACP and GTZ (German Technical Company); collaboration between the School of Public Health and the Nugochi Memorial Institute for Medical Research (which allows for a more holistic view of the epidemic not just medical but also other aspects like psychological) and with USAID for MSM research. Respondents at the School of Public Health also mentioned research collaboration with John’s Hopkins University in Maryland which they deemed to have been very successful. The World Bank treatment acceleration program was also identified as an example of successful collaboration with private health delivery enterprises.

Decentralization

The decentralized response was mentioned as a good example of cooperation among diverse individuals and groups in the HIV/AIDS sector. That initiative disperses HIV/AIDS activities among district AIDS committees, medical personnel, traditional leaders, religious people, the Ministry of Education, and PLHIV. Some respondents however tied effective care and support to the need for political leadership in, and political support for, the HIV/AIDS program as a whole. The view expressed was that without political support people are less likely to access available services even with the necessary structures in place. Involvement of civil society groups in treatment acceleration, helping set the agenda and providing the impetus for policy initiatives was viewed as a positive aspect of decentralization. Some respondents had a preference for a home-based care approach that involves family members at all stages of treatment including patients’ initial admission to hospital. The belief being that the strength of the family influence would encourage more victims to seek treatment when they become infected with HIV. Other respondents spoke of the importance of using social gathering like funerals, church services and other informal meetings/gatherings to spread the message of HIV/AIDS.

Donor Relations

Respondents reported strong relations with donor agencies. 82% of public officials thought their agencies had a good working relation with donor organization. There was equally positive assessment of the Ghana AIDS Commission's (GAC) dialogue with donors and development partners. Also a clear majority of Public officials (72%) believed their agencies had working relationships with NGOs in the field. However, the nature of that relationship is described as a "partnership". There was no mention of "dialoguing" between GAC and NGOs but the overall common sentiment was that there is meaningful dialoguing and information sharing on the national response.

Cooperation and Collaboration

While respondents universally agreed that there is good cooperation and collaboration, there was also mention of areas of weak collaboration among different public sector agencies. Officials of the School of Public Health decried the lack of collaboration between the public policy agencies (more specifically GAC and NACP) and academic institutions. The impression given was that any collaboration between The School of Public Health and other agencies was restricted to joint applications for research funding. School officials felt left out of all other aspects of the intervention. That point was illustrated by pointing to the lack of representation of the academic community in the Ghana AIDS Commission. Some researchers expressed a desire to see the composition of GAC changed include all professional groups involved in the national response so that decisions are not skewed towards any particular professional direction to the detriment of others.

6.1.2.4 Ideas on Improving HIV Intervention

Capacity Building

Capacity building³⁶ came up as an area of enormous concern to public official respondents. The survey identified a perception among those respondents that defines capacity building in terms of:

- ^ Freedom to use their skills to execute tasks assigned to them without much interference from above.
- ^ Availability of donor assistance to develop the capacity of private facilities to deliver ART.
- ^ Developing the general capacity of the health delivery system terms of infrastructure, logistics and human resource development.

Behavior Change

While, there was positive sentiment expressed about efforts to promote behavior change (for instance, NACP partnering with other groups to start a program to bring behavior

³⁶ Since the 1990s the term *capacity-building* has been used in UN circles to represent the processes of building technical and non-technical resource capabilities of local development partners at various levels of operation. It is often based upon assessments of local contextual imperatives such as existing capacities, potential and weaknesses. In health care, the term has been used to represent "building of infrastructure (staff, skills, resources, structures) across health and other agencies to tackle particular health problems." (Hawe et al.1998:285)

change to communities), several respondents mentioned a need for a more targeted approach to dealing with issues like stigma to replace the blanket approach currently in use. The idea is that issues like stigma are subject to the particular local culture of a community and therefore must be approached as such. The general view was that community gatekeepers are an important part of the partnership because in the words of one respondent, “they allow us to enter their communities and engage their people” so they represent an opportunity for a more community-centered intervention.

Funding

Among public official respondents there was acknowledgement that the large proportion of funding for HIV/AIDS policy coming from donors has been positive for the national response. Still respondents considered additional funding from the donor community (especially from the Global Fund) essential for government agencies to continue provide treatment services free for those who cannot afford them. “The estimated cost of the first line of therapy is USD30 per patient per month (GHS/MoH, 2006:12). Five Ghana Cedis co pay charged to patients covers the cost of delivering the drugs and conducting laboratory investigations.

Community

Opinions on the extent of community involvement in the national response were mixed. Respondents from The School of Public Health (University of Ghana) described their work with community members in Manya Krobo in the Eastern Region as yielding positive results. Generally however, most respondents opined that more community work is needed especially since behavior change initiatives seem to be falling short. The view was expressed that something different needs to be done about the knowledge base of HIV/AIDS among the Ghanaian population. Also community work was seen as essential to help alleviate the plight of PLHIV especially in villages where victims are shunned because even family members are afraid to have contact with them due to stigma and fear of contracting the disease.

6.1.2.5 Conclusion: Public Official Framing Strategies

To understand the policy differences and the specific preferences of stakeholders this study examined how actors conceptualize issues and define their social situations by investigating the framing strategies used. That approach is consistent with my conception of the HIV/AIDS policy in Ghana as a socio-cognitive process with the main the players (donors, NGOs and public officials) engaged in a discourse in which meaning is constructed through the use of thematic structures empirically operationalizable enough to allow us to find evidence of the framing of strategies related to the HIV/AIDS. As Chong and Druckman (2007:104) submit, “an issue can be viewed from a variety of perspectives and can be construed as having implications for multiple values or considerations. Framing refers to the process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue.”

Most public officials in this study find themselves in the positions they are as a consequence of the professional progression of their careers rather than any conscious

choice or preference to be working in that policy area. They are employed by civil and public service agencies steeped in administrative procedures that leave little room for individual initiative. They are also government bodies based on a colonial structure that has persisted several decades after the end of colonialism. The main difference is that these bodies have been transformed from entities established to extract wealth and resources to the colonial metropolis into civil and public service agencies that are largely intermediary agencies for utilization of development aid and disbursement of domestic resources generated by the Ghana government. Based on this what the survey data shows is that public officials do experience the intervention situation through certain interpretive schemata.

Capacity-building

One important frame that unfolds from analysis of survey responses is *capacity-building*. This may be viewed within the context of a Ghana position as a receiver of development aid. The use of the capacity-building frame is a reflection not just of the lack of capacity within the country to deliver essential health services in Ghana, but also of the frustrations encountered by public officials in their day to day work. Strengthening the health system institutionally and in terms of infrastructure and human resource development will make it easier for public officials to perform their tasks. The beneficiaries of improved capacity would not just be public officials and their subordinates but also users of the health sector which includes all citizens. While public officials may have many different motives in the performance of their duties the survey shows that many have a dedication and passion to perform their duties as effectively as they can despite relatively low wages. It is the passion to affect humanity and to keep people alive in a work environment dealing with a disease that has such devastating effects on people infected by it.

Being a developing country Ghana's public health system faces enormous challenges. The term *capacity-building* is used to define a weak public health infrastructure. There is both institutional and infrastructural weakness in the overall health system. While the need for improved capacity opens the door to international intervention, fulfilling that need becomes a form of empowerment that allows public officials to put their skills to better use and better manage the disease. It makes the work of officials easier if the capacity of the system to handle the problem is improved. One element of this frame is *technical assistance* signifying training as well as support in building systems and processes for the HIV program. Frequent references to infrastructure, logistics and human resource needs of public agencies and to systemic institutional development needs for the health delivery system in the country reflect the element of technical assistance. Because of a weak private sector in Ghana most public health service is provided by government agencies. Overtime public officials in that policy area develop an innate sense of service to the public without which victims of the disease would be much worse off. So the drive to provide specialized care and support for HIV patients seems strong among public officials out of a sense of duty, vocation and commitment. Improved capacity creates an enabling environment for these actors.

Collaboration

In a country with a sizeable portion of the country's budget funded from external sources many policy initiatives are in part aid receiving exercises. This is in part the result of weak capacity within the state and lack of financial resources to develop that capacity. Foreign aid being the principal source of finance for capital investment, public officials in Ghana have developed an inevitable collaborative relationship with officials of the aid-giving agencies that they have deal with to develop the capacity needed to deliver services to the population. The use of *collaboration* as a frame reflects the degree to which public servants place a premium on relations with donor agencies to ensure the continued availability of external funding. Such collaboration often leads to strong personal relations between individuals who work together on multiple projects over a long period of time.

In the survey statements about collaboration were embedded in ideas of global awareness and global networking. So the emphasis is on collaboration with donors not necessarily with other local groups like NGOs and CBOs. These actors serve at the frontline of foreign aid in Ghana and tend to cultivate active collaboration with representatives international agencies. Collaboration demonstrates not just actors' broad global view of cooperation but also local relationships with representatives of international organizations to further the objectives of intervention. In some cases it is to help avoid duplication as in public official actors ensuring that donor assistance is utilized in the most efficient way. One example is collaboration to avoid multiple agencies targeting the same areas to provide grant money towards the training of counselors. The same outlook facilitated transfer of personnel from donor organizations like the WHO to government agencies like NACP. Those kinds of arrangements further strengthen the use of this frame among public official actors. Examples include collaboration between the School of public health with Nugochi Memorial Institute for Medical Research and FHI for HIV/AIDS research and with USAID on MSM research and the World Bank treatment acceleration programme making it possible to build capacity for private facilities to deliver ART.

Globalism

In a sense, collaboration in the HIV/AIDS policy in Ghana is inevitable because many policy decisions implemented are actually crafted globally and public officials are tasked to manage projects in collaboration with their donor counterparts. In the survey public official actors demonstrated a high propensity towards subscription to the idea of a global village as a framework for addressing HIV/AIDS. *Globalism* reflects on one hand a historical reliance on international aid for national development and on the other hand acceptance of the fact that some issues are best dealt with at a global level. Actors cited ease of travel across national borders, international meetings and conferences, international dialoguing, international funding of and technical assistance for local programmes as reflective of the global village concept. A high value is placed on the notion of learning from other people's experiences a lot of which is encapsulated in official manuals used by government agencies. Since these actors conceptualize the problem in global terms this frame is contingent on the belief that a global approach is needed to combat a global problem. It projects an image of

public officials as local representatives of a culture of service and of doing things of which foreign donor officials have a natural role.

Public officials have become dependent on donor resources to help address health problems associated with HIV/AIDS. In many ways the activities of public servants in the HIV/AIDS field in Ghana is guided by their relationship with the principal benefactors of the programme the donor agencies. Their work is framed in collaboration terms because it is largely driven by financial resources and technical assistance provided by donors. Globalism also explains the urban-bias and large-scale approach that characterize HIV policy in Ghana.

6.2 NGO Component

NGOs play a vital role in Ghana's national response to HIV/AIDS ranging from policy implementation, advocacy to promoting the welfare of HIV/AIDS victims. The survey data shows NGOs constantly engaged in activity to influence public policy on HIV. Some NGO officials consider their role as one of policing government policy on HIV. This is best evidenced by their effort to influence the supply and cost of anti-retroviral drugs.

NGOs covered in the survey vary in size and orientation. Some are well-organized and well-resourced due to patronage of state and/or non-state agencies or organizations. Others are small in size and scope, not so well organized or resourced and a few are just one-person-operations. Most share the goal of helping improve the lives of PLHIV in one way or another.

Interviews were conducted between April and May 2010 at respondents' places of work. A total of 28 interviews were completed with NGO officials through electronic recording and handwritten transcripts. The data reported here is an aggregate of responses from NGO officials as a single group.

The NGO interviews were designed to elicit information on:

1. Perceptions of the policy process/output
2. Ideas about partnerships
3. Divergence with the other groups in the survey
4. Commonly repeated themes and points of view

Table 3: Breakdown of NGO data collection by site

NGO	Location	Respondents
Wisdom Association	Korle Bu Hospital	2
NAP+	Abofu - Achimota	2
GHANET	Secretariat, Accra	5
SURE Foundation	Korle Bu	1
SWAA	HFFG Office, Awudome	3
HFFG	HFFG Office, Awudome	2
CYIB (Curious Minds)	GBC, Accra	6
Theater for a Change	Labadi	3
CEPEHRG	Accra	1
PHOENIX Foundation	Korle Bu Hospital	1
Human Compassion	Ofankor	1
GBCA	Accra	1

6.2.1 Summary of Findings

- NGOs play the role of implementers in the NSF. Bigger NGOs operate at both the national and decentralized levels (regional, district and community). Their presence in the regions and districts of Ghana make them ideal for the work that is done on the ground, and NGOs generally favor strengthening of the decentralized structure.
- Funding is a major constraint for NGO work. To address that constraint some NGOs collaborate to raise funds. Their reliance on outside funding explains their support for the work being done by the Global Fund and other donors and their desire for more direct relations with donors to avoid the state bureaucracy and other filters imposed by public agencies. NGO officials generally subscribe to the idea that effective HIV/AIDS intervention is dependent on strong international cooperation.
- Many NGO are formed or run by people who are HIV positive. Most respondents agreed that public perception of PLHIV has improved over the few past years but stigma remains a major problem. Many express a need for more education and community involvement to address stigma.

- Anti-retroviral drugs are considered to have changed the landscape of HIV/AIDS in Ghana. Respondents universally agreed that the drug therapies have the effect of reversing the fortunes of victims of the disease and therefore must be provided free of charge and the service expanded to reach all PLHIV in the country.

6.2.2 Views on National Response to HIV/AIDS - NGO Officials

A good portion of the on-the-ground implementation of Ghana's HIV/AIDS policy is done by NGOs. Most of the funding for the program goes to Ghana AIDS Commission (GAC) which out sources implementation of individual projects to NGOs and other civil society groups. Otherwise these groups have no formal role in the decision making procedures of the Commission. Respondents questioned the wisdom of formulating HIV/AIDS policy without the active involvement of people living with the disease. GAC provides guidelines for use of the funds and training on how to report, monitor and evaluate the work of implementers.

35% of NGO respondents voluntarily identified themselves as HIV positive. Some are pioneers in PLHIV activism in terms of being among the first in the country to publicly disclose their status and openly discuss it on radio and TV. These respondents widely recognized the need to provide care for infected persons as well as those affected by the disease. Their passionate commitment to HIV/AIDS issues and their activism is epitomized by the work being done by groups like the WISDOM Association, a support group that helps provide care and support for PLHIV, orphans and vulnerable children (OVC), as well as engage in education and sensitization programs to fight stigma and discrimination. PLHIV at the Wisdom Association are engaged as Models of Hope³⁷, a concept aimed at promoting participation of PLHIV as “adherence and psychosocial counselors, peer educators, advocates of living positively with HIV, support staff at ART sites, and linkages between the sites and communities” (Ghana 2007 Progress Report on Universal Access:21).

6.2.2.1 Impact of HIV/AIDS

NGO respondents agreed universally that HIV/AIDS creates poverty which has community-wide and nation-wide implications. Many victims go through various channels seeking unconventional remedies for HIV before eventually ending up in hospital. Those remedies include herbal treatments and the work of magic doctors some of whom would mislead patients about possible cures for their ailment. In the process, patients use up their finances treating symptoms even before they receive their HIV diagnosis. That tendency progressively lowers patient's living standards irrespective of their status in society prior to falling ill. That financial crisis spreads from patients all the way to the government as resources are diverted from other areas of need to the treatment of HIV/AIDS patients. Economic effects of HIV on the workforce are profound not just because of those infected but also in terms of those affected. Respondents referred to the influx of male and female

³⁷The concept evolved from the collaborative effort of USAID/SHARP, GHS/NACP, WHO, UNAIDS, NAP+ and a number of ART sites in Ghana (Ghana 2007 Progress Report on Universal Access:21)

sex workers to new industries dealing with cocoa and mining as a major driver of the disease.

6.2.2.2 Results of the National Strategic Framework (NSF)

Strengths

Qualitative results of the survey showed that availability of anti-retroviral therapies (ART) is a subject of enormous importance to NGO respondents. All NGO respondents recognized ART as an important intervention in the lives PLHIV. The drug intervention lowers patients' CD4 cell counts³⁸. Respondents spoke of the pre-ART days when patients resorted to herbal treatments in the hope that the virus could be controlled by the herbs until a cure was found for the disease. Ghana has a history of herbalists (traditional healers) claiming to have a found cure for HIV, but verified result of a cure has ever been published. The general perception among these respondents was that PLHIV in Ghana are doing much better now, in terms of treatment and support, than was the case previously.

HIV/AIDS Drugs

Another aspect of successful ART intervention reported by NGO respondents was in regards to Prevention of Mother to Child Transmission (PMTCT). As with other African countries, it is believed that HIV transmission during childbirth or breastfeeding is the second most common transmission mode in Ghana, accounting for approximately 15% of new infections (Ministry of Health, 2008:7). PMTCT³⁹ is a comprehensive package of services designed to protect the baby from infection from the mother while in the womb, during birth and through feeding after birth. The program also includes prevention of infection in women, avoidance of unwanted pregnancies and treatment/support for women living with HIV and their families (UNAIDS, 2009:8). PMTCT started in Ghana with drugs supplied for free by Boehringer Ingelheim, a South African subsidiary of the parent German company. Ghana also benefited from another free donation of drugs for treatment of opportunistic diseases by Pfizer (NACP, 2007:9). One respondent narrated her own story to demonstrate the effectiveness of PMTCT. She was infected by her first husband who subsequently died of AIDS. She joined an NGO and has been on ART and been able to remarry a man who is HIV negative and deliver a baby also HIV negative all due to PMTCT treatment.

Life

The concept of “life” came out as very important to NGO respondents. Many who are also living with HIV expressed joy to be alive despite years of living with the infection. The hope to live even longer drives their support for the fight against the HIV. Almost all gave the credit to the ART drugs for their own lives and for the lives of countless others. For some respondents, losing partners to HIV made them more appreciative of their own lives. For all these reasons, many equated ART drugs to life as they enable people to live longer. NGO officials who did not have personal HIV stories spoke of clients whose health fortunes

³⁸CD4 cell count is the test by which doctors evaluate the strength of the patient's immune system.

³⁹Some researchers now say even without PMTCT only about 15 percent of HIV positive mothers we infecting their babies with the virus. This is based on the finding that the infection occurred during passage through the birth canal (<http://www.cnn.com/2011/HEALTH/06/01/scruggs.hiv.aids/index.html>).

had been reversed through their intervention, taking pride in helping save their lives. With growing confidence in the drug therapies, PLHIV now go in for treatment on their own free will and adhere to their drug prescriptions because of the desire to live and to increase their lifespan. Beyond that, with the virus being controlled by ART victims are now fighting to live fuller lives, to achieve a purpose in life.

Partnerships

While NGO partnerships with GAC, NACP and other government agencies are pivotal to those organizations' effectiveness, there is also considerable collaboration and partnership among NGOs for various activities and programs. GHANET is a major player when it comes to collaboration among NGOs. The survey results show that most NGO collaboration (often with state or other civil society groups) has a funding imperative. Inter-NGO cooperation also came up as a positive outcome of the intervention program. Representatives of GHANET and NAP+ point out that those organizations are successful because of dialoguing with other organizations. Some examples include NAP+ and WAAG (West Africa AIDS Foundation in Ghana) working together to organize a successful concert on HIV/AIDS at Alliance Frances in 200; NAP+ working in partnership with Plan Ghana on community mobilization; GHANET partnering with SIPAA to arrange provision of a regional office for GHANET; SWAA and PPAG working jointly to secure funds from the Global Fund; and partnership between Curious Minds and UNICEF to organize programmes to reduce HIV/AIDS.

Weaknesses

Stigma

“Stigma” or “stigmatization” emerged as a subject of great concern among this group of respondents. There was universal agreement that stigma is the biggest stumbling block in the fight against HIV/AIDS and should be aggressively addressed including from health center and community points of view. HIV/AIDS victims receiving treatment, with ART drugs, now have greater concern with stigma than they have with the virus. In the words of one respondent “HIV does not kill anymore, stigma kills”. Respondents spoke of the tendency for Ghanaians to refuse to purchase goods/services from vendors they know to be HIV positive. Many victims refuse to disclose their HIV positive status to avoid being stigmatized. One respondent said “‘big men’ are dying quietly from HIV because they refuse to disclose their status - ministers, chiefs, family elders etc - these are the people responsible for stigma which worsens the HIV situation and makes people fear the disease”. Consequences of stigma identified in the survey include:

- ⤴ PLHIV refusing to disclose their HIV positive status
- ⤴ loss of accommodation due to victims being evicted from places of residence when their HIV positive status became known to their landlord/landlady
- ⤴ PLHIV refusing to discuss their HIV positive status publicly
- ⤴ Deterioration in the lives PLHIV
- ⤴ Victims hiding their condition from spouses even while receiving treatment

In spite of all the physical effects of the disease, respondents widely agreed that many victims are unable to contribute to society because of stigma rather than their inability to be productive.

Funding

In spite of rapid increase in funding⁴⁰ for HIV/AIDS activities in Ghana, the majority of NGO respondents cited funding as their biggest challenge. This is confirmed by the Ghana National AIDS Spending Assessment Study, 2007 which states that “adequate funding remains the key challenge for implementers” (2007:6). Respondents said that because around 70% of funding for HIV/AIDS comes from external sources, challenges in the global economy, like the current financial crises in donor nations, lead to drastic reductions in funding. Even previously committed funds can be reduced without any discussion with recipients. Respondents from the WISDOM Association, an NGO based at the Korle Bu hospital in Accra, said they only receive funding for a few months in a year and are compelled, as a result, to seek independent sources of funding such as farming. The group engages in farming of grass-cutter and pineapple with plans to expand to include other crops like maize and peppers. In spite of, or perhaps because of, the funding shortage several NGO respondents expressed a belief in the concept of a ‘global village’ as it relates to HIV.

A minority of respondents opined that it is a challenge when funding organizations sometimes push things on NGOs based on their own perceptions. One respondent called it a “west-centric approach by which the development models of the west are supposed to be replicated in developing countries”. Others were unhappy about the policy of channeling funds either through district assemblies (which may use part of the money for their own political purposes) or bigger NGOs for further distribution to smaller ones. They expressed a preference for funds going directly from GAC to small NGOs without any intermediaries.

Religion

The role of religion in the fight against HIV in Ghana is controversial. 93% of NGO respondents said people's religious beliefs make a difference in their attitudes toward HIV/AIDS. Officials said religious organizations are partly responsible for the stigmatization of the disease in Ghana. Some teachings/practices of Christianity and Islam, the two main religions in Ghana, are believed to undermine the HIV/AIDS policy. Some churches refuse to mention HIV at all because of the stigma attached to it. Respondents said religious teachings lead people to associate contracting HIV with living an immoral lifestyle because religious leaders quote scriptures to support controversial views on HIV/AIDS. Victims of HIV have been suspended from churches because their status has become known. One HIV positive female respondent narrated an incident which occurred in church one day when the preacher said that only fornicators got infected with HIV. The lady had been infected by her husband who had since died of the disease. She walked out of the church in tears. Respondents said such religious teaching discourages congregants from obtaining treatment when they get infected with HIV and instead resort to unreliable alternate remedies. As one re-

⁴⁰Total expenditure on HIV/AIDS activities in Ghana increased by 61% between 2006 and 2007 to around US\$52.4m (Ghana National AIDS Spending Assessment Study, 2007:6).

spondent said, Christianity preaches love but does not extend it to PLHIV. Some respondents had difficulty reconciling religious condemnation of the disease on one hand with preaching against condom use on the other as is the case in some churches.

Despite apprehension of such attitudes toward HIV in religious circles, many respondents expressed strong religious views of their own. One HIV positive respondent answered the survey question “What word or phrase would you use to describe your agency’s most positive characteristic?” with the following bible quote “Goodness and mercy shall follow us...” Another respondent used a different quote in response to the same question “A beacon of light at the shore for the tempest-tossed sailors.”

Islamic teachings and practices were also reported to inhibit the fight against HIV. One respondent, who hails from the northern part of Ghana where Islam is the predominant religion, said Islamic marriage gives the man authority to do whatever he wants with the woman. “Women lose confidence in themselves”. It is a reference to the sexual subjugation of women which denies them the right to negotiate sex or safe sex. Other respondents mentioned the practice of polygamy and wife inheritance, also common practices in northern Ghana, as religious customs in the Islamic faith that fuel the spread of HIV. Marriage plays an important role in the fight against HIV because it legitimizes sex which is the main mode of transmission of the virus. Polygamy increases the possibility of multiple infections if any of the wives or the husband is exposed to the disease.

89% of NGO respondents believed tradition and culture have an important role to play in HIV/AIDS intervention. But they were not seen as always having a negative effect. While many cited significant cultural barriers to implementation of HIV policy, others viewed Ghana’s cultural traditions in a positive light as containing practices that could support the fight against HIV/AIDS. Aspects of the traditional system suggested as potentially useful for the fight against HIV include: having chiefs summon residents to HIV community events through the drum beat; paying due respect to the chieftains in the traditional areas to gain their support for the intervention programs; and encouraging rituals of puberty rites and rites of passage that forbid sex below a certain age or before marriage.

Those that seek to avoid the negative influences of culture speak of traditional beliefs said to reinforce stigma including the culture of arbitrary marriage and polygamy; taboo; and practices like female circumcision (banned in Ghana but still practiced in some areas). Most NGO respondents advocated modification of the traditional and cultural practices that undermine the rights of victims of HIV. Equally important to them was the need to weave human rights and values of decency into Ghanaian culture. Some voiced a preference for an educational system that starts from a traditional and cultural perspective. However, the difficulty of changing long held beliefs and customs was not lost on respondents. One respondent conveyed the sentiments of a common proverb among members of the Ga ethnic group from southern Ghana “*kusum goboo*” which literally means “custom/tradition never dies”.

Government Support

A third of NGO respondents (75%) did not believe their organizations received adequate support from government even though a majority (93%) acknowledged having some sort of relationship with government agencies dealing with HIV/AIDS. Perhaps as a result of this any perceived lapses in government response to HIV-related problems leads to NGO action to apply political pressure often through the use of the media. The preferred method of applying pressure is through press conferences, press releases and demonstrations to publicize delay/decline in delivering HIV services especially drugs. Examples include marches, press conferences and press releases organized by NAP+ working in concert with other stakeholders; and SWAA-organized demonstrations when drugs have been in short supply.

Despite skepticism of the role of government, 50% of NGO respondents acquiesced to the important role government plays in the response to HIV. When asked who would be most effective in dealing with the question of HIV and sexuality, 50% said they would trust the government to do that job. With the exception of one respondent who said his organization's relationship with the Ghana government is "not a healthy one", NGO officials generally spoke of what the Government of Ghana and its agencies do in the field of HIV/AIDS in positive terms.

Human Rights

Several NGO officials agreed that human rights, specifically PLHIV rights, were not being adequately addressed in Ghana. Many were critical of what they saw as the lack of political will within the Ghana AIDS Commission (GAC) to seriously address human rights issues. There was the sentiment that GAC spoke about human rights issues without doing enough to help the cause. For instance, infection rates among female sex workers in the two largest cities (Accra and Kumasi) are 8 to 20 higher than in the general population (UNAIDS, 2009:vi) and an analysis of the distribution of infection in Ghana in 2009 found that homosexual males (MSM) contributed 7.2% of all new infections despite constituting just 0.25% of the population. There was 9.6% of incidents per 100 among MSM, 4.0 percent among intravenous drug users and 1.5 percent among sex workers indicating transmission both among and outwards of high-risk groups (ibid:vii). Due these statistics many NGO workers expected GAC to focus more effort on addressing issues relating to those population groups and in particular to their human rights. That perceived neglect of human rights has encouraged some NGOs to incorporate human rights into their own work. For instance, HFFG works to educate PLHIV (and women and children) on their rights. CEPEHRG sees the effort to bring human rights to the issue of HIV/AIDS as its guiding principle adopting the slogan "Human rights for all - sexual rights are human rights" and GBCA speaks of the need to weave human rights issues in Ghanaian culture.

6.2.2.3 Essential Features of Ghana's HIV/AIDS policy

Advocacy

Many NGO officials saw their advocacy on HIV/AIDS issues both at national local levels (rather than implementation) as the most important aspect of their work. That advocacy touches on a wide variety of social issues surrounding HIV/AIDS including treatment and

support for HIV/AIDS patients and the rights of PLHIV to live in a safe, fair and stigma-free environment. It is a desire to create an enabling environment in which PLHIV can be able to access treatment free from stigmatization. While all the NGOs in the survey worked on HIV/AIDS related issues many focus on specific concerns or locations which may, or may not, have a broader social perspective. In many instances, their primary purpose is to provide a voice for a segment of the population that had no representation in the national discourse. “Providing a voice for the voiceless” in the words of one respondent. NAP+ was formed as a mouthpiece for PLHIV in Ghana. The Society for Women and AIDS in Africa (SWAA)⁴¹ specializes in educating and raising awareness of (especially rural) Ghanaian women about issues related to HIV/AIDS (SWAA, pamphlet). The organization is female-biased because of the proportion of female HIV/AIDS victims being higher than that of men. Because HIV affects many children and undermines their access to certain basic needs,⁴² the Children and Youth in Broadcasting - Curious Minds⁴³ aims to change perceptions towards children's rights in the country to include rights to education, food, water and to incorporate that objective into the HIV/AIDS discourse. Theater for a Change⁴⁴ uses theater performances to engage people in communities to promote behavior change.

Community

Respondents expressed a belief in community involvement as important to help address stigma and, among other things, make it easier for PLHIV to access health facilities (hospices) in their communities without fear of stigmatization. A significant portion of the work done by NGOs is done within their communities. Organizations like NAP+ provide leadership within communities (some rural) to sensitize people to HIV, sometimes in partnership with other organizations like WAAG (West Africa AIDS Foundation Ghana) and Plan Ghana. Respondents said because AIDS takes a very heavy toll on communities when its victims are consumed by the disease and are unable to contribute to their families and communities, involving community leaders (traditional leaders and community elders) is crucial to intervention. It allows the message to be framed in a proper and acceptable way for target populations.

Coordination

Most NGO respondents acknowledged the important coordinating role played by the Ghana AIDS Commission (GAC). 93% though GAC does a good job in terms of the integration and interaction of several different actors but expressed dissatisfaction with some policy outcomes. Many thought GAC could do a better job of laying out a vision and getting everybody to work together within that vision. One respondent wanted GAC to be made “lean and meaner and better at coordinating the national response. Right now they only coordi-

⁴¹SWAA is a Pan African women's organization based in Dakar, Senegal.

⁴²HIV prevalence among youth in age range 15-24 rose consistently between 2005 and 2007 (Ghana National AIDS Spending Assessment Study, 2007:8). Annual AIDS deaths of children in Ghana are estimated at 2,566 (NACP/GHS/MOH, 2010b:12).

⁴³CYIB Curious Minds was named global winner of International Children's Day of Broadcasting award- Radio Division (CYIB Quarterly Newsletter – Jan- Mar 2009)

⁴⁴This NGO is the local branch of a UK registered charity that uses interactive and legislative theater as tools for promoting behavior change and the rights of young people.

nate things for which they receive money” Table 4 shows the breakdown of all respondent responses to the question of coordination:

Table 4: Are there formal/informal coordination mechanisms?

Respondent Groups	Yes	No	N/A
NGOs	26	1	1
Donors	11	0	0
Public Officials	10	1	0
Total	47	2	1

While respondents acknowledged GAC's role, each NGO had its own critique of GAC. When asked the question “Which of the following statements best describes your impressions of the HIV/AIDS policy environment in Ghana?” (Table 5), the responses show that less than half of all respondents thought the policy was well coordinated.

Table 5: Impressions of the HIV/AIDS policy environment

	NGO	Donor	Public Officials	Total
Well Coordinated	7	5	6	13
Poorly Coordinated	7	1	0	8
Lacks the Requisite Technical Support	4	0	2	6
Has the Requisite Technical Support	3	2	0	5
Other	6	6	2	12

In terms of relations with donors most NGO respondents (93%) said they cooperated with donor officials. Still there is a strong desire by NGOs for more direct engagement with donor agencies.

Global Trends

NGO officials were in agreement that global trends affect the HIV program because the bulk of the funding for the program came from outside. 96% answered yes to the question “Do global trends have an impact on the HIV/AIDS program here in Ghana”? And a clear majority believed a global approach is required to deal with the problem (86%). Financial reliance on global partners for drugs is the main reason given by respondents for their global outlook. Also some technical issues were considered best dealt with at the global level because of weak technical capacity in Ghana, but many believed that efforts can be made to raise funds locally. The consensus of opinion was that the Global Fund initiative has been a lifeline for HIV/AIDS intervention in Ghana. Without it the outlook would have been much worse. In the absence of a cure for HIV, using ART drugs becomes a lifetime commitment for infected persons. Any interruption in the use of the drugs undermines their effectiveness and poses additional health risks to patients (FHI, NACP 2004).

Awareness

Awareness among the population of HIV/AIDS issues and among PLHIV and their families of treatment, support and prevention opportunities also ranked high among issues raised by NGO officials. Respondents widely held the view that HIV is driven by lack of knowledge and information. The dearth of knowledge is more profound among lower income groups and marginalized groups within which HIV is more prevalent. One poignant illustration of that is the narrative about an extensive campaign on female condoms which ended in failure when it was found that the women were wore the condoms as bracelets rather than use them for contraceptive purposes. Nevertheless, respondents generally agreed that awareness of the disease is up among the general Ghanaian population and this may have contributed to improving perception of PLHIV among the general population. But respondents were also united in the belief that while awareness is on a rise, it has not translated into behavior change among the Ghanaians. As one lady put it “there is a lot of awareness out there, but not much knowledge”.

6.2.2.4 Ideas on Improving HIV Intervention

Drugs

Availability and affordability of the drugs emerged as a major area where NGO officials would love to see better results. Supply of drugs has been intermittent and patients sometimes received lower doses than they have been prescribed. Drug shortages undermine the effectiveness of the treatment because frequent interruptions could ultimately lead to drug resistance (NACP, 2007:11). To assure affordability most NGO respondents favor incorporating treatment for HIV in the National Health Insurance Scheme⁴⁵ (NHIS). The belief is that having the HIV drugs covered by NHIS would eliminate the five Cedis co pay required to fill prescriptions.

Due to its importance for the well-being of patients, some NGO officials actually measured their effectiveness by the number of victims they are able to place on ART treatment. It is a commonly held view that ART has reduced the number full-blown AIDS cases in the country. In communities where people expect a certain physical deterioration to lead to death, the effect of drug therapies has been very fascinating to people. Respondents estimated that 90% of people who have been initiated into anti-retroviral therapies are still alive.

Education

Based on the believe that education is key to prevention and to addressing stigma, there was much concentration on prevention and behavior change communication in the 2000-2005 time period, but in this survey many NGO officials agreed that more “education” is needed: to help people understand the disease; reduce stigma; promote care and support for infected/affected persons and for youth (in-school, out-of-school and within communities); to allow people to open up and talk more freely about the disease; to encourage behavior change and promote testing for HIV. The hope is for an enabling environment in which people make informed choices and avoid risky behaviors. As with the issue of prevention,

⁴⁵Ghana established a National Health Insurance Scheme in 2003. The scheme pays for curative services for enrolled citizens but does not cover ART

respondents seemed to favor the use of a more interpersonal approach to education to address the problem of population groups identified as high risk in terms of exposure to the virus – men who have sex with men (MSM) and female sex workers (FSW).

Employment

That fact that even organizations state and non-state agencies working in HIV would not employ people infected with the virus (even for menial jobs) was used to illustrate the difficult employment situation faced by PLHIV. The only exception is the employment of one patient as a janitor by the Ghana AIDS Commission (GAC). GHANET officials spoke of clients who were once vendors (especially food vendors) who are boycotted by patrons because of their HIV status. Even when they are strong enough to work, PLHIV have difficulty finding employment due to stigma. To address this problem, some NGOs engaged in income-generating activities to help support their members financially. NAP+ officials expressed a preference for some form of arrangement to provide capital for PLHIV to start their own businesses in order to allow those who lost their jobs for stigma-related reasons to get back into the workforce through some form of “micro-finance” initiative. Others would like to see GAC employ PLHIV to help them formulate more HIV-centered programs.

Decentralization

Some respondents questioned the effectiveness of the decentralized response to HIV/AIDS because there is too much concentration on the cities and not enough work being done at the grassroots level. They spoke of the need to be flexible to allow interventions to be bottom-up from the grassroots. It boils down to the allocation and use of funds and the tendency for money to be spent in organizing multiple workshops in the cities while work in the communities has to be done voluntarily. Respondents highlighted the need for more attention to be paid to community mobilization to sensitize people in the rural areas. Tackling stigma at the village and district levels is said to be the most effective way to deal with that problem because rural communities take tradition and culture as a key part of their lifestyle. Officials said education on HIV/AIDS would be more effective if it starts from that level.

Change

NGO officials shared a universally perceived need for change in the field of HIV/AIDS. Areas said to be in urgent need of change were: greater efforts at the community level intervention; change to reduce and even to eliminate the co-pay for the ART drugs and save more lives; and changes to address the negative effects of culture and tradition. Some respondents wanted change in traditions that “have kept us behind” and use information and communication to drive change in societies perception of HIV and patients of HIV to be more positive. Others advocated change in the way children are perceived to include the right to education, food, water. Many want to see greater involvement of traditional leaders to drive change of perception of HIV victims within communities and to drive educational and social change that involves the target group in all stages of the process.

“Family” is an important social unit in Ghana. Unlike in the west, the term embraces the extended family not just one’s spouse and children. The extended family often includes

grandparents, uncles, aunts, cousins, nieces, nephews and others. Respondents expressed concern that when people get infected with HIV they are seen as a disgrace to their families hence PLHIV often become ostracized or there is outright rejection by families. For this reason NGOs advocate prioritizing efforts to bring families on board to support the program.

6.2.2.5 Conclusion: NGO Framing Strategies

As with other actors NGO officials construct meaning on the basis of their social positioning, cultural context and the discursive process involved in their engagement with other actors. As social agents NGO actors construct meaning in innovative ways that reflects the context in which they operate. Framing strategies are a normative process and can also be considered as problem solving mechanisms. The framing strategies of the groups discussed above help to explain some of the discontinuities in encounters and interaction that constitute the policy discourse for HIV in Ghana. We are able to think of Ghana HIV/AIDS policy as a discursive process because of acceptance of word and text as metaphor and acceptance of language and behavior as components of a discourse. Ideas are policy frames which are “coherent systems of normative and cognitive elements which define, in a given field, 'world views' mechanism of identity formation, principles of actions, as well as methodological prescriptions and practices for actors subscribing to the frame” (Bhatia and Coleman, 2003: 716).

Life

Life is a critical *frame* for NGO. These actors work primarily on implementation of the policy on the ground. The WISDOM Association is located in a hospital ward to gain easy access to newly diagnosed HIV victims who see their diagnosis as indicative of imminent death. The clientele and membership are both composed of PLHIV. HIV was once a death sentence but, thanks to new drug therapies, it is now a more of a life sentence if you have access to the drug therapies. By one estimate the drugs will cost \$400,000 per person over a lifetime. While the drugs are subsidized for use by PLHIV in Ghana, not all patients have access to them or can afford the co pay required. Treatment coverage is just around 50 percent of the PLHIV population. So NGOs face a tough challenge of fighting to keep their membership and clients alive. Framing life as a component of policy reflects the principal objective of NGOs to advocate on behalf of their clients and themselves and generally help HIV/AIDS victims prolong their lives.

Several of these actors are HIV positive themselves and/or deal directly with PLHIV. The determination to live full lives and/or help their clients to live full lives is what drives these actors. ART improves a patient’s CD4 count and gives life to people who could otherwise be facing death. These actors see the intervention as life-giving and contextualize issues in HIV policy in terms of their usefulness to the objective of furthering and sustaining life. It shows an appreciation for life which could otherwise have been lost to the disease either among NGO actors themselves or among their clients. It is a desire for long life. Confronting one's mortality at any stage in life can be a traumatic exercise. Confronting it at an early age is worse because the added complication of young children and the increased likelihood of being the principal wage earner for your family.

For PLHIV with access to the drugs their fight for life is not a fight against the virus but against stigma which at that stage is more life threatening than the virus itself. Any one of many possible outcomes of being stigmatized could be life threatening including loss of employment or failure to secure employment and being ostracized within one's family and/or community. Advocating life refers not just to pushing for the well-being of PLHIV in health matters and health policies but also promoting awareness creation to fight stigma.

Anti-retroviral therapies make up the principal element of the life frame. Some respondents had been taking the drug cocktails for almost a decade. For those actors the policy is in essence life-saving for both infected and affected persons. Some had lost spouses to the disease and had become sole supporters of their dependants and were determined to avoid what happened to their partners. Another element of the frame is treatment (clearly the most successful aspect of the programme) which represents good health and therefore is the foundation of a good life. Without it a person's very humanity is threatened. By framing aspects of the policy in life terms, NGO actors emphasize the importance of good health to a person's survival in an environment that harbors many other circumstances deleterious to the wellbeing of PLHIV.

Finance

NGO actors are in the forefront of the fight against HIV/AIDS doing most of the implementation. Many came from poor backgrounds or have been impoverished by the disease and most of their clients are also poor. The finance frame reflects the impoverishing effect of the disease. These actors, many of whom are PLHIV themselves, deal with poverty on a daily basis both in terms of their own sustenance and/or the ability of their clients to meet their basic needs of food, clothing, shelter, and employment. Stigma ensures that only the poor and lower class citizens disclose their status.

NGOs representatives in the survey cited funding as their biggest challenge. With donor money funding most of the HIV program, people in dire need of finance naturally associate donors with money. In such an environment of poverty there is a high likelihood of people framing issues based on an expectation of financial gain. The importance of money is also influential in the push by NGOs for direct engagement with donors. This framing strategy is a survival mechanism as money provides sustenance and builds capacity at the NGO level.

Having a Voice

NGOs have become the voice of PLHIV in Ghana. NAP+ is a principal voice for PLHIV and their support groups. Like many other organizations like it, it is an important mouthpiece for its membership because without it PLHIV would have no voice in the society. Networking allows PLHIV to acquire a voice. Something they would not get by acting individually. NSF provides the framework for a discourse therefore NGO actors frame the intervention in terms of providing a voice for themselves and/or their clients.

Especially for victims belonging to a demographic that is already disenfranchised like women, children, MSM and FSW, the importance of NGOs as a mouthpiece cannot be

overemphasized. Having a voice is useless unless you're being heard. Keenly aware of what an important vehicle the national program is for getting voices heard PLHIV use that voice to apply political pressure to push policy options favorable to them. Most of that pressure is focused on fighting for better access and affordability of anti-retroviral drugs. These groups use press conferences, demonstrations and press releases to push for favorable health policies and for government action where they see it is lacking. Those avenues and instruments serve as practical manifestations of the voice frame.

In all sections of Ghanaian society, PLHIV are subjected to all forms of abuse, rejection and discrimination. They have no voice in religious circles. Politicians shy away from actively advocating on their behalf. Only people professionally involved in the field in one capacity or another speak on the behalf of PLHIV. So the HIV program is the only platform that allows them to have a voice. NGO support for decentralization will extend that voice from the national platform to the regional and district levels and into rural areas where there is often very scant information. It is seen as a way to improve the lives of PLHIV within communities. This is because stigma is often perpetuated within communities where PLHIV are most visible. Also having a voice is critical for people's ability to fight for their rights including their human rights. The NSF thus provides a platform to champion the human rights of PLHIV.

6.3 Donor Component

Since the 1990s HIV has been the most visible public health issue internationally and within individual nations. The policy model developed internationally to combat the disease in the poor countries was one that focused on a treatment and care based on an internationally-financed state-run system. The system is internationally-funded because of weak state capacity, heavy dependence on public finance and minimal private health sector funding in those countries. It is state-run because market-oriented intervention in health care is very weak. International funding for HIV/AIDS took off about 10 years ago when the World Bank took a stand for controlling the disease and supported the creation of UNAIDS. The Bank saw HIV as a growing problem that could get worse with time and advocated active steps to combat the disease putting up a lot of money toward UNAIDS in the process.

Table 6: Breakdown of donor data collection by site

Organization	Location	Respondents
DANIDA	DANIDA Offices, Accra	1
World Health Organization	WHO Offices, Accra	1
Embassy of Denmark	Embassy Offices, Accra	2
UNAIDS	UNAIDS Offices, Accra	2
UNFPA	UNFPA Offices, Accra	2
UNDP	UNDP Offices, Accra	1
The World Bank	World Bank Offices, Accra	1
USAID	US Embassy, Accra	1

Interviews were conducted between April and May 2010 at respondents' places of work. A total of 9 interviews were completed with donor officials through electronic recording and handwritten transcripts. The data reported here is an aggregate of responses from donor officials as a single group.

The donor interviews were designed to elicit information on:

1. Perceptions of the policy process/output
2. Ideas about partnerships
3. Divergence with the other groups in the survey
4. Commonly repeated themes and points of view

6.3.1 Summary of Key Findings

- Funding from the Global Fund to AIDS Fight Tuberculosis and Malaria has been critical for implementing Ghana's National Strategic Framework for HIV/AIDS (NSF), but some questioned the wisdom of treating HIV as a separate programme from other health delivery services.
- There was no consensus among donors about the best way to fund the programme. Some donor agencies pursue their own interests without much involvement of GAC.
- There is a sentiment that there has not been a requisite requirement of accountability for the huge amounts of money being poured into HIV/AIDS intervention in Ghana nor a reliance on research data to determine what funding levels are needed.

- Respondents considered the national response to HIV/AIDS as well coordinated despite enormous challenges faced by the Ghana AIDS Commission but the decentralized response as relatively weak.
- Donor respondents universally believed that there was inadequate attention being paid to issues concerning marginalized sections of the population with high HIV prevalence (MSM/FSW) and to human rights and the welfare of children.

6.3.2 Views on National Response - Donor Officials

6.3.2.1 Impact of HIV/AIDS

The World Health Organization considers HIV/AIDS as a “major challenge to global health and socio-economic development of many countries including Ghana (NACP, 2007:6). Representatives of donor agencies in this survey were unanimous in identifying HIV/AIDS as an important factor in the country’s development with 91% agreeing that HIV should be rightly linked to support for Ghana’s socio-economic development while 100% considered their work to be in support of the UN Millennium Development Goals (MDG).

Providers of bilateral assistance often have specific interests which may or may not be linked to strategic and economic national self-interests. For instance, Denmark has an agenda to focus on Africa because of the perception that there is a need in the area of HIV/AIDS. Multi-lateral aid is less tied to national self-interest. The World Bank considers HIV/AIDS as a development issue based on evidence analytical work which formed the basis of their defining HIV in Africa as a major development problem. Some respondents viewed the involvement of the UN and the Global Fund as resulting from the perception that the disease does impact development prospects. UN support for Ghana’s development through the UN Development Assistance Framework (UNDAF) reflects the collective response of UN agencies to Ghana’s priorities of national development.

The qualitative results show that donor respondents widely agreed on the impoverishing effects HIV/AIDS because of the strain it puts on resources from all sectors of the economy, but 10% were skeptical about the impact on overall economic development. HIV is perceived to affect life expectancy, education, food and security in significant ways but the skeptics believed that since the disease in Ghana is very compartmentalized with high prevalence in particular population groups it may be an overstatement to suggest that HIV/AIDS is holding up development since Ghana is experiencing impressive growth and average incomes are on an upward trend. Besides HIV in Ghana is relatively stable and being a mixed epidemic with population segments with high and low prevalence, those skeptics believed that perhaps the question could be posed as to whether the reverse is equally true - that development affects HIV/AIDS. In one respondent’s words, “are there more poor people because of HIV/AIDS? I don’t know. Are there more people getting infected because they are rising out of poverty” implying that you need money to pay for the services of sex workers. Some donor officials voiced suspicion that Ghanaian officials may be shying away from the truth about HIV in the country because it could undermine fund-raising efforts and reduce

the amount of money being allocated for intervention in the country. One official was of the view that the low general prevalence in Ghana suggests that HIV does not affect the economy as a whole even though it significantly affects individuals.

6.3.2.2 Results of the National Strategic Framework (NSF)

Strengths

Like NGO and public officials in the survey, donor respondents considered anti-retroviral therapies (ART) as a positive outcome of Ghana HIV policy. They not only provide health improvements to infected persons but also have significant public health benefits for prevention and transmission. Some officials considered the positive public health benefits of ART so huge that they thought country must reach for universal access. Ghana currently has 120 treatment centers catering to 35,000 patients with about 100,000 in need of treatment. Meaning ART coverage is less than 50 percent across the country. So while there is an overall positive view of drug interventions, some donor representatives believed Ghana is underperforming in the area of universal access. Challenges preventing attainment of universal coverage include access to treatment, affordability, human resources, inadequate stocks, stigma and discrimination from health care providers.

Securing Global Fund support for Ghana (mainly to purchase and supply ART drugs) was a major collaborative effort that involved different partners including the Ghana Health Service (GHS), GAC and development partners. Officials spoke of such global collaboration as essential to addressing HIV/AIDS in a holistic way. Perhaps because of such collaboration, the survey data suggests that donor agencies speak with more of a united voice than the local agencies.

Another area of strength reported by donor agencies is their selective use of individual strengths to secure more effective utilization of their individual areas of expertise by allowing individual teams to deal with areas in which they have a comparative advantage. For instance UNFPA works on prevention based upon the division of labor within the UN system (prevention among young people, women, PLHIV and most at-risk populations MARPS) as its contribution to the entire UN response, the International Labor Organization (ILO) focuses on workplace HIV while the World Bank has the comparative advantage of being able to engage with large groups of public agencies (such as the Ministries of Finance, Local Government, Health) and so is well placed to bring the agenda to a wider audience and to explore the possibility of developing an inter-agency response. In the words of ban of officials, the Bank's other strengths include having a broader perspective which allows it to push for "sustainability in financing, capacity-building and building systems that can sustain things". Donor agencies in Ghana work together to increase their effect on the issues areas they involved in. By comparing notes and partnering they seek to avoid overlap and other problems associated with going it alone. Officials made reference to the Thematic Working Group (TWG) which includes NGOs, UN agencies, MDA (Ministries Departments and Agencies and some bi-lateral agencies. Also the Country Coordination Mechanism (CCM), which is the local office of the Global Fund, where several different groups including NGOs, ministries, departments, agencies of government, agencies of the UN and The World Bank work collaboratively received favorable mention. This group of

respondents perceived their ability to collaborate to be a critical component of the progress being made in Ghana.

Weaknesses

Like their counterparts in the public service, donor respondents expressed disappointment with the Ghana government approach to behavior change through radio messages, posters and other mass media programs. Despite extensive resources devoted to such initiatives there was a general view that behavior change strategies were being unsuccessful. The strategy was described as “not very innovative” and respondents lamented the absence of research data providing solid evidence of how those methods work and what effect, if any, they had on the epidemic. One viewpoint expressed was that behavior is not an explanation for the low prevalence in Ghana. Rather, something else must be going on with the virus that is, so far, unknown. It could be related to science and the epidemiology of the virus. There was disappointment that there is not a lot of work to reconcile scientific evidence with actions in the field. Respondents’ view of the need for application of evidence-based strategies is articulated by a DANIDA report which states that “health sector support aims at alleviating poverty through evidence-based health sector development work and the concept of Primary Health Care.” (2009:Introduction). Donor officials preferred more evidence-based advocacy based on the view that the epidemic could be country-specific in the sense that the drivers of the epidemic may be different from those of other countries and therefore required a better tailoring of the response.

A similar view was expressed on the question of awareness. Officials opined that external support only serves to accelerate or enhance effectiveness of awareness creation which ultimately depends on the individual. As with behavior change, they thought creative efforts at awareness creation in Ghana have waned and needed to be revived and enhanced. Respondents were particularly concerned about awareness within certain vulnerable and socially marginalized groups. Specific mention was made of the information and communication needs of marginalized people who may not attend forums, watch television, read and interpret wall posters. Officials said there was a need to engage such groups in direct communication as a way to provide them with information. Adequate flow of information to the grassroots including the rural poor appeared to be a key concern for this respondent group.

The health of children emerged as a priority area for donor officials many of whom stated that service in that area is acutely inadequate in Ghana. It relates to the specific need for strategies to reduce child mortality (as an objective of MDG 3), increase the Prevention of Mother to Child Transmission of HIV (PMTCT), address orphan drop-out rates in schools, and provide sex education at home and child care for HIV/AIDS patients.

Though not a widely shared view among respondents, disappointment was expressed about the tendency for some donor agencies pursue their own areas of interests in regards to funding without sufficiently informing the Ghana AIDS Commission (GAC). The findings suggest that GAC is not always informed of the what, when and where of donor funding. Some respondents thought that approach subverted GAC's ability to plan additional funding

baskets to fill the gaps. But there was broad agreement that cooperation with GAC is essential to avoid duplication.

Treatment of HIV/AIDS as a separate health program was considered as fueling a negative health worker attitude towards PLHIV. Respondents said HIV/AIDS should be accepted as a fully integrated part of the general health system in Ghana. 73% of donor respondents thought HIV/AIDS patients in Ghana are sophisticated enough to adhere to treatment regimes for their condition.

6.3.2.3 Essential Features of Ghana's HIV/AIDS policy

Donor respondents agreed that funding from the Global Fund had changed the prospects of HIV/AIDS in Ghana. Funding for Ghana HIV/AIDS policy vary in type, allocation and delivery. They include pooled funding (funds are pooled by development partners and given directly to GAC); earmarked funding (funds are earmarked by development partners to be used for special programmes and channeled through GAC or other government agency); direct funding (funding is provided direct to implementing agency by development partners or by government of Ghana (Ghana National AIDS Spending Assessment Study, 2007:9). Also, district assemblies in Ghana (seventy-three percent in all) contribute at least 1 percent of their common fund⁴⁶ to support HIV activities (Ghana 2007 Progress Report on Universal Access:3). Table 7 shows that direct funding support for the GAC's Programme of Work (POW) for 2009 from the Global Fund alone amounted to almost US\$21.5 million from a total of US\$34million from all direct funding donor support (GAC 2009:48). Other forms of funding include public financing which essentially is budgetary support for the government of Ghana, credit financing (e.g. World Bank) and technical assistance (e.g. UNAIDS).

Table 7: Direct funding 2009 POW

Institution	US\$	GH¢
USAID	5,641,380	6,198,918
Global Fund*	21,477,120	23,624,832
UN System	1,275,000	1,402,500
ALCO	1,800,000	1,980,000
GTZ	1,880,000	2,068,000
JICA	517,777	569,555
EKN	1,409,091	1,550,000
Total	34,000,368	37,393,805

Source: GAC HIV & AIDS Programme of Work 2009

*The figure excludes \$28,461,450 from the Global Fund Round 8

⁴⁶The Government of Ghana utilizes existing decentralized structures and process of the District Assembly and District Assembly Common Fund (DACF) to fund its financial contribution to the HIV/AIDS national response. (Ghana 2007 Progress Report on Universal Access)

Concern was expressed that the varied sources of funding coming in for HIV (not just in Ghana but also the rest of Africa like the Bill and Melinda Gates Foundation, Global Fund, all the non-traditional finance sources - bi-lateral, multilateral, NGO) tend to focus too much on technical issues without looking at the wider accountability issues. Those who held that view thought the HIV problem in Ghana may not be as big as it is made out to be. They suggested that because of the financing implications of making such a pronouncement, that aspect of the intervention is not made prominent or researched enough. The implication of that belief is that money is being wasted. One prominent example was the money being spent on behavior change initiatives. In one respondent's words, "the problem is the connection between policy and politics and evidence... it is easier to solicit for funding when you inflate the problem and sometimes those things are done by gut feelings where more involvement of evidence should be used in making decisions on how to spend this big bag of HIV money."

Although officials were concerned about the effectiveness of coordination aspect of the program, they generally spoke positively of the work being done by GAC. Many looked favorably on GAC efforts in, at least, discussing the issue of police rape of women arrested for prostitution, managing the issue of MSM in a way that is sensitive to Ghana's laws, beliefs and traditions and in building strong partnerships. Some attributed progress being made by GAC to a change in leadership at the GAC two years ago that seemed to have strengthened the commission politically and technically and changed the attitude towards most at-risk populations (MARPS).

91% of donor respondents believed tradition and culture played role in the spread of HIV/AIDS in Ghana. They pointed to gender issues as structural barriers that determine the way people behave. Specifically mentioned were the practice of wife-inheritance, gender inequality, and education of girl child as problem areas that have a big influence on HIV transmission. Gender is one of the pillars that UNFPA stands on globally and in Ghana (along with reproductive health and population/development). So the issue ranks high on the priority list of the organization. Respondents said that gender inequality denies women the freedom to express their views and the ability to negotiate condoms use or say no to sex. The practice in some parts of the country whereby a woman in labor needs permission from her husband to be admitted to hospital was mentioned as reflecting what some call the second class citizen status of women.

The vast majority of donor respondents (91%) believed that people's religious beliefs made a difference in their attitude towards HIV/AIDS. Religion was often mentioned along with culture, gender and the idea of sex as a taboo subject. Officials referenced specific conduits of HIV/AIDS related to the subject of tradition and culture such as polygamy, suppression of women, the freedom for men to engage in marital infidelity without sanction, the treatment of sex as a taboo subject between parent and their children and attitudes towards homosexuality that make gays reluctant to go to facilities for treatment. Respondents contrasted their views on culture in southern Ghana with the situation in the north where a

much more conservative society exists in which the tendency for women to engage in risky behavior is much lower.

On donor/government relations 82% of donor officials agreed to having a relationship with the agencies working for government of Ghana in the area of HIV/AIDS. The same number of respondents said the same about relations with NGOs. But only 45% believed the Ghana government is well equipped to deal with the issue of HIV and sexuality.

6.3.2.4 Ideas on Improving HIV Intervention

Coordination

Donor respondents perceived dialoging among stakeholders like GAC, GHS, civil society (NGOs) and development partners as an important aspect of the program. Among the three respondent groups in the survey, donor respondents expressed the most concern about coordination. As one respondent put it “HIV/AIDS is not a one institutional activity, it is a cross-sectoral activity so without a form of coordination and partnership-building among groups, it cannot be addressed so UNAIDS uses partnership building as its guiding principle”. Indeed when asked about their impressions of the policy environment only 45% of donors said it was well coordinated - compared to 55% of public officials and 64% of NGO officials.

Respondents were however sympathetic to the difficulties faced by the coordinating agency - the Ghana AIDS Commission (GAC). They spoke of challenges the commission faces in implementing the program and saw it as part of their role to support GAC in tackling those challenges. Some of the specific challenges mentioned include the need of marginalized people to be informed to create awareness. In that respect several respondents mentioned ‘Kayayee’ (female head porters). These are often young women who have moved to the cities from the rural areas and work as porters carrying head loads for clients in local markets. Many of them have no accommodation in the cities and sleep on the streets. They are poor, lack access to information because they are not formally organized and may not even have the ability to interpret a poster. Kayayee are said to be a very vulnerable group because they live on the margins of society. For these reasons respondents spoke of the need more interpersonal interventions for such groups.

Capacity Building

There was wide recognition among donor respondents of the need for capacity-building of government agencies at the national and local levels to manage the intervention in HIV effectively. This concern derives from a perception that the health sector lacks both the capacity and distribution of workers adequate to allow investment in the sector to reach levels where the most effective response to HIV/AIDS can be given. More specifically, respondents spoke of capacity building in terms of providing training support to GAC to help the agency develop the capacity to manage “opportunities under HIV from disease prevention to managing issues relating to the post-disease stage like people living with AIDS” as one respondent put it. Also of concern to officials was support for civil society groups to “be able to function effectively at the grassroots level”. One positive example

used to describe this effort is the World Bank Treatment Acceleration Program which is said to have enabled NACP to build the capacity of private facilities to deliver ART.

Decentralization

Donor representatives generally supported decentralization of the HIV/AIDS intervention but many thought the decentralized response (testing, counseling, ART provision and a referral system at the district level) needed to be strengthened. Support for that process was cited as a work in progress which includes UNAIDS and the Dutch Embassy providing support for the decentralized response within the government of Ghana through the Ministry of Local Government (national, regional and district administrations) and UNDP being instrumental in the implementation of the DRI (District Response Initiative⁴⁷) that aims to get districts equipped to respond to HIV/AIDS.

Working with GAC

While there seemed to be wide subscription to the idea of all donors and development partners agreeing with GAC on national targets and following a national plan, most donor officials appeared to favor direct funding to implementing agencies rather than going through GAC the coordinating agency. Ghana National AIDS Spending Assessment Study, 2007 found that “out of a total funding by international organizations only 23% was sent to the pooled or earmarked fund overseen by GAC. The majority, 77% was sent directly to implementing agencies (2007:12). This alludes to what appears to be a policy disagreement between GAC and some donors as to whether it is better to focus on the general epidemic or to devote resources to dealing with high risk groups such as men who have sex with men (MSM) and male and female sex workers (M/FSW), two groups that are growing importance as sources of new infections.

Cost Effectiveness

One variant of the policy difference between public agencies and donors is the controversy on whether investments in school-based and workplace-based interventions are as cost effective as investment in sex worker interventions. Some donor respondents had a negative view of the cost-effectiveness of the former. The survey however showed that there are efforts to deal with disagreement within the donor community. For instance, respondents spoke of efforts by the World Bank to get the development partners (World Bank, DfID, DANIDA, UNAIDS for technical support) together and work with them for joint resource mobilization into one pot in support of one agenda. There were also reports of efforts to address policy differences between GAC and USAID over the issue of homosexuals.

Civil Society

Amongst the three groups in the survey, donors reported the strongest views on the need to strengthen civil society groups and their participation in the national response to ensure their presentation in the field and especially with GAC, and their ability to function

⁴⁷ The District Response Initiative (DRI) “was a Local Government led project to provide 'Improved capacity to plan and implement preventive], Care and Support intervention. It included the provision of technical support by the WHO for its execution” (Ministry of Local Government and Rural Development).

effectively at the grassroots level. Donor respondents spoke extensively about partnering with civil society groups including those representing sexual minorities, victims of HIV like NAP+, commercial sex workers and local communities.

Human Rights

Donor officials expressed strong views about human rights as an area of concern in HIV/AIDS. The focus about human rights derives from the view that as more and more HIV patients receive anti-retroviral drugs (ART) and have their lives prolonged⁴⁸ there could be long terms issues about their right to be sexually active and to sexually reproduce. The most striking area of human rights that came up in my survey is the issue of the abuse of female sex workers by policemen. The illegality of the practice of prostitution seemed to allow policemen to rape prostitutes with no recourse to justice because they are engaged in an illegal activity. Respondents said those laws provide an excuse for the abuse⁴⁹. Some respondents thought there had been progress in that area but a lot of work remained to be done. Also because of laws considered to criminalize homosexuality in Ghana it is difficult for homosexuals to identify themselves as such and seek access treatment for health conditions related to their sexuality. As a result of such abuses, donor agencies pay considerable attention to the issue of rights. For instance the UNDP has championed the issue of the right to health⁵⁰.

The question of an enabling legal environment to address the problem of HIV/AIDS within the MSM and M/FSW communities emerged as major challenge. There are no existing laws in Ghana that specifically address HIV/AIDS and human rights laws in the constitution only speak broadly about rights for all Ghanaians. However officials viewed some current laws as being obstacles to implementation of an effective national response to HIV/AIDS. The consensus of opinion was that punitive laws did not create an enabling environment for interventions to target most at risk populations. On the other hand there are new laws in Ghana that are positive for anti-HIV/AIDS efforts including the law against “trokosi⁵¹”, a form of child enslavement that was enacted in Ghana recently.

6.3.2.5 Conclusion: Donor Framing Strategies

Frames can also be considered political agenda that influence decisions about what issues are relevant for consideration in the policy discourse, the definition of those issues, whose viewpoint is taken seriously and what solutions are applied. “These issues and problems do not exist apart from the words and symbols used to describe them. They are constructed in

⁴⁸Fewer than 50 percent of those who need it have access but 90% of those who initiated treatment at one point are still using the drugs.

⁴⁹An example is reports of policemen arresting women for having condoms in their possession and raping (sometimes gang raping) them, and of policemen using the services of prostitutes and refusing to pay because it is an illegal activity).

⁵⁰Respondents spoke of cases where gays have been turned away from health facilities because of existing laws.

⁵¹“Trokosi” is a practice whereby pre-teen and teenage girls are kept as unpaid servants and often forced into servile marriage by fetish priests to atone for sins their families supposedly committed against a traditional spirit.

the sense that political issues and policy problems are not inevitable and inherent. Whether we recognize them as political issues and policy problems, and what comes to mind when they are presented to our attention, both depend on the particular forces that shape the political agenda in a given society” (Brooks and Miljan, 2003;7). They produce what Fischer calls “a web of social meanings produced and reproduces through discursive practices.” (2003:13). In this context, beyond being mere linguistic and communicative processes, discourse is actually constructive of social processes by emphasizing, in specific contexts, some statements to the exclusion of others.

Partnership

As external groups working in a foreign country donor actors form partnerships in order to achieve their policy objectives. They partner with the private sector, with communities, with other donors agencies and with civil society groups in Ghana. They also partner with departments and agencies of government. Partnership with government is inevitable because donors work with government to formulate, finance and implement various activities in the HIV/AIDS program. But donors also need other partnerships arrangements to allow them operate without depending solely on the official government machinery.

Partnership with other development agencies is essential to work collaboratively to improve the response to HIV areas of their mutual interest. Instruments like the Country Coordinating Mechanism CCM (Global Fund) and the Thematic Working Group (TWG)⁵² represent important elements of the partnership frame. The frame is also reflected in arrangement that allow the World Bank, DfID, Danida and UNAIDS to work together each focusing on their area of comparative advantage and mobilizing resources together to support a particular agenda.

Partnership with civil society groups is growing and becoming more critical as more donors choose to use targeted spending in their operations, instead of discretionary spending through GAC. This approach arises out of a conscious effort to support groups that operate at the sub-national and thereby promote grassroots participation. Donor interest in strengthening civil society in Ghana is indicative of the desire for stronger partnerships with those groups. Being the main local advocates of human rights in Ghana civil society groups are indispensable to donors as partners in respect to the fight for human rights. The most visible human rights issue in HIV/AIDS has to do with the rights of MSM. Unlike in the west, the initial spread of the disease in Ghana was mainly through heterosexual sex. However in recent times, homosexual sex has become an important factor in disease transmission which is crossing over into the heterosexual population. Lack of political will among officials to deal with this issue makes urgent the partnership of donors and civil society groups to address that problem. Such partnerships also facilitate representation of constituencies on whose behalf civil society groups act. It often goes up against the government apparatus which is often anti-thesis to the grassroots approach with its city and urban-centered focus.

⁵² TWG is group of organizations including NGOs, UN agencies, ministries departments and agencies of government (MDA) and also some bi-lateral donors.

The frame is in part rooted in the realization that HIV/AIDS intervention is cross-sectoral. The fact of the problem not being a one institutional activity makes coordination and partnership inevitable. Coordination is essential to form partnerships exemplified by UN agencies which have to coordinate the work of multiple UN agencies working in the same field. The Joint UN Team (JUTA) on AIDS brings together around 20 HIV focal points including UNFPA to have a comprehensive team approach to the UN role in NSF, bringing different skills and expertise for the benefit of a particular programme.

Human Rights

Donors are principal promoters of *human rights* as part of HIV/AIDS policy. In a sense this is done by framing program objectives as a moral imperative. The human rights frame exists in the focus on vulnerable and marginalized citizens including women, children, homosexuals and sex workers who traditionally are frowned upon in Ghana. Also, the success of the treatment initiatives in the national response in Ghana brings issues of human rights to the fore.

One practical manifestation of donor human rights activity is in UNFPA working with the Ghana Police Service to redress violation of the rights of female sex workers who are often raped by police personnel taking advantage of the illegality of the practice of prostitution. Counterbalancing the illegality of the activity the person is engaged in with the abuse being meted out is a delicate matter. A UNFPA official suggested that it is not a matter of changing the law to legalize prostitution, but rather to work within current laws to isolate the abuse from the initial crime so that policemen who abuse prostitutes can be prosecuted. Traditionally, sex is a taboo subject in Ghana. That culture exposes prostitutes to vulnerabilities that they cannot address by themselves.

Another area in which this frame is seen at work is in the case of female head porters known as *Kayayee*. Their marginalization results in lack of access to information which exposes them to the danger of contracting HIV. Donor agencies actively work to address the problem of *kayayee*. UNFPA focuses on most at-risk populations such as young people and women. Issue four of the UN Millennium development Goals (MDG) deals with gender issues. UNFPA therefore has gender as one of three areas of primary focus - the other two being reproductive health and population. Gender inequality is an important aspect of donor policy as is education of the girl child.

Pushing for openness in addressing issues relating to homosexuality, which is still illegal in Ghana by some accounts, is another visible area of human rights championed by donor actors. Defining homosexuality as a human right often leads to clashes with the legal system in place in Ghana. The law against unnatural carnal knowledge (Based on British colonial law) is interpreted by some as outlawing homosexuality. Survey respondent narrated stories of gays being denied health services and being sent away from health facilities by workers who cite the law, morals and tradition as justification for denial of service.

Due to stigma and cultural obstacles, donor actors try to rope such marginalized and vulnerable people into the HIV/AIDS programme. In a sense all of PLHIV are vulnerable persons because they suffer the same stigma from people who think they got infected because of their sins. The longer infected persons live, the more questions need to be addressed in terms of their rights to be sexually active and issues concerning sexual reproductive rights. Human rights ties in with donor effort to facilitate modernization of the health delivery system in Ghana because development and modernization aim to address poverty among other things, and human rights supports the rights of marginalized and vulnerable people many of whom are impoverished, in some cases by the very condition that makes them vulnerable.

Development

Unlike NGOs and public officials who see the HIV/AIDS intervention as helpful and supportive of Ghana's development, donors frame the HIV intervention itself as a development project. The international approach to HIV fits into health delivery which traditionally is considered part of the international development agenda. HIV was defined internationally as a development issue with a focus on Africa. Even though some donor actors question the link between HIV/AIDS and development/poverty, the international initiative is couched in development terms so donor agencies are compelled address HIV in a development framework. With the disease affecting people in their most productive age (15-49) who will, supposedly, carry the burden of moving Ghana from low income to middle income status, the impact on the country of losing that generation of workers was seen as potentially devastating for development prospects. So HIV is seen not just as a health issue but as a development issue.

The international policy on HIV policy evolved after published reports about Africa's vulnerability to HIV and the experience in some African countries that were initially hit hard by the disease. The link to development often derives from what is on the international agenda and also what is on the agenda of major donor nations. Most donor agencies in Ghana deal with HIV under a previously existing development portfolio. Also many of the activities financed by donor agencies are activities that were agreed upon within a national development framework. The UN has a policy to support Ghana's development and the UN development assistance framework covers health, education, sustainable livelihoods, and governance. The UN approach is clearly spelled out in the UN Development Assistance Framework (UNDAF). Officials said the priorities in the health sector are somehow congruent with the MDG especially MDG 4 and 5 concerning women and children. Since HIV is regarded as a development issue and the UN works to promote development it is natural that HIV is part of that agenda.

6.4 Inductive Reflexive Model – (Prescriptive)

The discussion above has to identify a number of frames which stakeholders use to interpret HIV/AIDS policy and make sense of their participation in that process. They show that the stakeholders in this policy field frame aspects of the intervention and their role in it in significantly different ways. And this, rather than substantive policy differences, appear to account for the policy divergences that emerge. By framing issues the way they do, the

actors interpret situations, institutions and processes not necessarily to validate particular courses of action through some universal understanding of words. Rather they employ those frames based upon how useful they are to achievement of valued individual and social goals. Frames, in this context, are derived from value-based criteria not from universal laws. The frames identified here not exhaustive but stand out in the data and provide insight into some of the policy differences.

In all situations we are confronted with, often along with others face-to-face or otherwise, we tend to pose the fundamental question “What is it that is going on here”? This is always the case whether stated explicitly when there is doubt or implicitly when there isn't. This question is posed arbitrarily and without justification and there is no single theory that fixes one's span or level when it comes to answering that question. The same applies to the perspectives of individuals in differentiated roles. “[T]he view that one person has of what is going on is likely to be quite different from that of another.” (Goffman, 1974:8) Based on this thinking Goffman provides a approach through which we can attempt to establish frameworks of understanding within which people make sense of situations and events which are themselves based upon particular 'principles of organization'. That view is echoed by Chong and Druckman who suggest that “an issue can be viewed from a variety of perspectives and can be construed as having implications for multiple values or considerations.” (2007:104) Along with structures and codes, frames determine how people behave. So the intension is to address “the structure of experience individuals have at any moment of their social lives”... [and]... to isolate the basic frameworks persons utilize when they define their social situations.” (Denzin and Keller, 1981:54). When people interpret events, they are in effect selecting from a number of frameworks (or schemata of interpretation) to assign meaning to those events.

A political system is a “linguistic concept discursively invented and employed to describe a set of relationships that we can only partly experience” (Fischer, 2003:43) because it is an entity that nobody can experience in a visually tangible sense. It is in essence a set of socially constructed relationships discussed through the medium of language. Since the language of politics assigns meaning to policy problems “public policy is not only expressed in words, it is literally ‘constructed’ through the language in which it is described.” (ibid) Also, the importance of frames derives from the fact that policy is never self-explanatory. Each one can be defined in a variety of ways. Public policy is a struggle to make one meaning of an issue gain ascendancy over alternate meanings. The meanings of policy actions are therefore just as important as their empirical outcomes. As Fischer puts it “public policy is a discursive construct rather than self-defining phenomenon.” (ibid.69) Drawing on this theoretical orientation, this study builds on the view that ideas are important in public policy because they determine the trajectory of action taken by actors influenced among other things by interests, framing strategies, experience and preference.

Policy change is rarely, if ever, achieved by merely laying out options, selecting between different alternatives and evaluating how selected options were implemented. Rather, change often results from identifying problems, prescribing solutions and seeking the agreement of parties involved. What follows is a prescriptive version of my inductive

reflexive model with a number of policy proposals. The proposals are based on what has been identified from survey data and literature study as weaknesses in the current structure of HIV/AIDS policy in Ghana. It is an analysis of how the current policy model can be improved based on realities on the ground and prospects for the continued flow of donor funding.

Figure 1: Inductive reflexive policy model (Prescriptive)

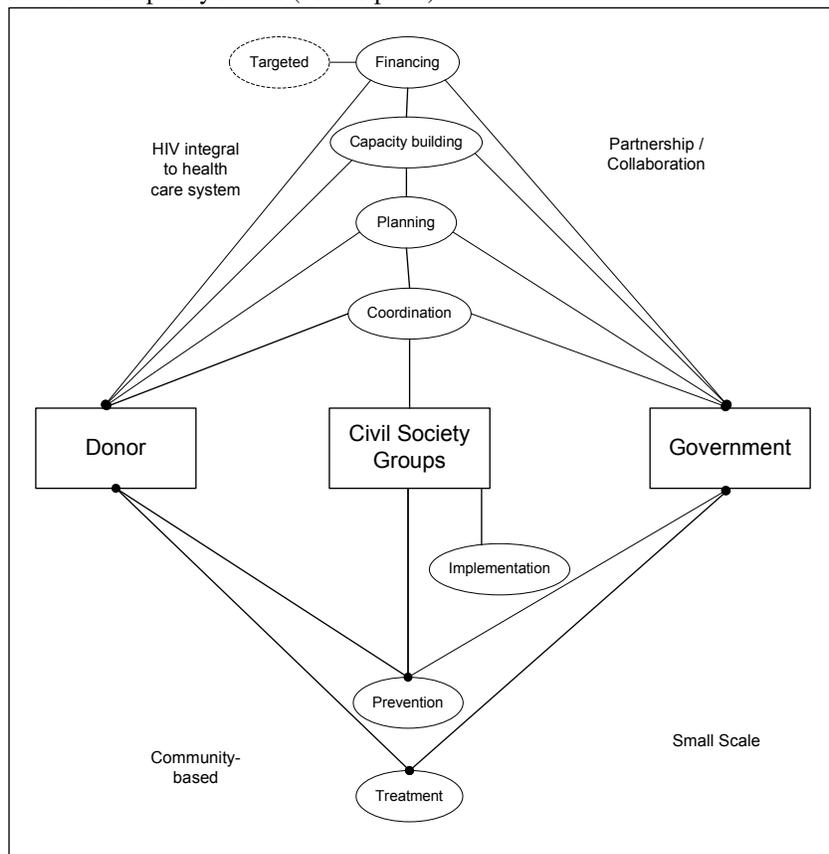


Figure 1 depicts an inductive reflective policy model for HIV/AIDS intervention in Ghana. The model components are:

Entities: This model has three groups representing the main entities in the model – *donors*, the *Government of Ghana* and *Civil society groups* representing non-state social organizations and institutional forms including, community-based organizations, women’s organizations, religious organizations and business associations.

Activities: The main activities are planning, coordination, financing, capacity-building, implementation, prevention and treatment.

Properties: The model has four basic properties community-based approach, uses a small-scale approach to intervention, treats HIV/AIDS as integral to general healthcare and a collaboration/partnership approach.

This model outlines the structure of the policy not processes of policy making or the flow of the policy process. The four distinctive characteristics (properties) of this model are:

- Interventions are tailored to the needs of individual communities both urban and rural
- Small-scale approach implying specific solutions to individual local situations
- HIV/AIDS in this model is integral to general health system (linking with general health, nutrition, access to health care)
- Collaboration and partnership based on the concept of policy as a discourse

Partnership/Collaboration (Discourse)

Partnership in this model means that parties have the ability to engage in constructive dialogue, to be different in terms of their own identities and able to communicate based on their own way of thinking and acting. All parties are full-fledged partners. In this context no actor is a parasite or a mere consumer in dialogue. It does not preclude the participation of outsiders like donor organizations. All human societies need to constantly renew themselves to stimulate their creative and productive impulse but it does not have to be at the expense of the sum of one society's experience accumulated over generations. Societal experience is the basis upon which societies define their past, present and future while assimilating contributions from other societies and simultaneously making contributions of their own. All cultures have efficient problem-solving mechanisms within them which are legitimate within that context. Understanding these processes is useful for gaining insight into local problems and possibilities for assimilating new ideas and processes.

In all situations, all actors do not have the same level influence. In the policy context governments tend to have a unique advantage to shape discourse because of their financial advantage over other groups. In the case of the HIV policy discourse in Ghana, the financial advantage is held by donor agencies primarily and by government secondly. Yet, no actor is powerless. All actors exercise power some forms of power which is manifest in different ways.

The community-based approach in this model implies also engaging with Christian and Muslim religious leaders. Religious leaders in Ghana are some of the most respected members of the society. To redress the problem of religion as an obstacle to HIV intervention (which is one of this study's key findings), it makes sense to engage evangelical priests and other religious leaders to support the cause. It also implies formally involving traditional leaders as custodians of tradition, and traditional religion, to help mitigate the negative impacts of traditional Ghanaian culture on HIV intervention.

Integration with General Health Care

In this model, HIV is not treated as a separate program of health delivery. Rather it is integral to general health services in Ghana. The special treatment for HIV was associated with it's the mode of transmission and the early association with gay and drug users. There is no reason for HIV should continue to be treated as separate from the general health

delivery system. In Ghana HIV services are already being mainstreamed into general care in some locations such as in the Eastern Region. Given the weakness of the overall health system in terms of infrastructure, logistics and human resource development, there is no reason to have a separate system for HIV/AIDS.

Planning

Planning is done with the involvement of all stakeholders including civil society groups. HIV patients live in communities and most of the policy implementation takes place at the community level. As a result, community input in decision-making for planning and programming is critical for success. A community-focused approach means the goals and expectations of the program should be realized within communities so it is essential that organizations within the community participate in the planning process. Even where there is lack specific requisite expertise within the community involving implementers in planning is critical for success and to facilitate understanding of goals. Being a part of the planning process gives local groups a voice and an opportunity to provide input on organizing the intervention.

Prevention

This policy model is centered on a prevention-based strategy, as opposed to the treatment-based approach currently in use. Prevention of HIV infection is cheaper than treatment of victims and it also saves more lives. While it is harder to quantify the results of prevention, (compared against counting the number of patients receiving drugs for treatment), it is still the single most effective path to sustainable control of HIV/AIDS both through ensuring that people avoid new infections and also that those already infected avoid transmission. There are several potential prevention tools that could also be explored including male circumcision and nutritional strategies. Also, prevention efforts would be more effective at a community-based level because educational campaigns, behavior change initiatives and other prevention strategies such as those dealing with gender inequalities can be tailored or customized for specific communities.

Treatment

Treatment is an important aspect of every HIV intervention program. In the case of Ghana, it is the most successful aspect of the current policy. But the current approach is unsustainable with dwindling financial resources hence the importance of placing more focus on prevention in this model. The community-based, small-scale structure and funding mechanism incorporated in this model eliminates a lot of waste and opportunities for corruption. This approach also would make it possible for treatment to reach larger percentage of patients. Less bureaucratic involvement should translate into better coverage for anti-retroviral drugs. Government involvement in treatment is inevitable but with emphasis shifting from treatment to prevention there should be less reliance on the government apparatus. Due to scarcity of private health care facilities especially in rural communities in Ghana, there is inevitable reliance on state-run hospitals and clinics, but increasing local capacity-building should be incorporated in the intervention program. The Ministry of Health which manages government hospitals and clinics only plays an advisory role in this model even though branch officials on the ground are actively involved in implementation.

Capacity-building

This model requires development of capacity at sub-national levels in towns and villages rather than in big cities. A lot of potential existing in communities is not being adequately tapped. Community volunteers are the mainstay of community HIV initiatives many of which are short-lived because of the lack of long-term funding support. The focus has been on building capacity nationally because of the urban-based approach. The capacity to deal with HIV has been set up at the national level. While administrative capacity, human capacity and spending efficiencies of civil society groups may be low, with capacity-building aid agencies can get better results than they do currently.

Developing local capacity would augment regional and national resources. The government of Ghana should be able to maintain and enhance that capacity. In this model, planners of the intervention develop strategies to enhance community capacity with long term funding support not dependent on donor funding cycles. Use of community-based and community managed projects will lead to reduced waste and with the right mechanisms in place increase accountability. Even with long-term funding there must be an exit strategy to promote community ownership of these programs.

Community capacity building includes not just infrastructure to deliver services but also the ability to monitor and evaluate programs to allow for greater accountability in the allocation of financial resources. Building capacity at the grassroots would support treatment services for other diseases besides HIV. The idea of devoting resources to building capacity to deal with HIV alone in a country that has weak capacity for dealing with diseases across the board is highly questionable. Given the variety of diseases treated by the prevalent in Ghana, keeping HIV/AIDS as a separate branch of health delivery makes even less sense considering the fact that HIV victims are also susceptible to multiple other disease like malaria, tuberculosis and many others.

Coordination

The initial response to HIV as an emergency prompted many governments set up national coordination boards to coordinate the national response. The Ghana AIDS Commission set up under the presidency as the principal coordination body. The emergency phase of HIV seems to have passed. In this model the structure of the coordination body includes representatives from all stakeholders not based on a top-down structure. Also the coordination body does not channel money but facilitates the program. Activities are coordinated by a small appointed board of representatives from government, donor agencies and civil society. Effective coordination requires that actors share common priorities and common goals, agree on an approach and jointly monitor progress.

Implementation

Civil society groups have been effective in dealing with various tasks at sub-national and community levels in the HIV program in Ghana. That strategy is strengthened in this model by making implementers active in program formulation and planning to help develop a home grown approach to implementation. As implementation resources NGOs and other

civil society groups are tasked with the engaging in activities to realize the established goals of the program. The Government of Ghana has a role in implementation to protect human rights by regulating the legal framework of the program. It a basic requirement for policy implementation that there is an understanding of what is to be done. As Hill (2003:265) points out, often policy as written falls short of teaching implementers what they need to know to do policy. This failure leaves a gap which is often filled by "implementation resources" - non-state policy professionals who help formulate, recommend and publicize the individual exercises needed for implementation. Ignoring non-state actors implies leaving out an important component of street-level implementation [271]

Funding/Financing

To maintain the positive aspects of aid and avoid some of its pitfalls, this model recalibrates all bi-lateral and multi-lateral aid to go directly to local civil society groups working at the grassroots level. It also calls for a more direct donor/civil society engagement with a limited role for government in that arrangement. The idea is not for government to withdraw from that policy area. Rather the government of Ghana should continue to perform its functions using alternate financing arrangements while facilitating direct donor/civil society engagement to address community needs.

In the current system a lot of money is either wasted or spent on administration while implementation falls short. A Ghana National AIDS Spending Assessment Study found that "40% of funds from International Organizations was spent on programme management and administrative strengthening and another 40% went into treatment and care and 9% on prevention programmes (2007:13). Around the same time 2005-2007 there was a decline of expenditure on prevention (ibid:19). To redress that problem, this model eliminates pooled and discretionary funding disbursed through the Ghana AIDS Commission. That approach creates waste opportunities for corruption and lack of accountability. By proposing a targeted funding as the only finance strategy it eliminates multiple middle men, agencies and institutions of government. Instead funding goes directly to implementers to promote accountability. There will be more money available for implementation if less is being spent on administration. Less money will be spent on administration if the program has a community focus.

This model also eliminates coordinated investments by multiple donor agencies. The bigger the pool of money the greater likelihood there is for waste. The problem with pooled money is having multiple agencies with multiple goals. That funding model lends itself to redundancy, inefficiencies and neglect of some goals. "Having multiple goals... is equivalent to having multiple principals. It is well known in principal-agent theory that having multiple principals weakens overall incentives for the agent to deliver to any one principal." (Easterly, 2006:9). Besides, likelihood of waste and corruption increases exponentially with the amount of money in the pot.

Small-Scale Projects

Executing projects on a smaller scale, as this model proposes, leads to more accountability for resources devoted to the project and to less waste. The specter of international

bureaucracies transferring large sums of money to government bureaucracies rarely ensures that funds reach the objective of addressing the needs to which they are intended. In the current structure aid money has to go through state treasury, multiple national, regional, district offices to get to the ground where it is meant to fund a project. At each stage there is a likelihood of the amount reducing due to theft or administrative costs. Another advantage of doing things on a smaller scale is that if aid money dries out it would be easier to find alternate funding sources to sustain those programs within communities.

Feedback and Accountability

African leaders often have a preference for large-scale projects which tend to set goals that are too optimistic goals to be able to hold anybody accountable if they fail. In this model, by planning on smaller scales there is an opportunity to set more realistic goals and be able to hold people accountable for their work. Funding smaller scale projects will reduce the trend of extorting bribes and diverting funds because as Moyo (2009:51) puts it, “[t]he bigger the project, the greater the opportunity” for corruption.

Focus on local civil society groups furthers the requirement for feedback and accountability which could be greatly improved as aid agencies will be closer to customers in the grass-roots rather than attempt to evaluate progress from the top. It is to allow for strong monitoring and accountability as well as to be sustainable that this model proposes a small scale approach.

Chapter 7 – Conclusion

Ghana’s HIV policy did not evolve from a combination of executive and legislative initiatives within the Ghana government. It evolved from a coalition of international actors working on behalf of the state of Ghana. The UN and other international agencies developed health policy guidelines which were adopted by the Government of Ghana. The three groups covered by the study (donors, NGOs and public officials) include some of the most important players in the HIV/AIDS policy in Ghana. The study found that while the groups concur on a number of significant policy areas they also disagree in several others.

The absence of a cure for HIV leaves policy makers with two main options to address the disease - prevention or treatment. Most experts will support an integration of both strategies as the most effective way to achieve long term decrease in infection and large declines in AIDS mortality. One important finding of this study is that while all stakeholders agree on the importance of treatment, not all are incline to support prevention strategies being used. Public officials and NGO officials favor more focus on prevention through education and behavior change initiatives whereas donor officials are less supportive of that approach and seem more focused on a treatment-centered strategy. Donor apprehension with prevention programs results from the lack of quantifiable data showing the effectiveness of those programs. It is the difficulty of estimating how many people are prevented from contracting HIV through information campaigns. The lack of data is problematic for those who favor an evidence-based approach or more scientific data on effectiveness of such media campaigns to justify continued funding for those programs. Besides the use of prevalence data, it is dif-

difficult to quantify the effectiveness of programs aimed at promoting behavior change.

That sentiment is not without basis however. There is evidence that important progress has been made in terms of awareness creation but little evidence of behavior change. Initial media campaigns used by the government of Ghana may have done more harm than good. By casting the disease in negative terms through the use of scary images like skeletons it shaped people's perception in a manner tinted with a bias which has been hard to change. That bias may have also account for the lack of progress in behavior change initiatives. The use of skeletons and other images depicting death in such a superstitious society can only generate a negative response. Since most Ghanaians already believe HIV can be caused by spiritual means, that method is unlikely to be effective in promoting change in people's behavior. As demonstrated by the experience with printing scary images on cigarette packs in other countries, humans can get used to anything including scary images. That experience shows that such campaigns are not ineffective, but the experiment proved that after the initial shock or scare people tend to acclimatize in a way that neutralizes the effect of subsequent exposure to those images. Since we get used to seeing those images, the scare/shock is not repeated every time we are exposed to them. In the case of Ghana poor results from the media campaign for behavior change is not the worse part of it. Rather it is the fact that those campaigns may have reinforced stigma and stereotypes related to people living with the disease.

One area where the effect of the stigma attached to HIV is clearly visible is in discrimination against PLHIV for employment including in agencies working in the field of HIV/AIDS. In reality however, it is more than likely that there are HIV/AIDS victims working in various capacities in both public and private sectors. They are still employed because they are either not aware of their status or hide their status to avoid being stigmatized. Lack of confidentiality for victims who seek treatment creates the risk of loss of employment. In that environment, some PLHIV refuse treatment as a way to hide their status. Others ignore the disease after a positive diagnosis, or opt to use traditional medicine, until their health deteriorates to the stage where they are unable to work. At that stage even if they seek treatment, the long sickness and the greater likelihood of their positive status being made public undermines any chance of them returning to their jobs or finding new employment. If Ghana is successful in reducing stigma associated with HIV/AIDS, it could help reduce the cost of intervention as there would be less need to provide treatments free of charge and PLHIV will stand better chance of being gainfully employed.

In regards to how HIV affects employment, one striking finding of the survey concerns agriculture. Only 6% of respondents mentioned the effect of the disease on employment in the agricultural sector. This is remarkable because Ghana is predominantly an agricultural nation. That omission reflects the urban-bias of the policy since agriculture is a predominantly rural industry. Irrespective of the reason, it is fair to assume the HIV infection and eventually AIDS would have devastating effect farming communities due to the nature of the labor-intensive nature the farming occupation.

Another area of focus for anti-stigmatization efforts in Ghana concerns persons who fall within the category of Most At-Risk Populations or MARPS. They generally include men who have sex with men (MSM), male/female sex workers (M/FSW) and *kayayee* (female head porters). The stigma attached to these population groups leads to their marginalization and puts them at a higher risk for HIV infection. Donor agencies generally were most vocal in their support for marginalized groups especially MSM. Their focus on MSM and M/FSW derives from a concern for proper targeting of vulnerable groups which may otherwise not receive adequate attention in the program. Even though MSM and M/FSW have become major threats segments in HIV infection, it is really the carry over into the heterosexual community that is the real risk. The concept of gay rights is relatively new to Ghana (as with many African states) and the movement is still mostly underground. Any mention of homosexual activity creates an uproar with political and religious leaders leading with condemnation of that lifestyle. A few local human rights activists have spoken up in favor of gay rights but their voices are drowned in the “sea” of opposition and in many cases accused of being gay themselves. Some Ghanaian laws have been interpreted as forbidding homosexuality, even though there are different schools of thought on that subject. It is significant that Ghana’s current legal system is a by-product of British colonial law and like other institutions in the country a sizable portion of the colonial heritage remains intact.

Stakeholders also disagree on the definition of the epidemic. How one defines the problem determines the approach used to address it. While government officials generally treat HIV as a general epidemic, some donor agencies prefer to think of it as a compartmentalized. Adopting the compartmentalized epidemic approach implies promoting health services for homosexuals which is not only politically unpopular but also could ignite a public outcry due to negative attitudes towards homosexuality. . Also sex is generally considered a taboo subject and is rarely discussed in public. This situation leaves sexual minorities on the margins of the HIV/AIDS debate and poses enormous risk to the general population since that demographic is said to account for 7.2% of all new infections.

Donors expressed a desire to focus resources in areas the considered to be most cost effective. It understandable why donors would think in terms cost-effectiveness of the programs they fund. So while workplace and school-based HIV intervention is being promoted in Ghana and many donor respondents believed there is not enough focus on child welfare, some donor agencies did not think that neither is cost-effective. NGOs and public officials, on the other hand, see both types of intervention as very essential. We could make the argument that cost-effectiveness and the welfare of communities or of the nation are identical goals but aid money is rarely given without strings attached.

HIV is a politically sensitive subject in Ghana because of the stigma attached to the disease – the reason why UNAIDS asserts that HIV programs need political visibility and support to be successful. As a result to political will and commitment from government is lacking. And so an enabling environment to address HIV/AIDS effectively is lacking. Political leaders in Ghana to provide only limited political leadership or political support because of the fear of

sustaining political costs by being identified with HIV. This lack of leadership has a negative impact on the national response.

Aid Dependence

A huge portion of funding for the HIV/AIDS program in Ghana (mostly from The Global Fund to Fight AIDS, Tuberculosis and Malaria) goes to procurement of anti-retroviral drugs for victims of HIV and AIDS. Recent negative trends in international finance and economic problems within donor nations threaten to derail the program. In light of these financial crises the current system for funding HIV/AIDS in Ghana is not sustainable. The likelihood that there will be enough money and political will to continue to subsidize ART drugs is very slim. Traditionally, programs sponsored by foreign donors get cut when there's an economic recession. But funding of international programs, such as the global HIV program, is also impacted by political realities of donor nations. During the George W. Bush administration an anti-abortion and anti-reproductive health law passed into law a gag rule that affected organizations involved in condom distribution. Organizations like Planned Parenthood in Ghana had their funding from USAID cancelled due to the gag rule.

There is high probability for contraction of international aid to rather than its expansion. The downside of dependence on international aid is that programs based on aid cannot survive without that assistance. Availability of funding for HIV in Africa is subject to vagaries of the economic realities of rich countries. Even at current funding levels treatment services for HIV only reaches just over 50% of all patients in Ghana. Dwindling donor funds could lead to the curtailment of services to many, if not all, of these victims. Ghana, like other poor countries must find ways to do more with less money. The UN push for universal access seems unattainable given current trends. The estimated cost of lifetime treatment per individual is \$400,000 US. There is hope for a vaccine for HIV but the earliest estimates for a vaccine are still years in the future. A new prevention drug that recently completed trials with a 60 to 70% success rate is estimated to cost \$6,000 a year. It is doubtful that international aid will be ramped up enough to keep the majority of victims alive throughout their lives.

This study found that some HIV patients periodically receive less dosage of anti-retroviral drugs than they are prescribed. Budget-slashing in the US Congress this year and next year threatens to bring to a catastrophic halt the progress that has been made in treatment. There are calls in the Congress for overseas aid to be cut or eliminated altogether. UNAIDS maintains that "the certainty of some prior funding commitments must now be in doubt; failure to meet these commitments given the increasing number of people infected and the growing need for antiretroviral therapy, could adversely affect the lives of millions" (2009:11). Uncertainty of funding commitments and increasing cost of the global effort against HIV threatens serious disproportionate impact on the poorest, and could leave 80% of the world's population without a social safety net (UNAIDS, 2009:3).

Proposals for Change

This study elaborated an inductive reflexive model of policy making that was used to describe the current HIV policy structure and also outline a prescriptive model with some concrete proposals for reform of the policy. The distinguishing features of the inductive reflexive model is an increased focus on prevention; use of a more community-based approach; a small-scale format; modification of finance strategy from pooled, discretionary and direct financing through a government-appointed coordinator to targeted finance going directly to implementers on the ground. This broad framework of the model aims to make the program more efficient and more sustainable. But these proposals are more likely to be effective if they are accompanied by fundamental restructure of the aid architecture as a whole. A range of policy instruments is needed to address a host of issues that lie beyond the scope of this study. But, in short, restructuring would shift not just perceptions of aid but also the substance of aid away from being a hand out to a system that strengthens capacity not at the national level but at the community level. It would be a force for change coming from within recipient countries like Ghana rather than a continuation of the current system of giving them handouts. It would require effective government intervention to create wealth within those countries. Ultimately, responsibility for the health of citizens must rest with their governments not with aid agencies.

7.1 Future Research Agenda

Then next stage of this research will be to address a fundamental limitation in this study. That is the fact that while proposing a grassroots community-based approach to HIV intervention, the study itself was essentially urban-based. All interviews were conducted in Accra, the capital of Ghana, and surrounding areas. In a sense that was inevitable given the fact that Accra hosts the offices of all donor agencies, ministries and departments of government and the main offices of the major NGOs. Still there are numerous government and NGO operatives working on implementing the policy in the rural countryside whose input would be very useful for understanding the HIV policy.

Another aspect of my future research plans is also related to what I see as a second limitation of this study. The lack of a comparative perspective based on HIV/AIDS policy from elsewhere in West Africa or other part in Africa. It would be interesting to see how inductive reflexive model can be used to analyze HIV intervention in another country with similar entities, activities and properties in its policy structure.

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Appendix 1 Map of Ghana



Appendix 2 Survey Instrument – Public Officials

Ghana Government Officials Questionnaire

Respondent Background Questions

Q1. Gender:

___ 1. Female

___ 2. Male

Q2. Nationality/Ethnic group:

Expatriate – Nationality _____

Ghanaian

1. Akan

2. Ewe

3. Mole-Dagbane

4. Guan

5. Ga-Adangbe

6. Other _____

Q3. Employer/Location: _____

Q4. Number of years in HIV/AIDS Program: _____

Q5. Current Position/Title? _____

Interview Date: _____ Place: _____

General Questions –All Respondents

G1. What tasks do you perform in your agency relative to HIV/AIDS?

G2. What, in your view, is the guiding principle underpinning your agency's HIV/AIDS policy?

G3. Does your agency's mission differ from those of other organizations/agencies working in the field?

___ 1. NO

___ 2. YES: If yes, how?

G4. Are there formal/informal coordination mechanisms for the various groups working in this field?

___ 1. NO

___ 2. YES: IF YES, Could you describe them?

G5. Have things changed since you started working in this field – for better or worse?

Please elaborate.

___ 1. Things have improved

___ 2. About the same

___ 3. Conditions have worsened.

G6. Does your organization's approach to HIV/AIDS differ from what pertains in other organizations/agencies working in the field? Government agencies/donor organizations/NGOs.

- 1. NO
- 2. YES: If yes, how?

G7. Does AIDS affect poverty/development in Ghana in your opinion?

- 1. NO
- 2. YES: If yes, how?

G8. Do global trends have an impact of on the anti-HIV/AIDS program here in Ghana?

- 1. NO
- 2. YES: If yes, how?

G9. Does it require a global approach to deal with the problem?

- 1. NO
- 2. YES

G10. What is the overall strategy for your agency's policy? Please check all that apply?

- a. Prevention
- b. Care/Treatment
- c. Education
- d. Psycho-social support services
- e. Fighting stigma and discrimination
- f. Promoting change in social/sexual behavior
- g. Integrated approach (which options?)

G11. Looking at your entire work experience in this field, when did you feel most excited about your involvement in the HIV/AIDS sector?

G12. What made that experience so exciting? Was anybody else involved?

G13. Is there anything in your personality that made it a peak experience?

G14. What word or phrase would you use to describe your agency's most positive characteristic?

G15. Without being humble, what do you value the most about yourself - as a man/woman?

G16. What is the most important thing you do in your work?

G17. What is the most important thing your agency does?

G18. Despite significant challenges in the fight against HIV/AIDS, there have been some impressive examples of success. Such success could be the result of an especially effective intervention program, a community effort or leadership. What, in your mind, is the most outstanding or successful achievement you have been involved in? An effort or accomplishment of which you are particularly proud?

G19. Did any of these factors contribute to these successes? Please check all that apply.

- a. Leadership
- b. Teamwork
- c. Culture
- d. Innovation
- e. Effective policy framework

G20. The fight against HIV/AIDS is being led by the collective hard work of several groups and individuals. Many human and financial resources are being mobilized to fight this disease. It has been said that it is especially through partnership and collaboration that these resources can be leveraged for maximum success. Can you give me any examples of successful partnerships or joint efforts in this sector that you are aware of? Is there a particular reason why they were successful?

G21. Can you describe for me an extraordinary display of cooperation among diverse individuals or groups in the HIV/AIDS sector?

G22. Can you recollect a successful partnership or network (aimed at a common goal) that you have been part of. What factors made it successful?

G23. If you could develop or transform the way in which HIV/AIDS is approached here in Ghana, what changes would you make to increase the likelihood of success in containing and eradicating this disease?

G24. What is the most important change you would make if you could to increase the likelihood of success?

G25. Are there other changes you would make?

G26. What is the most important first step that can be taken to achieve these wishes?

G27. Which one of the following best describes the HIV/AIDS problem in Ghana?

- a. Medical
- b. Health Care
- c. Economic
- d. Social
- e. Cultural
- f. Political

- g. ___ Security
- h. ___ All of the above

G28. How would you characterize the HIV/AIDS situation in Ghana?

- a. ___ Crisis
- b. ___ Health care issue
- c. ___ Medical issue
- d. ___ Human rights issue
- e. ___ Moral Problem
- f. ___ Socio-economic problem
- g. ___ Privacy issue
- h. ___ Other (Elaborate)

G29. Do you think people with HIV/AIDS in Ghana are: (Please check all that apply)

- a. ___ Powerless
- b. ___ Poor
- c. ___ Hopeless
- d. ___ Unfortunate
- e. ___ Unlucky
- f. ___ Careless.
- g. ___ Being punished for their sins

G30. Which one of these alternatives do you think would be most effective for mitigating the impact of the disease in Ghana?

- a. ___ Support for government initiatives
- b. ___ Empowerment of women
- c. ___ Increased budgetary support to Ghana government
- d. ___ Increased financial support to HIV/AIDS NGOs
- e. ___ Information, Education and Communication
- f. ___ Distribution of condoms
- g. ___ More international aid
- h. ___ Change in cultural and religious beliefs and practices
- i. ___ Stepping up of anti-poverty measures

G31. What, in your opinion, is the biggest obstacle to effective HIV/AIDS intervention in Ghana?

- a. ___ Traditional beliefs
- b. ___ Poor health care infrastructure
- c. ___ Poverty
- d. ___ Underdevelopment and backwardness
- e. ___ Lack of access to anti-retroviral drugs
- f. ___ Sexual behavior
- h. ___ Prevalence of sexually transmitted infections (STIs)

i. ____Lack of sanctions against promiscuity

G32. Which of the following statements best describes your impressions of the HIV/AIDS policy environment in Ghana?

1. Well coordinated
2. Poorly coordinated
3. Lack the requisite technical support
4. Has the requisite technical support
5. Other: Describe _____

G33. What are the three main challenges faced by your agency in terms of tackling the HIV/AIDS problem and how may these be addressed?

<u>Challenges</u>	<u>Possible Solution</u>
1.	1.
2.	2.
3.	3.

G34. How do measure your personal success in your work?

G35. Who are your agency's main national, international and regional partners, if any?

G36. Do you think your partners share your philosophical and tactical approach as they relate to HIV/AIDS?

- ____1. NO – IF NO, why not?
____2. YES

Government Officials Interview/Questionnaire

The questionnaire below is a survey about opinions of employees of agencies of the Government of Ghana working in the anti-HIV/AIDS program. This study is part of a dissertation project to fulfill the requirements of a doctoral degree at West Virginia University, Morgantown, in the United States.

The answers you give will not be identified with you personally. You will remain completely anonymous. The questions asked are based on opinions not facts therefore there is no such thing as a right or wrong answer. It is only requested that you be as frank as you can in your responses.

Government Employees - Specific Questions

P1. Can you please tell me what got you into this line of work with HIV/AIDS?

P2. Did you come into your current employment with any initial hopes and aspirations for the battle against HIV/AIDS?

P3. Have they been fulfilled?

P4. If yes how, if not why do you think so?

P5. Does your agency have a relationship with donor organizations dealing with HIV/AIDS?

___ 1. NO

___ 2. YES: If yes, what is the nature of that relationship?

P6. Does your agency have a relationship with NGOs working in the same field? If yes, what is the nature of that relationship?

P7. What do you think of the idea that disease and death often have their sources in witchcraft or other forms of black magic? I would ask this as strongly agree to strongly disagree.

___ 1. Strongly agree that disease and death have sources in witchcraft or black magic.

___ 2. Somewhat agree

___ 3. Unsure

___ 4. Somewhat disagree

___ 5. Strongly disagree

P8. Where does the impetus for your agency's policy initiatives come from?

P9. Who are the principal beneficiaries of your policies?

P10. Do you think that people's religious beliefs makes a difference in their attitude towards HIV/AIDS?

P11. Who do you think is better able to deal with the issue of AIDS and sexuality?

___ 1. Government,

___ 2. Donors

___ 3. NGOs?

Appendix 3 Survey Instrument – Donor Officials

Donor Official Questionnaire

Respondent Background Questions

Q1. Gender:

___ 1. Female

___ 2. Male

Q2. Nationality/Ethnic group:

Expatriate – Nationality _____

Ghanaian

1. Akan

- 2. Ewe
- 3. Mole-Dagbane
- 4. Guan
- 5. Ga-Adangbe
- 6. Other _____

Q3. Employer/Location: _____

Q4. Number of years in HIV/AIDS Program: _____

Q5. Current Position/Title? _____

Interview Date: _____ Place: _____

General Questions –All Respondents

G1. What tasks do you perform in your agency relative to HIV/AIDS?

G2. What, in your view, is the guiding principle underpinning your agency's HIV/AIDS policy?

G3. Does your agency's mission differ from those of other organizations/agencies working in the field?

- ___ 1. NO
- ___ 2. YES: If yes, how?

G4. Are there formal/informal coordination mechanisms for the various groups working in this field?

- ___ 1. NO
- ___ 2. YES: IF YES, Could you describe them?

G5. Have things changed since you started working in this field – for better or worse? Please elaborate.

- ___ 1. Things have improved
- ___ 2. About the same
- ___ 3. Conditions have worsened.

G6. Does your organization's approach to HIV/AIDS differ from what pertains in other organizations/agencies working in the field? Government agencies/donor organizations/NGOs.

- ___ 1. NO
- ___ 2. YES: If yes, how?

G7. Does AIDS affect poverty/development in Ghana in your opinion?

- ___ 1. NO
- ___ 2. YES: If yes, how?

G8. Do global trends have an impact of on the anti-HIV/AIDS program here in Ghana?

1. NO

2. YES: If yes, how?

G9. Does it require a global approach to deal with the problem?

1. NO

2. YES

G10. What is the overall strategy for your agency's policy? Please check all that apply?

h. Prevention

i. Care/Treatment

j. Education

k. Psycho-social support services

l. Fighting stigma and discrimination

m. Promoting change in social/sexual behavior

n. Integrated approach (which options?)

G11. Looking at your entire work experience in this field, when did you feel most excited about your involvement in the HIV/AIDS sector?

G12. What made that experience so exciting? Was anybody else involved?

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G19. Did any of these factors contribute to these successes? Please check all that apply.

f. Leadership

g. Teamwork

h. Culture

- i. ___Innovation
- j. ___Effective policy framework

G20. The fight against HIV/AIDS is being led by the collective hard work of several groups and individuals. Many human and financial resources are being mobilized to fight this disease. It has been said that it is especially through partnership and collaboration that these resources can be leveraged for maximum success. Can you give me any examples of successful partnerships or joint efforts in this sector that you are aware of? Is there a particular reason why they were successful?

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G26. What is the most important first step that can be taken to achieve these wishes?

G27. Which one of the following best describes the HIV/AIDS problem in Ghana?

- i. ___Medical
- j. ___Health Care
- k. ___Economic
- l. ___Social
- m. ___Cultural
- n. ___Political
- o. ___Security
- p. ___All of the above

G28. How would you characterize the HIV/AIDS situation in Ghana?

- i. ___Crisis
- j. ___Health care issue
- k. ___Medical issue
- l. ___Human rights issue
- m. ___Moral Problem
- n. ___Socio-economic problem

- o. ___ Privacy issue
- p. ___ Other (Elaborate)

G29. Do you think people with HIV/AIDS in Ghana are: (Please check all that apply)

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- j. ___ Hopeless
- k. ___ Unfortunate
- l. ___ Unlucky
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___ 1. NO – IF NO, why not?

___ 2. YES

Employees of Donor Organizations Interview/Questionnaire

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Employees of Donors Organizations – Specific Questions

D1. Can you please tell me what got you into this line of work with HIV/AIDS?

D2. Did you come into your current employment with any initial hopes and aspirations for the battle against HIV/AIDS?

D3. Have they been fulfilled?

D4. If yes how, if not why do you think so?

D5. Does your organization have a relationship with the Ghana government agencies dealing with HIV/AIDS?

___ 1. NO

___ 2. YES: If yes, what is the nature of that relationship?

D6. Does your organization have a relationship with the local NGOs working in the same field?

- ___ 1. NO
- ___ 2. YES: If yes, what is the nature of that relationship?

D7. Do you see tradition and culture as playing any role in the spread of HIV/AIDS in Ghana?

- ___ 1. NO
- ___ 2. YES: If yes, please elaborate?

D8. Where does the impetus for your organization's policy initiatives come from?

D9. Who are the principal beneficiaries of your policies?

D10. Does your work here in Ghana support the UN MDG goals – if so how?

- ___ 1. NO
- ___ 2. YES: If yes, how?

D11. Is your HIV/AIDS work related to your organization's work in support of socio-economic development in Ghana?

- ___ 1. NO
- ___ 2. YES: If yes, how?

D12. Do you think that people's religious beliefs makes a difference in their attitude towards HIV/AIDS?

- ___ 1. NO
- ___ 2. YES: If yes, how?

D13. Do you think that participation of marginalized groups is important in the fight against HIV/AIDS?

- ___ 1. NO
- ___ 2. YES: If yes, how?

D14. Who do you think is better able to deal with the issue of AIDS and sexuality?

- ___ 1. Government,
- ___ 2. Donors
- ___ 3. NGOs?

D15. Is there (or should there be) a relationship between your organization's overseas aid policy (development strategy) and the policy on HIV/AIDS?

- ___ 1. NO
- ___ 2. YES: If yes, please elaborate?

D16. Do you think the health delivery system in Ghana is sophisticated enough to deal with the complexity of treatment for HIV/AIDS?

- ___ 1. NO

___ 2. YES

D17. Do you think HIV/AIDS patients in Ghana are sophisticated to adhere to treatment regimes for their condition?

___ 1. NO

___ 2. YES

D18. Do you consider your work in Ghana to be a humanitarian project?

___ 1. NO

___ 2. YES

Appendix 4 Survey Instrument – NGO Officials

NGO Officials Questionnaire

Respondent Background Questions

Q1. Gender:

___ 1. Female

___ 2. Male

Q2. Nationality/Ethnic group:

Expatriate – Nationality _____

Ghanaian

1. Akan

2. Ewe

3. Mole-Dagbane

4. Guan

5. Ga-Adangbe

6. Other _____

Q3. Employer/Location: _____

Q4. Number of years in HIV/AIDS Program: _____

Q5. Current Position/Title? _____

Interview Date: _____ Place: _____

General Questions –All Respondents

G1. What tasks do you perform in your agency relative to HIV/AIDS?

G2. What, in your view, is the guiding principle underpinning your agency's HIV/AIDS policy?

G3. Does your agency's mission differ from those of other organizations/agencies working in the field?

___ 1. NO

___ 2. YES: If yes, how?

G4. Are there formal/informal coordination mechanisms for the various groups working in this field?

___ 1. NO

___ 2. YES: IF YES, Could you describe them?

G5. Have things changed since you started working in this field – for better or worse? Please elaborate.

___ 1. Things have improved

___ 2. About the same

___ 3. Conditions have worsened.

G6. Does your organization's approach to HIV/AIDS differ from what pertains in other organizations/agencies working in the field? Government agencies/donor organizations/NGOs.

___ 1. NO

___ 2. YES: If yes, how?

G7. Does AIDS affect poverty/development in Ghana in your opinion?

___ 1. NO

___ 2. YES: If yes, how?

G8. Do global trends have an impact of on the anti-HIV/AIDS program here in Ghana?

___ 1. NO

___ 2. YES: If yes, how?

G9. Does it require a global approach to deal with the problem?

___ 1. NO

___ 2. YES

G10. What is the overall strategy for your agency's policy? Please check all that apply?

o. ___ Prevention

p. ___ Care/Treatment

q. ___ Education

r. ___ Psycho-social support services

s. ___ Fighting stigma and discrimination

t. ___ Promoting change in social/sexual behavior

u. ___ Integrated approach (which options?)

G11. Looking at your entire work experience in this field, when did you feel most excited about your involvement in the HIV/AIDS sector?

G12. What made that experience so exciting? Was anybody else involved?

G13. Is there anything in your personality that made it a peak experience?

G14. What word or phrase would you use to describe your agency's most positive characteristic?

G15. Without being humble, what do you value the most about yourself - as a man/woman?

G16. What is the most important thing you do in your work?

G17. What is the most important thing your agency does?

G18. Despite significant challenges in the fight against HIV/AIDS, there have been some impressive examples of success. Such success could be the result of an especially effective intervention program, a community effort or leadership. What, in your mind, is the most outstanding or successful achievement you have been involved in? An effort or accomplishment of which you are particularly proud?

G19. Did any of these factors contribute to these successes? Please check all that apply.

- k. Leadership
- l. Teamwork
- m. Culture
- n. Innovation
- o. Effective policy framework

G20. The fight against HIV/AIDS is being led by the collective hard work of several groups and individuals. Many human and financial resources are being mobilized to fight this disease. It has been said that it is especially through partnership and collaboration that these resources can be leveraged for maximum success. Can you give me any examples of successful partnerships or joint efforts in this sector that you are aware of? Is there a particular reason why they were successful?

G21. Can you describe for me an extraordinary display of cooperation among diverse individuals or groups in the HIV/AIDS sector?

G22. Can you recollect a successful partnership or network (aimed at a common goal) that you have been part of. What factors made it successful?

G23. If you could develop or transform the way in which HIV/AIDS is approached here in Ghana, what changes would you make to increase the likelihood of success in containing and eradicating this disease?

G24. What is the most important change you would make if you could to increase the likelihood of success?

G25. Are there other changes you would make?

G26. What is the most important first step that can be taken to achieve these wishes?

G27. Which one of the following best describes the HIV/AIDS problem in Ghana?

- q. Medical
- r. Health Care
- s. Economic
- t. Social
- u. Cultural
- v. Political
- w. Security
- x. All of the above

G28. How would you characterize the HIV/AIDS situation in Ghana?

- q. Crisis
- r. Health care issue
- s. Medical issue
- t. Human rights issue
- u. Moral Problem
- v. Socio-economic problem
- w. Privacy issue
- x. Other (Elaborate)

G29. Do you think people with HIV/AIDS in Ghana are: (Please check all that apply)

- o. Powerless
- p. Poor
- q. Hopeless
- r. Unfortunate
- s. Unlucky
- t. Careless.
- u. Being punished for their sins

G30. Which one of these alternatives do you think would be most effective for mitigating the impact of the disease in Ghana?

- a. Support for government initiatives
- b. Empowerment of women
- c. Increased budgetary support to Ghana government
- d. Increased financial support to HIV/AIDS NGOs
- e. Information, Education and Communication
- f. Distribution of condoms
- g. More international aid

- h. ___ Change in cultural and religious beliefs and practices
- i. ___ Stepping up of anti-poverty measures

G31. What, in your opinion, is the biggest obstacle to effective HIV/AIDS intervention in Ghana?

- a. ___ Traditional beliefs
- b. ___ Poor health care infrastructure
- c. ___ Poverty
- d. ___ Underdevelopment and backwardness
- e. ___ Lack of access to anti-retroviral drugs
- f. ___ Sexual behavior
- h. ___ Prevalence of sexually transmitted infections (STIs)
- i. ___ Lack of sanctions against promiscuity

G32. Which of the following statements best describes your impressions of the HIV/AIDS policy environment in Ghana?

- 1. Well coordinated
- 2. Poorly coordinated
- 3. Lack the requisite technical support
- 4. Has the requisite technical support
- 5. Other: Describe _____

G33. What are the three main challenges faced by your agency in terms of tackling the HIV/AIDS problem and how may these be addressed?

<u>Challenges</u>	<u>Possible Solution</u>
1.	1.
2.	2.
3.	3.

G33. How do measure your personal success in your work?

G34. Who are your agency’s main national, international and regional partners, if any?

G35. Do you think your partners share your philosophical and tactical approach as they relate to HIV/AIDS?

- ___ 1. NO – IF NO, why not?
- ___ 2. YES

Employees of NGOs Interview/Questionnaire

The questionnaire below is a survey about opinions of employees of local NGOs working in the anti-HIV/AIDS program in Ghana. This study is part of a dissertation project to fulfill the requirements of a doctoral degree at West Virginia University, Morgantown, in the United States.

The answers you give will not be identified with you personally. You will remain completely anonymous. The questions asked are based on opinions not facts therefore there is no such thing as a right or wrong answer. It is only requested that you be as frank as you can in your responses.

Employees of NGOs – Specific Questions

N1. Can you please tell me what got you into this line of work with HIV/AIDS?

N2. Did you come into your current employment with any initial hopes and aspirations for the battle against HIV/AIDS?

N3. Have they been fulfilled?

N4. If yes how, if not why do you think so?

N5. Who will be the principal beneficiaries of this NGO's work?

N6. Where does the impetus for your NGO's policy initiatives come from?

N7. Does your NGO receive any support from the government for its work?

___ 1. NO

___ 2. YES: If yes, what is the nature of that support?

N8. Does your NGO have a relationship with the government agencies dealing with HIV/AIDS?

___ 1. NO

___ 2. YES: If yes, what is the nature of that relationship?

N9. Does your NGO have a relationship with the donor organizations working in the same field?

___ 1. NO

___ 2. YES: If yes, what is the nature of that relationship?

N10. Should tradition and culture play a role in the fight against HIV/AIDS?

___ 1. NO

___ 2. YES: If yes, how?

N11. Do you think that people's religious beliefs makes a difference in their attitude towards HIV/AIDS?

___ 1. NO

___ 2. YES: If yes, how?

N12. What do you think of the idea that disease or death often have their sources in witchcraft or other forms of black magic?

N13. Who do you think is better able to deal with the issue of AIDS and sexuality?

____ 1. Government,

____ 2. Donors

____ 3. NGOs?