



USAID/GHANA

HIV/AIDS Strategic Plan

(2004-2010)

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I. Acronyms

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
ARH	Adolescent Reproductive Health
ART	Anti retroviral treatment (therapy)
ARV	Anti-Retrovirals
BCC	Behavior Change Communication
CBO	Community-Based Organization
CSO	Civil Society Organization
CHC	Community Health Committee
CHPS	Community Based Health and Planning Services
CIDA	Canadian International Development Agency
CHV	Community Health Volunteers
CRS	Catholic Relief Services
CSW	Commercial sex worker
DA	District Assembly
DAC	District AIDS Committee
DAP	Development Assistance Program
DCE	District Chief Executive
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
DHMT	District Health Management Team
DRI	District Response Initiative
DRIMT	District Response Initiative Management Team
DOTS	Directly Observed Therapy-Short Course for Tuberculosis
EPI	Expanded Program for Immunization
EU	European Union
FAO	Food and Agriculture Organization
FHI	Family Health International
FHU	Family Health Unit
FP	Family Planning
FSW	Female sex worker
FY	Fiscal Year
GAC	Ghana AIDS Commission
GARFund	Ghana AIDS Response Fund
GDP	Gross Domestic Product
GF	Global Fund
GIPA	Greater Involvement of People Living with or Affected by HIV/AIDS
GOG	Government of Ghana
GTZ	German Agency for Technical Cooperation
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home-based Care
HIV	Human Immunodeficiency virus
IDU	Injecting drug users
IE&C	Information, Education, and Communication
IGA	Income Generating Activities
ILO	International Labor Organization
IPPF	International Planned Parenthood Federation
JHU	Johns Hopkins University
JICA	Japanese International Cooperation Agency

JSS	Junior secondary school
KAP	Knowledge, attitudes and practices
MAP	Multi-country HIV/AIDS Program
MDA	Ministries, Departments and Agencies
M&E	Monitoring and evaluation
MOFA	Ministry of Food and Agriculture, Ghana
MOE	Ministry of Education, Ghana
MOH	Ministry of Health, Ghana
MSM	Males who have sex with males
MTCT	Mother to child transmission
NACP	National AIDS/STI Control Program
NGO	Non-Governmental Organization
NMIR	Noguchi Memorial Institute of Medical Research
OICI	Opportunity Industrialization Centers, International
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAHA	Persons Affected by HIV/AIDS
PLACE	Priorities for Local AIDS Control Efforts
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive health
SO	Strategic Objective
SSS	Senior secondary school
STI	Sexually transmitted infections
SW	Sex worker
TA	Technical assistance
TB	Tuberculosis
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WB	World Bank
WFP	World Food Program
WHO	World Health Organization
WHO/GPA	World Health Organization/Global Program on AIDS

1. Country Situation

A.

1.1 Background

Ghana is a developing country in sub-Saharan Africa with a population of 20.3 million (projection from 2000 census) and an annual population growth rate of 2.6 percent. Forty-six percent of the population is below the age of fifteen and 51 percent of the population is female. According to the Ghana Living Standards survey, in 1999 forty (40) percent of the population was below the poverty level and 27% were living in extreme poverty (defined as those whose standard of living is insufficient to meet their basic nutritional requirements even if they devoted their entire consumption budget to food). UN Human Development Indicators rank Ghana 119 out of 162 countries (1999). This poverty encourages behaviors such as the commercialization of sex and an increase in numbers of street children.

The Ghanaian government relies on external donors for 50% of its operating funds. Ghana is an agricultural economy with more than 70% of the population involved in agriculture, and still relies on primary exports (cocoa, gold, timber) for most of its foreign exchange earnings. Educational level is low. Based on the Ghana Living Standards Survey, in 1999, only 37% of women and 65% of men were literate. The adult literacy rate was 66% in urban areas and 41% in rural areas. The ability to read with comprehension is even lower, particularly in the rural areas. Of the literate adults only 10% had completed senior secondary school or above. However, school enrollment has been increasing. There are presently three million pupils enrolled in public schools: two million in Primary Schools, 700,000 in Junior Secondary Schools, 230,000 in Senior Secondary Schools and 70,000 at tertiary levels. Another 500,000 pupils are enrolled in private schools. Social sector spending levels are low, even relative to African averages, with spending on health at 2% of GDP and education at 2.8% of GDP. Over 90% of government expenditure is for recurrent costs including personnel.

According to the Ministry of Local Government and Rural Development, Ghana's administrative system is based on a five tier decentralized hierarchy: the nation (1), regions (10), districts (110), sub-districts/zones (about 1218) and units (16,000 settlements with populations between 500-1,500). Within this arrangement, the national level is responsible for policy and strategy development; the regional level for translating national policy into regional strategies and coordination of district actions; and the district for implementing all government policies. Each district is governed by a District Assembly (DA) whose Presiding Member is elected from among its members, and a District Chief Executive appointed by Government to execute District Assembly as well as central government policies and plans.

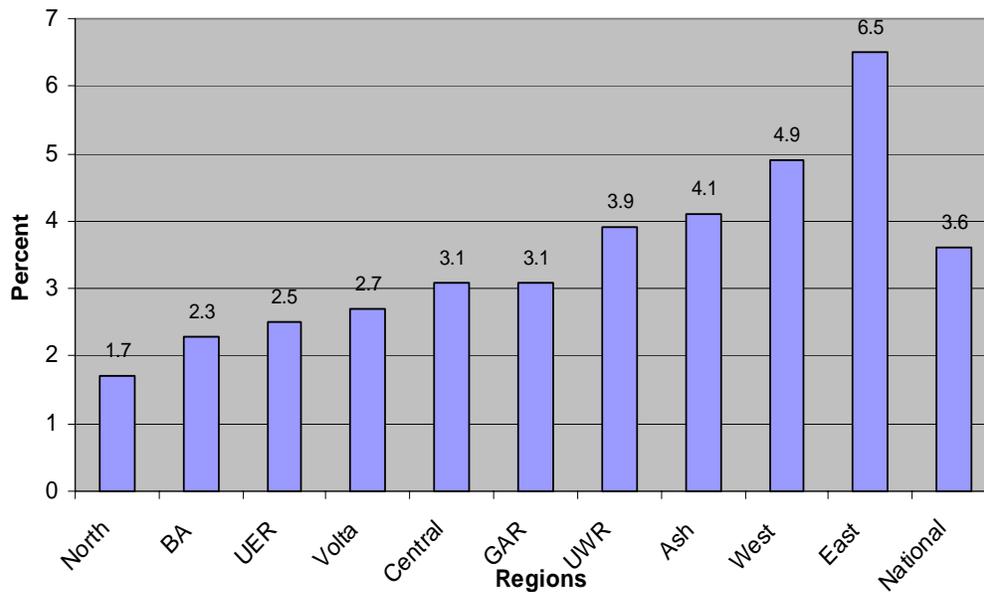
The DAs are the highest political and administrative authority at the local level. The DAs harmonize and coordinate actions of the decentralized ministries through their subcommittees. They also facilitate grass roots participation and community involvement in socio-economic development programs. The DAs Social Services subcommittees have direct responsibility for developing an information base, and plan and execute social sector development including health, education and social welfare.

1.2 Current Status of the Epidemic

Ghana is a generalized low prevalence country by the United Nation's Joint Program on AIDS (UNAIDS) definition. Approximately 400,000 adults are living with HIV/AIDS. The prevalence among sexually transmitted infection (STI) patients and among blood donors is 17% and 4% respectively (NACP, 2000). Unpublished surveillance information puts the 2002 HIV prevalence at 4.1%, after six years hovering between 3% and 4%. Computer modeling based on 2000 HIV surveillance information estimates an increase to 6.9% by 2009, although it is unclear what the assumptions of the model are. What is clear is that the HIV epidemic in Ghana is of a different nature than that of southern and eastern Africa; it is

spreading much less rapidly. While it is too early to conclude that HIV prevalence is at a plateau, there is an opportunity to put well-targeted interventions in place to reduce HIV transmission.

Figure 1: HIV Prevalence by regions 2001



Source: MOH/NACP, Ghana

As Figure 1 shows, HIV prevalence rates are not uniform across Ghana’s regions. They range from a low of 1.7% in the northern region to a high of 6.5% in the Eastern region. Above average rates are seen in the Western region at 4.9%, the Eastern region at 6.5%, Ashanti 4.1% and the Upper West Region 3.9% (Upper West Region’s high rate is not consistent with previous measurements and might therefore be an outlier). There are additional pockets throughout the country, generally along main transportation routes, which have high rates. The distribution of HIV/AIDS is higher in densely populated areas, particularly in densely populated regional capitals such as Kumasi, Koforidua and Accra. Prevalence is also high in mining towns such as Obuasi and Tarkwa, as well as in border towns.

Figure 2 gives the cumulative number of AIDS cases by age and sex from 1986 when the first case was reported, to 2000. Two-thirds of reported AIDS cases have been female, but this is leveling off, with 58% of cases being female in 2001. The majority of cases are in the economically productive age groups. Although children under one constitute 4% of the total population, they account for 15% of AIDS cases in Ghana. It is also estimated that an average of 200 new infections and 130 conversions to AIDS occur every day. Heterosexual transmission accounts for 75-80% of infections, while mother to child transmission (MTCT) accounts for 15%. Transmission through other routes, including blood transfusion, contaminated needles or sharp objects is considered to be very low, and little data available on these.

HIV prevalence rates are much higher in identified “most at risk” groups such as commercial sex workers (CSW) with a 1999 prevalence rate of 77% in Accra and 82 % in Kumasi (1997 data is available for Accra only, at 74%). Comprehensive correct knowledge about HIV is very low among CSW, and reported condom use during last commercial sex is inconsistent, particularly outside of metropolitan areas. Several other groups are known to have risky behaviors. Forty two percent of professional drivers had higher-risk sex in the last year and only 56% used a condom during last higher-risk sex. About one-quarter of professional drivers who were having commercial sex did not use a condom. A full two-thirds of policemen had had sex with non-regular partners during the previous year, but condom use is high (98% during commercial sex, and 83% during higher risk sex). Miners in the Obuasi area, where

extensive safer sex interventions have taken place, have reduced higher-risk sex and commercial sex. Condom use has increased, and the incidence of STIs has decreased. However, consistent condom use is still low among miners, especially during commercial sex.

Youth (in-and-out of school combined) have high levels of sexual activity, with increasing, but still insufficient use of condoms during last sex, ranging from 54% to 74%. They report high levels of STI. In-school youth report much lower levels of sexual activity, slightly lower levels of condom use and very low levels of STI awareness. Forty six percent of sexually active female students report force or rape during first sex. Annex 1 gives an overview of the available behavioral information of most at-risk and vulnerable groups.

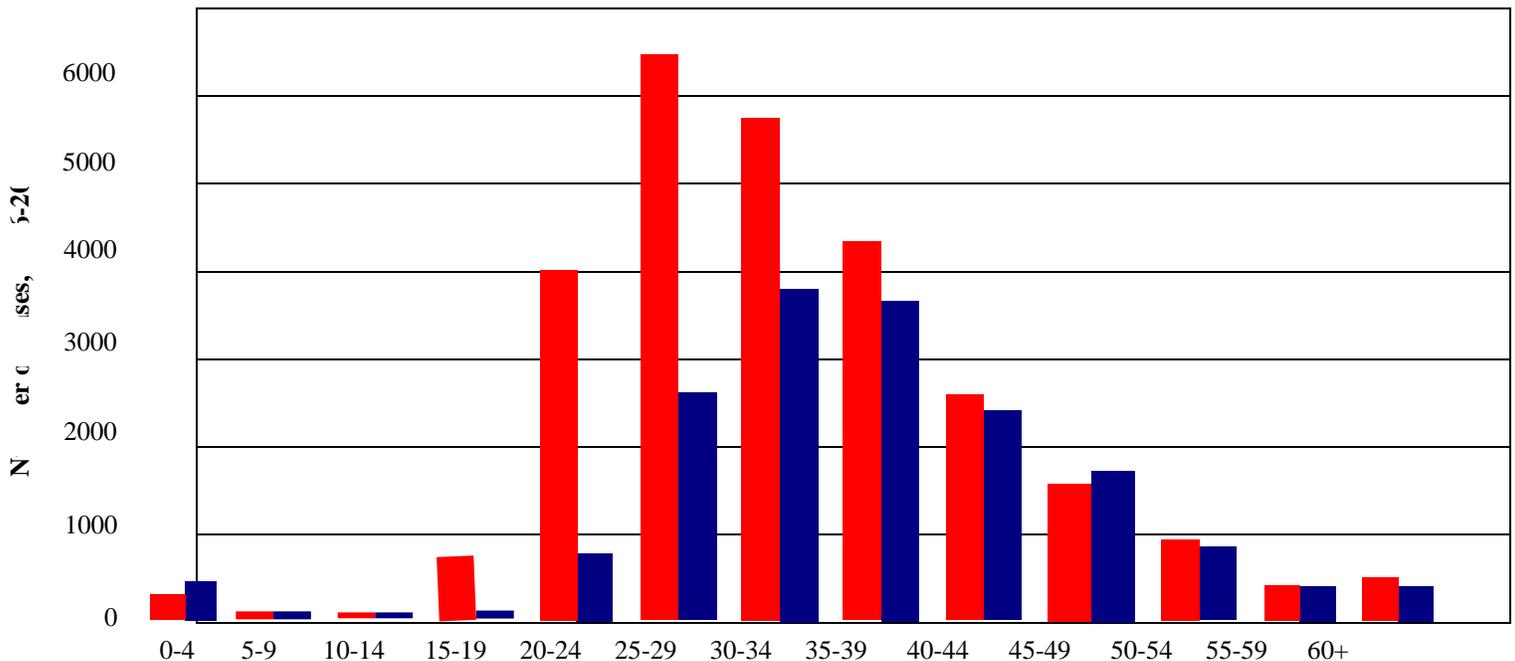


Figure 2
Cumulative Number of AIDS Cases by Age and Sex 1986 - 2000 (NACP)

Much less is known about other groups thought to be most at risk, including public servants that travel extensively or wield specific powers over the public with whom they interact, apprentices, waitresses and bargirls, itinerant traders, and men who have sex with men. Female porters, young women who work in market areas helping to carry loads, have been associated with high-risk behaviors, including commercial sex work. Teachers are widely thought to be at risk but behavioral information is lacking. One MOH report indicates that the number of deaths among teachers went from 49 in 1995 to 270 in 1998, an increase of 500 percent, which might possibly be due to AIDS. These figures represent an increase from a death rate of about 2 per 1000 in 1995 to 15 per 1000 in 1998. Ghana's overall death rate is 10 per 1000 population.

Because some most at-risk groups are not yet clearly identified more information is needed to design a full range of well-prioritized intervention methods to curtail further spread to the general population. USAID currently supports behavioral surveillance systems among groups considered to be most at-risk (commercial sex workers, police, miners, rural and urban youth). To build on this and pursue the process

of identifying most at risk groups, USAID is working with Health and Development Africa to develop an overall approach and standardized survey instruments and methods, to be applied to a wide array of potentially most at-risk groups. Once potential most at-risk groups are identified through a thorough assessment of currently available information, they will be the subject of behavioral and sero-prevalence surveillance. Surveillance, along with an overlay of HIV prevalence and location considerations, will be used to identify those for whom interventions would have the greatest impact. Behavioral surveillance, i.e., the identification of risky behaviors by group, will inform the design of interventions including what additional studies might be needed on determinants of behavior. Sero-prevalence information by group and location/area will contribute to determining magnitude of interventions. In addition, the Office of HIV/AIDS will make available methodologies for estimating the size of the most at risk populations and work with USAID/Ghana to establish estimates of these in the next six months.

Once behavioral and sero-prevalence surveillance is initiated among the highest most at-risk groups, it will be continued once every two years. Given USAID/Ghana's interest in teachers as a potentially most at-risk group, teachers will automatically be included among those groups whose behavior and sero-prevalence will be the subject of surveillance.

A conservative estimate of the number of AIDS orphans (children who have lost one or both parents due to AIDS) was 204,000 in 2001 (Children on the Brink 2002). It is projected that this figure will increase to 263,000 by 2010. Orphans' education is generally curtailed after the death of both parents. Additionally, many children of people living with HIV/AIDS (PLWHA) are being taken out of school, either because they need to take care of their parents, or because their parents have lost their jobs or are too sick to work and therefore cannot pay school fees.

Tuberculosis (TB) is the single most important cause of mortality and morbidity in HIV-infected people. TB is on the rise in Ghana. Case notification in absolute numbers has increased from 8251 in 1996 to 11836 in 2001. While this number may seem low, the National Tuberculosis Program identified low cure (58%) and treatment success rates (65%) as well as a high defaulter rate (18%) in 2000. These rates are worrying because a substantial rise in burden by TB is expected with the greater number of AIDS and cases in the coming years. The rationale for targeting TB in HIV control is that it is a common HIV-associated condition that also affects a large number of HIV-negative individuals, and is relatively easy and cheap to diagnose and treat.

1.3 Socio-Economic Impact of HIV/AIDS in Ghana

HIV/AIDS, if not curtailed, could have a devastating impact on the future growth of the economy and the wellbeing of the people of Ghana.

Labor Force (public and private sectors): The number of workdays lost due to illness for a person with HIV/AIDS is thought to range from one to twelve months a year. Even healthy persons may need time off from work to attend funerals of relatives and co-workers. Should high levels of HIV infection develop in Ghana, businesses will find it difficult to survive. For large employers in Ghana's mining, timber, tourism and transport industries, the effects of declining productivity and increased health care costs are of particular concern.

The public sector: The potential economic burden of mitigating the effects and impact of HIV/AIDS is enormous. Just the cost of treating opportunistic infections (OI) experienced by PLWHA is, for all practical purposes, prohibitive.

Health System: The burden on the health system is growing, with hospital bed occupancy rates due to HIV related illnesses increasing from 20% in 1995 to about 40% in 2000, possibly reaching 60% by 2005.

The expected increase in the number of AIDS cases will dramatically increase the workload for health workers and put an additional drain on an already overburdened system.

Educational Sector: Ghana's national policy to reduce poverty and increase democratic participation in governance is dependent on an education system that provides children and youth with basic life skills for active participation in economic, social and political activity. The spread of HIV infection among both teachers and students poses a serious threat to the attainment of sector goals. Demand will be lower as there will be fewer children to educate and less ability to pay for educating those who survive, creating a less educated nation. Supply will be lower with fewer teachers and administrators to deliver the services. And resources will be strained with monies reallocated to address the needs of the sick and dying.

The Agricultural Sector: Ghana relies on its agricultural sector for its food security and for providing exports to earn foreign exchange. Pockets of high incidence of HIV/AIDS are found in some rural areas where agriculture is the mainstay of the economy (Eastern, Western and Volta regions). HIV/AIDS means loss of labor, and thus loss of production thereby threatening to reverse the downward trend in poverty rates and attainment of USAID's goals in Ghana.

1.4 Factors Influencing the Spread of HIV in Ghana

This section examines the factors that threaten to further spread HIV, as well as those that have successfully impeded the spread of the epidemic in the general population, as a basis for determining the types of interventions required.

a. Factors Predisposing the Spread of HIV in Ghana

Ghana is faced with the possibility of an expanding epidemic if it does not remain vigilant in preventing the spread of HIV in the general population. Experience in other countries shows that rapid increases in infection rates among most at-risk groups is often a precursor to the transfer of HIV/AIDS from these most at-risk groups to the general public. The actual rate of increase in prevalence among most at risk groups in Ghana, however, is yet to be documented (only 1997 and 1999 data for commercial sex workers in Accra is available, at 74% and 77% respectively). Factors that seriously compromise this country's continued success include:

Lack of Information on most at-risk groups: Although behavioral information of some of the best known most at-risk groups (sex workers, professional drivers, miners, police, and youth) is now available, there is insufficient information on other potentially high- risk groups/bridging populations. Illustrative examples include teachers, itinerant traders, market women, members of the uniformed services other than the police service, public servants likely to engage in casual and transactional sex, porters and street children (estimated 18,000 in Accra). So-called second-generation surveillance (combining behavioral and serological information) has not yet begun in Ghana. Moreover, available information is not sufficiently detailed, and is insufficiently focused on determining geographical variations. More information is therefore needed to target the program and ensure that behavior considerations of important bridging populations are understood and addressed.

Peer pressure and sexual risk perception: There are indications that popular culture is negatively influencing populations, particularly youth, to respond to peer pressure about condom use and abstinence. Furthermore, low perception of personal risk translates into a casual attitude towards unprotected sex. According to the 1998 Demographic and Health Survey (DHS), about 55% of the population said they have no chance of getting HIV/AIDS. This is changing, however, with the implementation of behavior change communication (BCC) programs. By June 2001, the percentage of sexually active men who

thought that they were not at risk of becoming infected decreased from 46% in 1998 to 33% in 2001; and the percentage of sexually active women who thought that they had no risk declined from 40% in 1998 to 29% over the same period.

Marriage practices and gender relations: The median age of first sexual intercourse and first marriage is 18 years and 19 years respectively for women. For men it is 19 years and 26 years, respectively (DHS 1998). Women tend to marry older men, thus inheriting their sexual history and that of their previous partners. Although HIV/AIDS affects both men and women, women in Ghana (and elsewhere in Africa) are more vulnerable because of biological, social, cultural and economic factors. Gender inequalities make it difficult for women to negotiate on issues of sex, reproduction and condom use. Supply-side factors such as gender insensitive health facilities and medical procedures may further constrain women's ability to seek support and defend their reproductive health.

Socio-cultural practices and beliefs: Certain socio-cultural practices also put Ghanaians at increased risk. Among these are polygamy, tacit approval of men having extra marital affairs, and heavy consumption of alcohol on certain occasions (e.g., weddings, funerals), thus increasing the likelihood of indulging in risky behavior. The high level of awareness about HIV/AIDS among the general population has not yet resulted in any significant change in behavior.

Mobility: Ghana is bordered by three francophone countries, all of which have higher prevalence of HIV/AIDS (between 7% and 10%). Its borders are porous, with easy uncontrolled movement at borders, a situation that facilitates the spread of diseases across the borders. Within Ghana, economic and social considerations contribute to high mobility, with market women moving between towns; youth moving from the rural to urban areas in search of employment; entire groups commuting to villages around the country for funerals, weddings, etc. Additionally, the huge public servant population (300,000), by nature of its job requirements, is subject to frequent moves, as are people employed in trucking, shipping and road construction. These populations have independence, money and opportunities for multiple partners.

Poverty: In addition to the obvious links between poverty and health, poverty can be a driving factor for risky behavior. Men can impress young girls (including those in school) with money and gifts because of the girls' poverty. An ever-growing number of street children in Accra, Kumasi, Tema and other large towns risk being involved in transactional sex. Despite the low cost of condoms, many sexually active children cannot afford them.

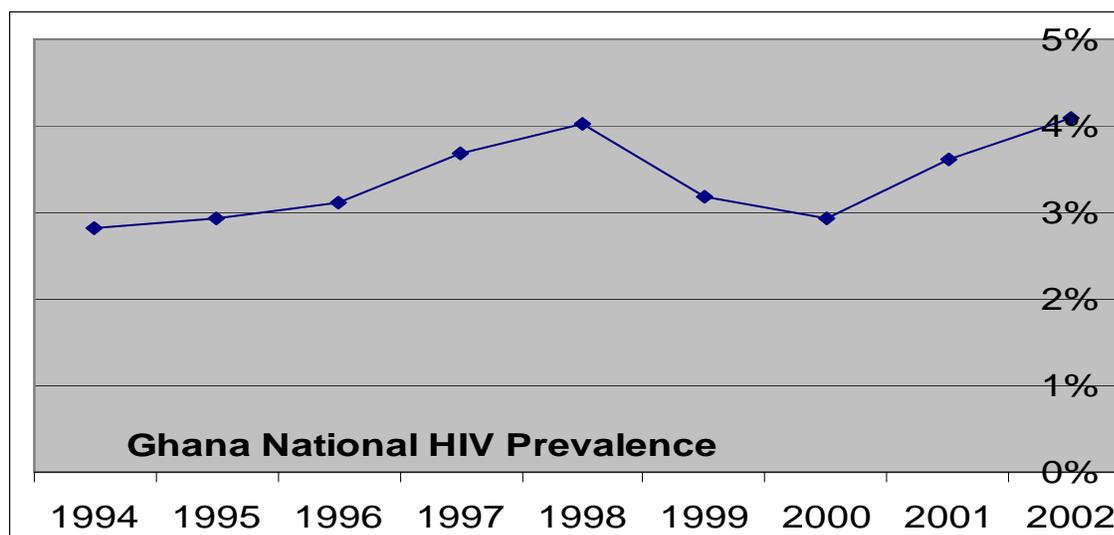
Political Instability: The West African region is politically very fragile. Currently, a near civil war is taking place in Ghana's neighbor on its western border. Political turmoil increases the flow of immigrants/refugees into Ghana. In addition, Ghanaian armed forces are frequently solicited to participate in peace-keeping operations, often in countries with high HIV prevalence levels.

Stigma and discrimination: Ghanaians with HIV have been relatively slow in coming out to give a human face to AIDS. HIV/AIDS stigma is high and it is only recently that some PLWHA have come out in the open. This is a disincentive for enrolling in VCT and PMTCT programs.

b. Factors that have slowed the spread of HIV in Ghana

While there have been no community-based HIV prevalence studies done in Ghana to date (DHS 2003 planning, including HIV sero-prevalence testing, is currently underway), the MOH's well-established sentinel surveillance of HIV among pregnant women has consistently shown a prevalence rate of 3% - 4% for a period of six years. Yet to be published data by the NACP, however, indicates that the rate may have risen to 4.1% in 2002. Given the factors that are listed in the previous section and the nature of the

HIV/AIDS epidemic itself, this is somewhat surprising. The epidemic seems, therefore, to be of a different nature than that of Southern and Eastern Africa.



The following is thought to contribute to Ghana's ability to contain the spread of HIV/AIDS:

Awareness/Knowledge levels: Awareness of HIV/AIDS in Ghana is almost universal, with 97% of women and 99% of men having heard of AIDS, with radio being the most important source of information, followed by television, friends, workplace and, even, religious establishments (DHS 1998). Furthermore, knowledge of some means of preventing HIV/AIDS has increased significantly in recent years (Stop AIDS, Love Life Campaign Evaluation findings, 2002).

Level of sexual activity: Culturally, Ghanaians are not highly promiscuous; rather, sexual norms are relatively conservative. Ghana's apparently low HIV sero-prevalence may possibly be attributed to the late age of sexual debut among Ghanaian youth and high level of stable, mutually monogamous partnerships as compared to many other African countries.

Male Circumcision: Practically universal male circumcision in Ghana contributes to mitigating the spread of HIV.

Social Organizations: Social groups based on religion, profession, ethnic affiliation are well organized. This provides an on-the-ground advantage as networks for reaching affected populations already exist. (Nevertheless, given the stigma associated with HIV/AIDS, mobilizing these groups to address HIV/AIDS and/or to work with PLWHA and affected groups remains a challenge.)

Strong national leadership, multi-sectoral response: Ghana's response is considered to be relatively strong, with strategic direction being provided from the national level and encompassing all sectors. This phenomenon is fairly recent, but nevertheless significant.

Sentinel surveillance: The Ministry of Health, National AIDS Control Program, has been monitoring HIV sero-prevalence on a continuous basis since 1994, through a national sentinel surveillance system of relatively high quality at antenatal clinics.

Condom access: Ghana's public sector and private (social marketing) condom distribution efforts have made condoms readily available through over 5,000 outlets, complemented by a network of community distribution.

Resources: Ghana has recently seen the results of renewed international support for combating HIV/AIDS, with multiple donors bringing significant resources to this effort.

Donor Coordination: Ghana has had excellent donor coordination, especially since formation of the UN Theme Group, which now includes bilateral donors.

1.5 Government of Ghana's Response

With the confirmation of the first few AIDS cases in Ghana in 1986 and the recognition of the potential impact that HIV/AIDS could have on Ghana's socio-economic development, the Government of Ghana (GOG) established the National AIDS/STI Control Program (NACP) in 1987. NACP was charged with coordinating the national response, which initially meant treating HIV/AIDS as a medical problem. This phase led to the development of the Ministry of Health's Short Term Program and subsequently the Medium Term Program I and II. It has become widely accepted that HIV/AIDS is a developmental issue and must be addressed through a multi-sectoral response in a developmental context.

In September 2000, the Ghana AIDS Commission (GAC) was established under the leadership of the President. This is the coordinating body for all HIV/AIDS related activities in Ghana and oversees an expanded response to the epidemic. In this capacity and under the joint direction of the MOH and the National Population Council, the GAC published a National Strategic Framework on HIV/AIDS for the period 2001 to 2005. The Strategic Framework sets targets for HIV/AIDS infection reduction, addresses service delivery needs and individual and societal vulnerability, and promotes the establishment of a multi-sectoral, multidisciplinary framework for coordinated implementation of HIV/AIDS programs. The Framework also sets out goals, objectives and specific activities for all sectors, including the Government and various Government Ministries, the private sector, non-governmental organizations and civil society at large. Five key intervention areas are identified as follows

- Prevention of new transmission
- Care and support for PLWHA
- Creating an Enabling Environment for National Response
- Decentralized Implementation and Institutional arrangements
- Research, Monitoring and Evaluation

Each area is supported by a set of broad strategies that are to guide the development of action plans by all Ministries, Departments and Agencies, Non Governmental Organizations and other Private Sector Institutions. Sectoral plans -- including those for the Ministry of Education, the Ministry of Health (MOH) and Local Government--have been developed, although coordination among them is still lacking. The Ministry of Education concentrates on providing adequate information on HIV/AIDS to enrolled students, the MOH has the mandate to put clinical services for STI management and treatment of PLWHA in place, and Local Government concentrates on setting up a decentralized response to HIV/AIDS, particularly at the District level. A draft national HIV/AIDS policy has been prepared and is ready for discussion in Parliament. It will serve as a basis for further development of legislative instruments to govern the treatment of employees, regardless of their HIV status.

District Assemblies (DA) have taken hold of a District Response Initiative (DRI), launched in 2000 at the urging of UNAIDS, to develop specific strategies for HIV/AIDS activities with their own funding and

incorporated into their poverty alleviation programs. To date, 44 districts are involved in this decentralized approach. In addition, the GAC is embarked on a program that supports hundreds of NGOs at the community level (GARFund/MAP). The GOG has also successfully applied for a first round of Global Funds that largely support treatment of HIV/AIDS-related conditions in the public sector. A second round of applications for community mobilization are being prepared, including care and support through NGOs, and Anti-Retroviral (ARV) treatment and workplace prevention through the private sector.

Until recently, the involvement of religious bodies was limited to initiatives coordinated through the health institutions of the Christian Health Association of Ghana's. These efforts have largely been in the area of care and support. Over the past year however, there has been rapid growth and positive involvement of Christian and Muslim religious leaders. Ghana is a religious country and the involvement of religious leaders augers well for the fight, especially in combating stigma and discrimination.

Other key thrusts of Ghana's response outlined in its strategic framework include blood screening for HIV and increased access of PLWHA to care and support services within a human rights framework. The framework also supports the promotion of safe sex behaviors among most at-risk groups (out-of-school youth, uniformed services, vulnerable women, commercial sex workers, mobile population including teachers); outlines efforts to develop an enabling political, legal, economic and social environment; expands of MTCT and VCT services; supports ARV procurement/treatment; strengthens the national HIV and STI surveillance system; and supports orphans and PLWHA.

Prevention of MTCT was introduced on a pilot basis in 2002. Through the Ghana Poverty Reduction Strategy/HPIC funding, Global Funds and limited USAID support, ART is expected to be available for 4000 person years by mid -2003 on a pilot basis through the Public Health System. Guidelines for use have been developed. Originally the government intended to set up its own production facilities with assistance from the Government of Thailand. However, since some of the international drug companies have agreed to reduce their prices, no final decision has been made.

In summary, the Government's response to dealing with HIV/AIDS had a relatively slow start, but recent steps have been taken to muster political support and mobilize a decentralized response of interventions that address the entire continuum of care. However, several challenges to mounting an effective program remain, including the complications of coordinating a multi-sectoral, multi-donor supported response. While much of the coordination mechanisms are now in place, a concerted response effort is still needs to be created. A weak civil society and undeveloped capacity among NGOs are challenges that need realistic planning and resource allocation. Finally, there has yet to be a discussion on how to balance long-term prevention with immediate needs in care, support and treatment, setting clear priorities.

1.6 Current USAID/Ghana and Other USG Program Coverage

With the development of the new USAID/Ghana Country Strategic Plan 2004-2010, all SO teams have been mandated to consider respective efforts in support of HIV prevention in Ghana. Recently, a mission-wide HIV/AIDS working group was established under the leadership of the Health Strategic Objective (SO) to develop a stand-alone HIV/AIDS strategy for USAID/Ghana, encompassing all sectors' contributions. The working group is establishing communication and collaboration mechanisms on planning and implementation of HIV/AIDS activities.

1.6.1 USAID/Ghana's Health Strategic Objective

USAID/Ghana's Health SO works to ensure that relevant information, commodities and services are available to Ghanaians. HIV/AIDS funds were first allocated in FY1998, and program implementation began in 1999 with condom distribution, mass media activities, and peer education among the uniformed services. USAID has played a leading role in putting HIV/AIDS high on the national agenda, largely due to assistance with gathering data for decision making through surveillance, computer modeling and forecasting of the epidemic, and supporting major surveys.

USAID's program has been gradually shifting its focus towards higher risk groups and vulnerable groups, e.g. professional drivers, miners and sex workers; has pioneered private sector HIV/AIDS programs. Most recently, USAID has supported the initiative of creating a Ghanaian response in the areas of treatment, care and support, by providing technical assistance for developing national policies and guidelines, and supporting pilot programs for home-based care, VCT, PMTCT and ART in the public and private sectors.

Leveraging: USAID has a history of developing technical interventions and promoting scale-up with joint funding from other donors (e.g., workplace programs, condom social marketing). USAID/Ghana has excellent working relations with the government and other development partners working in HIV/AIDS. Furthermore, USAID is a participant on the UN HIV/AIDS Expanded Theme Group, and an active voice on the UN Technical Working Group, as well as on several technical sub-committees of the GAC. USAID contributes to, even leads, forward thinking on emerging issues, and provides strategically placed technical assistance to enable issues to be addressed correctly and in a timely manner. Examples are numerous: coordinating GAC monitoring and evaluation system development; introducing most at-risk mapping methodology in support of the District Response Initiative (DRI); identifying ARV and HIV/AIDS commodity logistics management issues and work plan development for logistics strengthening; and initiating private enterprise HIV/AIDS prevention and treatment (HAART). As opportunities present themselves (e.g., NGO strengthening in support of World Bank loan (GARFund) grants through the GAC; PMTCT and VCT expansion), USAID will continue to play a crucial role, consistent with USAID/Ghana HIV/AIDS strategy directions.

Reflecting its comparative advantage, USAID supports the following technical inputs:

Behavior change communication/demand generation: To increase the demand for HIV/AIDS prevention services, USAID provides technical assistance for multi-media educational efforts. These include television and radio programs for youth; peer education through youth and other vulnerable group organizations (in- and out-of-school youth, uniformed services, apprentices); and community health education kits. USAID has also developed HIV prevention, compassion and anti-stigmatisation campaigns that are being implemented.

Most at-risk group behavior change: USAID supports behaviour change activities among most at-risk target groups, including sex workers, professional drivers and the travelling public, miners, teachers, the youth and uniformed services personnel.

Private sector programming: USAID supports the implementation of workplace programs in the private sector, focusing on prevention and the development of corporate HIV/AIDS policy. Another initiative is the development of private sector ART and OI management capacity in autonomous treatment centers, focusing on—but not limited to—employees of companies that are prepared to provide HIV-related medical treatment for their employees.

Condom promotion and distribution: Access to condoms has been improved through greater distribution of condoms through both the public and private sectors. USAID supports a national condom social marketing program through approximately 9,000 retail outlets nationwide.

Training: USAID supports training to improve the quality of HIV prevention services. Workshops for health staff are underway to support counseling and syndromic management of sexually transmitted infections (STI) and to strengthen infection prevention techniques. Through a Prevention of mother-to-child transmission (PMTCT) pilot project in the Eastern region, USAID has been supporting the training of counsellors and nurses in ART as well as the training of volunteers in home-based care (HBC).

Voluntary Counseling and Testing: USAID has supported the establishment of Ghana's first two voluntary counseling and testing centres in the Eastern region, followed by a VCT site at the Accra Police Hospital (open to the public). Three other VCT sites are being developed and will be functional later this calendar year.

Advocacy: Advocacy forms an important component of the USAID program. Efforts to date include the development and dissemination of a computer model (AIM) that projects the impact of HIV/AIDS in Ghana. USAID routinely supports the GAC in its HIV/AIDS policy and strategic framework development.

Care and support: PMTCT has been started at two pilot sites in Ghana with USAID's support; two more sites are being developed. USAID is also supporting the NACP to introduce ART at these centres on a pilot basis before expanding the program to the rest of the country.

Monitoring/surveillance: To monitor the HIV epidemic and the impact of USAID-supported interventions, the Mission contributes to a nation-wide sentinel surveillance system involving 24 antenatal clinics. For quality control and HIV testing, USAID supported the establishment of four regional public health laboratories and the development of standard operating procedures for laboratories. Currently, USAID is contributing to the development of a national monitoring and evaluation system for HIV/AIDS in Ghana, as well as the establishment of a risk-based methodology for planning and programming.

1.6.2 HIV/AIDS Interventions within the Education SO Team

USAID has been one of the strongest supporters of HIV/AIDS education in the education sector in Ghana since 1999. USAID assisted the MOE in developing its HIV/AIDS Strategic Framework, which subsequently led to the establishment of an HIV/AIDS Secretariat, the first of its kind among Ministry Departments and Agencies. The HIV/AIDS Secretariat coordinates HIV/AIDS prevention activities among the many agencies that fall under the auspices of the MOE.

The Education SO has worked with the MOE to initiate HIV/AIDS education activities among MOE staff, Teacher Training Colleges, schools and communities. It has also worked with civil society organizations to increase their capacity to support HIV/AIDS activities more effectively, through teacher training, peer education, after-school clubs and SMC/PTA meetings. USAID supports training to improve the quality of HIV/AIDS education within the Teacher Training Colleges, targeting all principals and tutors. The purpose of the latter program is to establish a foundation of accurate information about the threat of HIV/AIDS among teachers during pre-service training and to encourage them to behave ethically towards students and serve as role models.

1.6.3 HIV/AIDS Interventions within Democracy and Governance

The Democratic and Governance SO will help communities and civil society organizations concerned with HIV/AIDS issues to raise those issues with local government. The program's partners also assist DA and DCE to budget and plan for HIV/AIDS activities which are responsive to the stated needs of the communities. The SO will also advocate, on behalf of the DRI, to facilitate prompt disbursement of the 1% of the common fund to the DRI Management Teams.

1.6.4 HIV/AIDS Interventions within Food for Peace:

The Food for Peace Office distributes food through the Adventist Development Relief Association (ADRA), Opportunity Industrializations Centers, International (OICI) and Catholic Relief Services (CRS). CRS presently reaches several hundred PLWHA in the Northern Regions with nutritional and psychosocial support. USAID is currently in discussions with CRS and OICI on the possibilities of expanding food aid to PLWHA and OVC.

1.6.5 Other USG Support

Peace Corps: Peace Corps Ghana provides education, supplies and services to its volunteers for prevention of STI/HIV/AIDS, and collaborates programmatically with international and local government, NGOs and community members on HIV/AIDS prevention, care and support.

Department of Agriculture: CARE and ADRA have received USDA funding for HIV/AIDS interventions among most at-risk groups located along major transportation corridors in Ashanti, Brong Ahafo, Eastern, Central and Greater Accra regions. A mapping exercise has been conducted and an initial selection of NGOs has been made, based on capacity and experience. Implementation is about to begin.

Department of Labor: A new program being developed by the DOL will collaborate with Ghana's Ministry of Manpower to address the impact of HIV on labor supply. The DOL will work through a tripartite agreement among government, employers associations and trade unions on workplace policy including stigma and employee rights, pre-employment testing/insurance company considerations, behavior change communication and services, and links to community-based services. The program will also conduct research on the impact of HIV on social security, government budgets and businesses.

Department of Defense: The DOD is providing support to the Ghana Police Service to strengthen HIV/AIDS peer education in the Service.

U.S. Mission Workplace Program: The U.S. Mission has launched a workplace HIV/AIDS program, including education and sensitization activities, condom supply, and referrals for voluntary counseling and testing (VCT).

1.7 Lessons Learned from Prior USAID/Ghana Assistance

Lessons learned from the past five years of USAID HIV/AIDS assistance in Ghana should guide the future direction of the HIV/AIDS program. Some key lessons are:

- A significant proportion of interventions need to be targeted to groups according to their relative risk, with information and services provided in a manner most appropriate for each group's particular circumstances and environment. To accomplish this, a solid information base that includes locations

and determinants of behavior, as well as surveillance and monitoring and evaluation (M&E) systems, is critical.

- In an era of an ever increasing spotlight on HIV/AIDS programming where resource availability is tied to results, coordination among and between development partners, the GAC, the NACP and implementing organizations is absolutely critical. However, it is also labor intensive, requiring active and even pro-active participation on the part of all stakeholders.
- To be effective, HIV/AIDS interventions must be based on a decentralized response. A successful decentralized response requires enormous and widespread management and institutional capacity. The involvement of NGOs, under the normative guidance and direction of the GAC, is critical to effective program implementation. Their capacity, however, has not yet been developed.
- The temptation to quickly use the significant resources at Ghana's disposal for HIV/AIDS programming must be adequately counterbalanced with technical support and capacity building.

1.8 Main Partners and their Contributions

HIV/AIDS prevention and vulnerability mitigation are priorities for most donors working in Ghana. Ghana therefore benefits from substantial donor funding to address HIV/AIDS. The significant funding sources contributing to national program efforts and to scaling up current capacity and interventions include:

The World Bank: Supports the implementation of the GAC's National Strategic Framework on HIV/AIDS. Known as the "GARFund", this IDA loan for financing Ghana's multi-sectoral program is part of the first phase multi-country HIV/AIDS program (MAP). The GARFund is a US\$25 million credit which provides seed money to finance specific activities undertaken by Ministries, Departments and Agencies (MDA), civil society organizations, trade and professional organizations and associations of PLWHA; and supports the district-level coordination mechanism, the DRI. The objective is to strengthen Ghanaian society as a whole to undertake and rapidly scale up activities in response to the AIDS epidemic. Activities presently being funded are primarily community level programs designed to prevent or curtail the spread of the disease and provide care and support for those infected or affected. As program implementation evolves, the DRI will assume increasing importance to the GAC's decentralized response mandate.

The British Department for International Development (DFID): DFID is supporting GAC's activities with an £20 million to be used for: strengthening the capacity of the GAC to coordinate, monitor and evaluate AIDS programs; supporting condom supply and distribution; capacity building for MDA and civil society organizations; and providing specific support to the MOH and Ministry of Education.

Global Fund for AIDS, Tuberculosis and Malaria: Ghana's Global Fund award will be used for up-scaling care and support activities including VCT and PMTCT, expanding the DRI, and ARV drug purchases. The first round of funding in HIV/AIDS was primarily for clinical interventions implemented by the MOH. The next application will support complementary activities through the private sector and NGOs. Specifically, if awarded, the funding will be used to establish 20 private sector autonomous treatment centers for HIV/AIDS and related conditions; VCT through private medical laboratories; and community mobilization and psychosocial support. As part of the proposal, multi-national businesses will assume costs for their employees and dependents.

UNFPA: The UNFPA provides support to strengthen the implementation of RH services and to OVCs, specifically young women porters.

UNICEF: UNICEF's program supports education, peer counseling, social mobilization and orphans and provides specific HIV/AIDS support to selected districts in the Northern part of the country.

WHO: WHO collaborates with the GAC in support of VCT and PMTCT, and supports the MOH in HIV-surveillance.

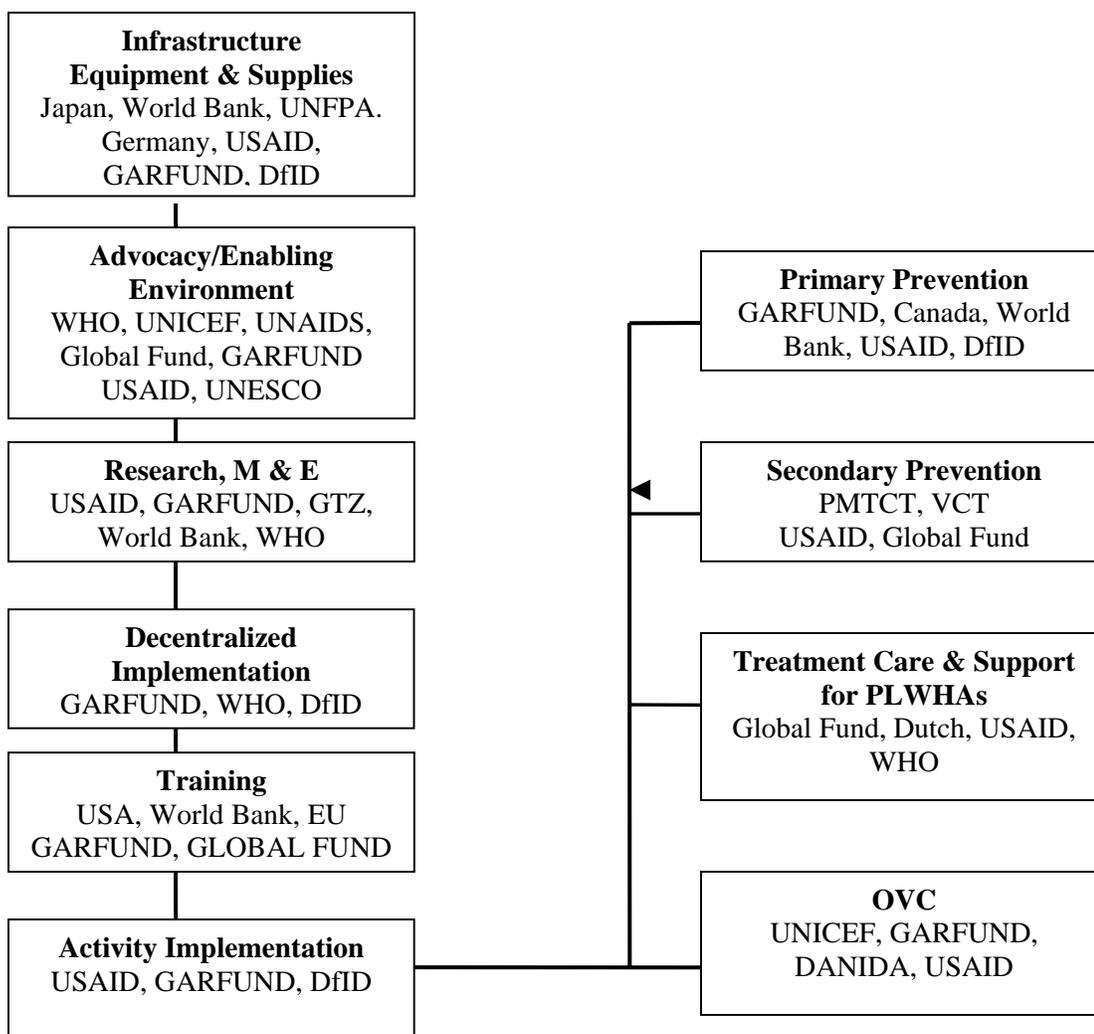
The Royal Dutch Embassy: This program emphasizes care and support of PLWHA, workplace programs and developing private sector ART capacity.

DANIDA: DANIDA's program is supporting HIV/AIDS NGOs, prevention activities and gender-based promotion of female condoms. It also supports a unique initiative to mitigate the impact of child labor practices.

European Union: The EU supports a national STI and HIV/AIDS control program focused on school children, commercial sex workers, the military and civil servants.

The diagram below summarizes the actual and proposed interventions of donors along the prevention-to-care continuum.

**Diagram One: Donor Interventions in the Ghanaian Response to
AIDS**



1.9 Assessment of Ghana's Needs in Prevention, Treatment, Care and Support

What is known about the HIV/AIDS epidemic in Ghana, coupled with an understanding of Ghana's multi-donor, multi-sectoral response, implies the need to address particular most at-risk groups/high transmitters with intensive interventions, complemented by behavior change promotion among most at-risk groups and the general population. Elements for consideration include the following:

Identification and surveillance of vulnerable/high transmission groups and behaviors: Not enough is known about who, besides commercial sex workers (CSW), constitute most at-risk groups and where they are located. To make informed decisions on where to target interventions criteria such as relative risk of infection, accessibility of the targeted group, size of the group, potential impact of interventions and cost need to be assessed and monitored. For this, research and surveillance mechanisms need to be established and maintained.

Special approaches for most at-risk groups: These groups need better coverage and access to activities that will provide prevention and treatment information and services. Several among the most at-risk groups such as CSW, men who have sex with men (MSM), intravenous drug users (IDU), uniformed services members, etc., have special needs or circumstances, which therefore require innovative and targeted interventions, informed by determinants of behavior and other research.

Local response, behavior change interventions for vulnerable/high transmission groups/areas: Emerging experience indicates that involvement in and ownership of responses to HIV/AIDS interventions increases the likelihood of success. New methodologies, like the Priority for Local AIDS Control Efforts (PLACE) methodology can be applied in Ghana to enhance the DRI and give individuals the information, knowledge and tools to address their needs.

Voluntary counseling and testing linked to PLWHA service: Currently, VCT centers in Ghana are few (4) and far between. Two being implemented in conjunction with PMTCT have been established in the context of providing a continuum of care, i.e., from behavior change communication (BCC), to VCT services, PMTCT services, clinical management of infections, AIDS and opportunistic infection (OI) treatment and to programs for orphans and vulnerable children (START program). Links with local organizations, particularly through the GOG's DRI, are also being developed. These interventions have been set up as learning sites for HIV/AIDS treatment, so that lessons learned can be applied and expanded to other sites. Most significantly, as individuals begin to understand that a range of support services can be accessed through VCT referrals, more are likely to avail themselves of VCT programs.

Pregnant women: 4.1% of pregnant women in Ghana are HIV positive, few know it and fewer still have access to prevention of MTCT. HIV testing services need to be made more available and the right to know one's status a more integral part of antenatal care services. PMTCT services are currently being piloted in two districts and need to be expanded. Lessons learned from pilot programs can be fed back into strengthening antenatal care efforts and, more significantly, to guiding PMTCT under the Global Fund activity as it expands, including targeting toward higher/highest prevalence areas.

Social-marketing of voluntary counseling and testing, links with community support/treatment: Knowledge of one's HIV status is an important element in decision-making concerning high risk behavior. VCT provides an opportunity to reiterate prevention messages and is an entry point for support networks and, hopefully, treatment. While plans for substantial scale-up of VCT sites are being implemented, there is still confusion among the population about the implications of stepping into a VCT site, as well as a lack of understanding of what VCT services can do for individuals besides provide potentially devastating news.

Condom Social Marketing: Condom supply needs to be maintained and expanded as a complement to demand creation for other preventive measures. Specific target groups, beginning with most at-risk groups should be targeted; use of non-traditional outlets, particularly those linked to high transmission locations, should be emphasized.

STI are known to facilitate the transmission of HIV, but syphilis surveillance shows that their prevalence is well below 1% in most areas. We assume that overall STI prevalence is relatively low in Ghana. Most STIs are treated outside of the formal health care system. Traditional healers, pharmacists and chemical sellers are known to treat STIs. As a result, interventions targeting doctors and nurses will have limited success. The quality and targeting of STI services need to be addressed.

Generalized IEC: There is a need to complement targeted prevention activities with support for generalized prevention. High-profile multi-media campaigns put HIV/AIDS high on the national agenda and made HIV/AIDS a reality in most Ghanaians' lives. They should be continued and refined. Changing

campaign themes over time allows for flexibility in addressing difficult issues such as stigma, and allows for emerging issues to be addressed as the response to the epidemic evolves and behavioral gaps are identified through research.

PLWHA: Approximately 400,000 HIV positive individuals are living in Ghana, of which only 2,000 are presently organized into mutual support groups. Based on international estimates, less than 10% of PLWHA are aware of their sero-prevalent status; and only a few dozen persons are under ART. PLWHA need better access to VCT to know their status and understand how to prevent its spread to others. Further, the structures for ART need to be expanded; nutritional aspects of services needs to be improved; greater provision of financial support established; and community support--including decreased discrimination--established.

HIV/AIDS and TB: HIV is generally known to account for the recent rise in TB in cases. An estimated 50% of the Ghanaian population is believed to carry a latent TB infection which is suppressed by a healthy immune system, but which will manifest itself if the immune system is compromised by HIV. Currently, absolute numbers of TB infections in Ghana are still low. However, the National Tuberculosis Program is ill-prepared for a potential rise in TB cases. There is also no current link to HIV surveillance and testing among TB patients. More generally there is no program to provide opportunities to prevent/decrease opportunistic infections (OI) of HIV/AIDS, including TB.

Orphans and Vulnerable Children (OVC): In some high prevalence areas, the social fabric is no longer able to cope with the large numbers of orphans. Their are insufficient interventions in place to target vulnerable children including no treatment options directed at HIV+ children, child laborers, or street children.

Traditional medical practitioners: More than 60% of Ghanaians are thought to patronise the services of traditional healers, most of whom are strangers to germ theory. They frequently use sharp piercing objects without proper sterilization/disinfection. They are however good at counseling and people seem to trust them and turn to them for advice and support. USAID will explore the feasibility of training programs for traditional practitioners to promote their use of safe procedures and their participation in community-based support programs.

Commodity logistics support: Ghana faces a substantial challenge in financing, procuring and distributing anti retroviral (ARV) drugs. The high cost of patented ARV, World Trade Organization (WTO) constraints surrounding intellectual property rights protection, and the challenges of procuring and safely storing high value drugs all are significant issues that might require technical support to the MOH.

Post Exposure Treatment: Health personnel are known to avoid certain procedures for PLWHAs for fear of contracting the disease. USAID will support the development of a post-exposure treatment program for health personnel.

Policy and Advocacy; Basic human rights: A sustained effort is needed to secure and retain high-level commitment, increased awareness and action among decision-makers in both the public and private sectors. Government managers, directors of private sector workforces and religious leaders should be targeted to assure appropriate policies and programs are in place and run by adequately trained personnel. Legal and ethical issues such as mandatory testing and disclosure, confidentiality, employment, mandatory medical examination, willful transmission and insurance are still to be addressed in Ghana.

Monitoring and evaluation: M&E systems at the national level have been designed (although not yet tested), but M&E systems at the local level are weak. Most baseline data is available at the national level

but there is a need for improved reporting from the private medical sector. A coordinated management information system (MIS) needs to be put in place.

Civil society response: Aspects of stigma reduction, care and support, and empowerment to act when personal HIV status is concerned are very much dependent on individuals' and communities involvement in addressing these issues. Furthermore, local response to HIV/AIDS through the GAC's DRI (financed through the "GARFund"/World Bank) is dependent on civil society and community-based organization programs. However, the institutional capacity of civil society organizations is weak, and there is an urgent need to strengthen these organizations' ability to carry out such activities.

2. USAID/Ghana HIV/AIDS Strategy

2.1 Strategic Objective

The USAID Ghana Mission formulates its strategic objectives for HIV/AIDS for the period 2004 – 2010 as follows:

HIV Transmission Reduced and HIV/AIDS Impact Mitigated

The HIV/AIDS strategy is integrated into the overall Mission Strategy. As such, various aspects of its interventions are addressed through the various SOs and programs, most notably in Health, Education, Democratic Governance, and FFP. During the seven-year period of the Mission Strategy, the HIV/AIDS program will provide support to interventions that decrease HIV transmission and mitigate the impact of HIV on individuals and society as a whole.

2.2 Rationale for the Strategy

The strategic principle of the program is to focus resources where the most impact can be expected, and to build on previous program successes of both USAID and the overall country response. In a generalized low prevalence stage of the epidemic, there is a need to focus prevention programs on those groups that are at highest risk of infection and most likely to bridge infection into the general population, and those that are most vulnerable. Prevention programs will be strategically combined with close monitoring of behavior and infection levels of these groups.

Key to the program will be the use of evidence-based programming to target those interventions that will avert the most cases, and where mechanisms exist to effectively reach the targeted groups. The relative risk of specific groups, their accessibility, their actual size and expected impact will be key factors taken into consideration to focus the program.

USAID's HIV/AIDS program will complement the GOG's overall response program, and will take into consideration the substantial resources already available in certain areas to ensure program synergy and complementarity. For instance, USAID will provide technical assistance to support the implementation of the Global Fund for AIDS, Tuberculosis and Malaria (round one, public sector; round two, private sector); and institutional strengthening to governmental and non-governmental organizations involved in the World Bank-funded Multi-Country HIV/AIDS Program (MAP) activities (GARFund). USAID will also address critical gaps in Ghana's response to the epidemic, including monitoring and evaluation.

The essence of USAID's HIV/AIDS program will thus be a strong focus on effective prevention programs – but with the understanding that creating a continuum of care is crucial for strengthening the impact of prevention programs. USAID will thus support the GOG's development of nascent treatment, care and support programs with selected interventions such as high-quality technical assistance and the provision of food and other commodities.

2.3 Target Population

The HIV epidemic is not homogeneously spread, as 70% of reported cases are concentrated in four of Ghana's ten regions, and additional high-prevalence pockets exist in other regions. HIV prevalence among stationary commercial sex workers in the major cities such as Accra and Kumasi is between 75% and 85%. Information on HIV prevalence and/or numbers among other potentially most at-risk

populations such as miners, long-distance drivers, men who have sex with men, teachers, and youth in and out-of school is currently lacking, but will be pursued starting in FY 2004. The program will target groups based on likelihood of increased risk, exposure, and ability to transmit HIV/AIDS, as well as focus on high-prevalence pockets that will become more precisely defined by further studies and data collection. Care and support activities will logically be targeted to groups infected and/or affected by HIV/AIDS and will consider highest impact potential, including the presence of on-the ground NGOs and/or faith-based organizations actively involved in developing home-based care and support programs.

Stratified targeting will be used to ensure that activities are carried out where the need is highest and/or the yield is best, as follows:

Geographic targeting: HIV sero-prevalence and sexual behavior surveys suggest that Ashanti, Eastern, Western, Greater Accra, and Western Regions demonstrate the highest prevalence of HIV in Ghana. Fifty five percent of the national population is located in these regions. Further targeting within regions will be based on district and municipalities with higher HIV prevalence rates or socio-economic and behavioral information. Outside the four selected regions, ‘hot-spots’ (pockets of high-prevalence) such as Wa in Upper West Region and Ho in Volta Region will be targeted based on updated surveillance data to be reviewed annually, or when important new information becomes available.

Most at-risk group targeting: Within the selected geographical areas, prevention interventions will address most at-risk and bridging populations. A number of illustrative target populations include: CSW; bar girls and waitresses; funeral participants; female apprentices (e.g. hairdressers and tailors); itinerant traders; teachers and other civil servants predisposed to risky behavior; uniformed services personnel; harbor workers; miners; truckers; and timber industry workers.

The selection from among these groups for interventions will be based on behavioral and bio-medical evidence from HIV and sentinel surveillance, and a series of assessments and studies that will take place throughout the strategy (see above, pp. 7-8, for discussion of procedures for identifying most at-risk groups). Other factors influencing the choice and design of interventions include access to the sub-population, the expected efficiency of the intervention, cost; and whether the population can be reached through high-transmission targeting (see below).

High-transmission area targeting: A complementary targeting approach is that of concentrating on a ‘place’ rather than a ‘group’. The rationale for this approach is that high-risk behaviors (e.g. meeting new sexual partners) occur predominantly in a limited number of places, so-called “high-transmission areas”. Such places could be bars, brothels, lodges and hotels; funeral grounds; schools; churches; and specific streets and areas. Using an evidence-based approach, high-transmission areas will be prioritized and targeted for key prevention activities such as peer education and condom promotion.

Vulnerable groups:

- **Girls:** Girls are vulnerable to being coerced into transactional sex to feed and cloth themselves (the “sugar daddy” phenomenon). Girl students are also said to be targeted by teachers for sex.
- **Kayayes and street children:** Out of school youth are often marginalized by societies. Hawkers, kayayes (porters mainly from the Northern part of the country) and street children often arrive in the cities looking for work but with no place to stay. Many sleep on the streets and involve themselves in transactional sex. Many have never been to school and have low literacy levels. Poverty, lack of self worth, inadequate negotiating skills and lack of support combine to put them at risk. They need to be reached through creative counseling and sensitization programs.

Treatment, Care and Support Targeting: Treatment care and support activities will be concentrated in areas where most cases can be expected. These areas will be similar to the overall geographic focus of the strategy, but might also include newly developing “hot-spots”. Target groups included in this intervention area include:

- **HIV Positive Mothers:** USAID will provide complementary support where needed to dramatically increase the coverage of PMTCT programs, in close collaboration with the implementers of the Global Fund-financed activities. Areas of higher prevalence as indicated by antenatal surveillance data, will be targeted. The availability of support systems and ARVs will be taken into consideration.
- **PLWHA:** There is a great need to create an environment where PLWHA are able to reveal their HIV status without societal repercussions; where treatment options (first for opportunistic infections, later for ART) are widely available; and where psycho-social support is accessible. Only about 2,000 PLWHA are organized and attrition is at 20%; links with faith-based organizations need to be established.
- **Orphans:** Estimates on numbers of orphans in Ghana vary widely depending on the source and method used. According to Children on the Brink 2002, by the end of 2005, there will be 237,000 HIV/AIDS-related orphans in Ghana, increasing to 263,000 by 2010 (Children on the Brink 2002). Whereas Ghana’s traditional family system would automatically have absorbed these children into the larger family, the traditional family is fast giving way to nuclear families, especially as the young migrate from rural areas. In high prevalence areas, the social fabric simply cannot absorb the increasing numbers of orphans, whose low economic status often results in their having to drop out of school.

2.4 Strategic Objective Indicators and 2010 Targets

Indicators and 2010 targets are as follows:

1. HIV/AIDS prevalence among 15-24 year olds
 - **Target straight-line funding scenario:** HIV/AIDS prevalence among 15-24 year olds will be reduced by 40% in 2010
 - **Target high funding scenario:** HIV/AIDS prevalence among 15-24 year olds will be reduced by 50% in 2010
2. National adult HIV prevalence below 5%.
 - **Target straight-line funding scenario:** Adult HIV prevalence will be maintained at below 5% throughout the strategy period
 - **Target high funding scenario:** Adult HIV prevalence will decrease to less than 4% .
3. HIV prevalence among most at-risk and bridging populations.
 - **Target straight-line funding scenario:** HIV prevalence among female commercial sex workers during their first visit to sentinel sites decreased by 15% in 2010.
 - **Target high funding scenario:** HIV prevalence among female commercial sex workers during their first visit to sentinel sites decreased by 25% in 2010.
4. PLWHA receiving ARV treatment
 - **Target straight-line funding scenario:** The number of HIV-infected persons receiving ARV treatment will reach 15,000 in 2010.

- **Target high funding scenario:** The number of HIV-infected persons receiving ARV treatment will reach 25,000 in 2010.

2.5 Intermediate Results

2.5.1 Outcome IR: Risk behavior reduced and use of HIV/AIDS services increased

The Health SO of USAID/Ghana’s CSP has developed the hypothesis that positive behavior change is a necessary precedent to impact on health status. Behavior change is the sine qua non for reducing HIV infection and ensuring societal and government preparedness to deal with the impact of HIV/AIDS on individuals and communities. As an intermediate step to achieving its strategic objective, then, USAID will hold itself accountable for a “behavioral conversion” at the “Outcome IR” level as a measure of its success. The Outcome IR represents the result of actions emanating from the lower IRs: IR1) prevention: beyond knowledge, to actions that reduce the risk of infection and make use of appropriate services; IR2) care and support: the continuum of services should prevention no longer be an option for oneself or ones’ family members; IR3) an environment that enables policy makers, service providers and clients to act appropriately; and IR4) adequate institutional support for quality HIV/AIDS programming.

Outcome IR indicators

- Higher-risk sex in the last year among target group (proportion of respondents 15-49 years old who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months)
- Condom use at last risky sex among target groups
- Food supplementation for PLWHA

2.5.2 IR 1: Prevention programs strengthened

Consistent with current experience on addressing HIV/AIDS in generalized low prevalence settings, USAID will support an emphasis on most at-risk groups and bridging populations, including teachers as a potential most at-risk group. To ensure correct targeting, USAID will collect additional information to identify most at-risk groups and serve as a basis for decision-making on further targeting of interventions. Information gathering will focus on criteria such as relative risk of infection, accessibility of the targeted group, size of the group, potential impact of behavior change interventions and cost. Once information has been generated and assessed along side other studies (e.g., GAC’s study of men who have sex with men/MSM), activities that address the needs of the identified most at-risk and bridging groups will be designed and implemented.

USAID will work through NGOs and faith-based organizations to reach specific target groups, most importantly and immediately the different categories of sex workers and their clients. Many NGOs have now sprung up to build on World Bank/GARFund initiatives through the GAC, but targeting of interventions has been limited and there are questions about the quality of implementation, particularly in peripheral areas. Where needed, management and programmatic support will be provided to carry out these programs (see IR4). In partnership with the private sector, USAID will build on the successful workplace HIV/AIDS experiences to strengthen and expand workplace programs, in collaboration with the sector Ministry and the International Labor Organization.

USAID will support the establishment of VCT centers in higher prevalence areas. Throughout, the program will apply experience gained through current initiatives (see pp. 19, 27) to the planning and implementation of VCT centers supported through the Global Fund (23 centers first round), including

links with medical, psychosocial, legal, spiritual and community support options (see IR2). In the public sector, VCT services as part of PMTCT programs and special most at-risk groups will need to be expanded, in close collaboration with the NACP, GAC and the Global Fund. Furthermore, services will be established in environments that are more neutral and reassuring to clients, e.g. run by private companies, faith-based institutions and NGOs. Quality control for VCT will be an ongoing activity during the strategy. STI services will be directed towards most at-risk groups and access improved for the general population, e.g. through strengthening services of chemical sellers. Treatment protocols for syndromic management, which has been adopted in Ghana for STI diagnosis, will be up-dated.

In order to avoid extremely high costs per infection prevented, USAID support to PMTCT will focus on the highest prevalence areas, and leverage funds from the Global Fund, thus ensuring the availability of VCT services and using ART as an incentive for program participation. Particular attention will be paid to civil society and community groups' ability to create demand for services and provide psychosocial support.

A wide array of behavior change communication (BCC) programs are currently in place in Ghana. Some programs, such as mass media campaigns and condom promotion programs, have been highly successful in increasing knowledge of HIV/AIDS, risk perception and condom use. These programs will be continued and expanded. Condom social marketing will also be continued, but with increased emphasis on high prevalence, high risk areas and groups. To further promote prevention, social marketing principles will be applied to voluntary counseling and testing, with the aim of encouraging information-seeking behavior on one's HIV status, and thereby promoting behaviors that will help maintain negative status and/or mitigate the effects of positive status on oneself, one's family and community members.

There have been successful experiences with multi-media BCC campaigns that address specific themes and topics (e.g. Chiefs speaking out against AIDS, compassion for those living with HIV & AIDS, reduction of the number of partners). These will be continued while the response to the HIV/AIDS epidemic evolves, and will be based on careful monitoring and evaluations of knowledge and behaviors. A focus on youth as a window of hope will be maintained through information, education and communication (IE&C). Multi-media BCC campaigns will contribute to increasing risk perception and decreasing stigma amongst the general population and health workers.

USAID will also pilot innovative approaches to working with in- and out-of-school youth and conduct operations research (OR) on the interventions. Using a phased, evidence-based approach in select regions, after-school activities such as peer education and HIV/AIDS clubs will be supported in order to establish healthy sexual behaviors and attitudes among young persons. A rigorous operational research program will be developed as an integral part of these activities to: a) determine the effectiveness and cost-effectiveness of these interventions and, should the interventions be effective, b) provide important information to modify and/or adjust the program to achieve greater impact. Should the nature of the epidemic change, i.e., should the epidemic become more generalized, USAID will be in a position to scale up these activities.

Illustrative activities

- Most at-risk group strategy development and operations research
- BCC for most at-risk and bridging groups
- VCT (and PMTCT) services in high prevalence areas
- General behavior change communication and information, education and communication activities, including mass media
- Social marketing of condoms and STI and VCT services
- Most at-risk group STI case management

- Workplace programs in private and public sector

Indicators

- number of sex workers and other most at-risk groups reached through prevention programs (“reached” is defined as attending counseling sessions and/or peer education; or using specialized services such as STI case management and VCT services)
- number of clients seen at VCT centers
- condom use during most recent higher risk sex among youth
- number of condoms sold in non-traditional outlets
- percentage of STI clients in targeted areas that are accurately diagnosed and treated

2.5.3 IR2: Treatment, Care and Support Programs Strengthened

Availability of treatment, care and support programs is still limited in Ghana, with most activities still in their infancy. Although USAID’s HIV/AIDS program emphasis will remain on prevention of HIV transmission, some degree of support will be provided and/or leveraged for selected treatment, care and support activities in the following areas:

- START program expansion/leveraging (PMTCT/VCT referral options/access to care and support)
- ART (logistics management; private sector HAART)
- Opportunistic infection management (PLWHA testing for TB, links to management; TB patient links to VCT)
- Local response (community support groups, DRI, local risk mapping and interventions)
- PLWHA networks; faith-based groups
- OVC (alternative learning opportunities; local response; food supplementation)

START program expansion: USAID has initiated four “START” program sites for comprehensive care, support and treatment for PLWHA, two hospitals serving two high prevalence districts, and subsequently expended to two teaching hospitals (Kumasi and Accra). (Three of these sites include PMTCT.) The START sites have been established in the context of providing a continuum of care, i.e., from BCC, to VCT, PMTCT services, clinical management of infections, AIDS and OI treatment, programs for OVC. START builds on an extensive network of links with community organizations for mobilization and psychosocial support.

As a pilot program, START activities provide learning opportunities for HIV/AIDS treatment, in that lessons learned can be applied and expanded to other sites. Leveraging Global Fund and World Bank/GARFund resources, USAID will support expansion of PMTCT (and VCT) sites, but targeted to those areas of high HIV prevalence, where pregnant mothers will be likely to seek services, and where there is a likelihood of reaching a large number of PLWHA. As such, the development of PMTCT (and VCT) will be closely coordinated with ARV drug availability, availability and/or development of community-based support groups, and opportunities to mitigate stigma. These efforts will be complemented by demand generation and service quality efforts (IR1).

Antiretroviral Treatment (ART): The START program has initiated ART in the public sector, and the USAID-Netherlands Embassy collaboration on workplace ART marks the launch of ART in the private sector. These programs will expand to 15,000-20,000 clients by 2008 as ARV become available through the Global Fund and private financing. USAID will work to improve access to ART and prepare the private sector for these clients. USAID will address ARV medication, OI treatment drug and HIV test logistics and management issues to ensure availability, curtail abuse and maintain

conformance to MOH-established protocols. USAID will also provide technical assistance to MOH to ensure that protocols define treatment guidelines for HIV+ children.

Opportunistic infection management: USAID proposes to strengthen the linkage between TB and AIDS clinical programs. By testing TB patients for HIV health centers will be able to identify and treat higher numbers of PLWHA. TB centers will be used as entry points for VCT services, and linked to treatment of other OI and to referral to community care and support services. Conversely, PLWHA will be linked to OI/TB management and treatment programs.

Local response: Along with activities under USAID/Ghana's Health Strategic Objective IR1 (community and individual empowerment), community organizations and members will be mobilized to help ensure communities' active participation in health service provision, including care and support. USAID will support activities such as Queen Mothers associations that support orphans, facilitate schooling opportunities, and foster links/referrals to food supplementation. USAID will provide complementary support to GOG's DRI in the form of 1) technical assistance to develop and use a local mapping methodology, and 2) institutional capacity building for civil society and community organizations.

PLWHA networks: The GAC estimates that approximately 40 PLWHA groups exist in Ghana, although organization is lacking and attrition is high. USAID will complement the GAC's initiative to establish networks of PLWHA associations by promoting links with faith-based organizations, providing training and building NGO capacity.

OVC: USAID has the unique comparative advantage of managing the Food for Peace (Title II) Program that distributes large amounts of food commodities in Ghana. Provision of food is the highest priority for PLWHA and serves as a key incentive to promote VCT services and encourage PLWHA to reveal their HIV-status. Food rations are also a key to implementing successful orphan programs. USAID will work with the Food for Peace program to develop home based care, increase distribution of food supplements to PLWHA and orphans, and focus on training and employment opportunities for street children in metropolitan areas, to the extent resources permit. Options for alternative learning opportunities for OVC who drop out of school will be pursued with links to USAID's Education SO (SO8). USAID will also identify and support orphans with scholarships so that they can continue their education.

Illustrative activities

- Increased access to a range of support services for PLWHA and to OI treatment
- Strengthened linkages between TB and HIV treatment programs
- Food distribution for PLWHA and OVC
- Private sector service provision of ARV, PMTCT and OI treatment
- Monitoring of decentralized VCT and PMTCT linked to quality improvement
- Orphans scholarship program

Indicators

- number of USAID supported ARV treatment programs
- number of USAID supported basic care and psychosocial support programs
- number of USAID supported health facilities providing PMTCT services
- number of OVCs enrolled in scholarship program
- number of TB cases among HIV+ persons detected through VCT referral

2.5.4 IR3: Enabling environment for HIV/AIDS programming improved

Widespread HIV/AIDS-related stigma and discrimination persist. Stigma increases PLWHA's vulnerability and isolation and also deprives them of care and support, worsening the impact of infection. Stigma thus impedes every step of an effective response, from prevention to treatment, care and support. Family members and children affected by HIV/AIDS are suddenly faced with social and economic burdens that are reinforced by other stereotypes, prejudices and social inequalities relating to gender, ethnicity, sexuality, and criminalized activities such as sex work and male-male sex. Stigma, discrimination and human rights violations form a vicious circle, legitimizing and spurring each other on.

In conjunction with targeted advocacy programs, IE&C activities will be directed at a range of opinion leaders and decision makers. This will be done to expand program momentum by maintaining and expanding traditional healers', traditional leaders' and religious bodies' involvement in HIV/AIDS prevention and compassion promotion.

USAID will help create an enabling legal environment for fighting discrimination. This will be done by supporting the GAC to continue policy dialogue with stakeholders and develop policy documents and guidelines. USAID's Democracy and Governance program will advocate anti-discrimination policies and attitudes to parliament district political leaders, religious groups, selected Ministries, Departments and Agencies, the Police and community leaders. Political, traditional and business leaders are encouraged to visibly challenge HIV-related discrimination. USAID will promote district and community level commitment in response to the epidemic by actively involving PLWHA.

Fighting stigma and discrimination can be done effectively by providing universal access to prevention (IR1) and by diminishing the enormous isolation that comes with being associated with HIV/AIDS through strengthened and expanded treatment, care and support services (IR2). Private employers will be sensitized to enable their employees to demand HIV/AIDS services through special benefit packages, e.g. by developing special financial analysis tools to demonstrate the cost effectiveness of such interventions. Insurance companies will be provided with technical assistance to develop insurance packages that include HIV-related services to be marketed with USAID support.

Illustrative activities

- Policy and advocacy for PLWHA, CSW, MSM, and workplace programs
- Sponsor and coordinate dialogue sessions among leaders to discuss emerging issues such as stigma and discrimination of PLWHA to promote access to VCT, MTCT, etc.
- Document legal and social barriers to effective HIV/AIDS prevention and care activities and lobby for policy change to improve the legal and social environment
- Develop or adapt existing program development tools for use in workplace-based HIV/AIDS programs
- Develop innovative ways to ensure dissemination of surveillance data to opinion leaders involved in advocacy and policy issues

Indicators

- percent of women and men age 15-24 who believe that HIV can be transmitted by sharing meals with an infected person
- percent of enterprises/companies employing 30 or more employees that have HIV/AIDS workplace prevention and care policies and programs
- number of districts spending one percent of their common fund for HIV/AIDS activities
- public/private partnerships
- number of civil society organizations advocating on HIV/AIDS issues

2.5.5 IR4: Institutions strengthened for HIV/AIDS programming

With the recent adoption of the multi-sectoral approach and the involvement of new Ministries, departments and Agencies (MDA), the NGO community, faith-based institutions and community-based organization, Ghana's HIV/AIDS program is in full swing. Development of institutional capacity to implement and manage the necessary programs has been identified as crucial. Local and sometimes national skill levels and coordination efforts fall short of what is needed to be "AIDS competent". They sometimes do not have the ability to plan, coordinate, monitor and evaluate the local HIV/AIDS response (PLACE methodology). USAID will implement support programs in selected areas to strengthen institutional capacity in the country. At the national level, USAID will emphasize support of the GAC, the MOH/GHS and the MOE. USAID will also support district institutions, NGOs working with most at-risk groups, and selected care and support organizations.

Program content will be adapted to the organizations, based on an assessment in four program areas: participatory planning and program development; financial and managerial skills; program technical skills such as peer education, food distribution or counseling; and monitoring and evaluation. Within the MOH and the Ghana Health Service, the emphasis will be on developing skills to implement the Global Fund. Ensuring sufficient and uninterrupted supply of test kits, STI drugs, OI medication, and ARV is a special concern. Rapid scale up of HIV/AIDS interventions has the inherent danger of burdening the logistics systems to meet demand; risking consumer confidence and engendering antiretroviral resistance if a regular supply of recognized commodities is not available. USAID will concentrate on issues throughout the supply chain, from demand forecasting to inventory control for test kits, ART drugs and laboratory products.

With rapidly increasing access to clinical treatment of HIV/AIDS and related conditions, USAID will support the NACP in developing quality control systems in both public and private sectors for adherence counseling and monitoring (e.g., directly observed therapy), provider prescribing practices, laboratory testing, and patient follow-up. Equal attention will be given to the quality of preventive services (VCT, PMTCT), related to pre- and post-test counseling and referrals. Selected private companies will develop workplace programs and be supported in program planning, peer education and monitoring and evaluation.

USAID will continue efforts to strengthen national monitoring and evaluation (M&E) systems with the GAC, the MOH and the MOE. USAID will build on earlier success in developing a national M&E plan for HIV/AIDS, which will include information from activities to be carried out in the private sector with Global Fund support.

Illustrative activities

- Institutional capacity building for selected district level institutions, NGOs, faith-based institutions, MDA and community organizations to develop, implement and evaluate HIV/AIDS prevention & care activities
- Capacity building of community-based support groups for PLWHA and affected.
- Capacity building of community organizations to fight against stigmatization and discrimination of PLWHA and those affected.
- Support Global Fund implementation.
- Provide commodity security/supply chain management
- M&E systems strengthening, surveillance, research and assessments

Indicators

- number of districts who developed district workplans using participatory planning methods (PLACE)
- number of NGOs trained
- percent of VCT centers with test-kit stock-out in the last 3 months

2.6 Critical Assumptions and Concerns

Several assumptions are critical to ensuring optimal performance and achievement of the strategy's objectives. The most important are listed herein:

- Political and financial support:
 - High-level political support will be sustained
 - Donor funding for HIV/AIDS will be maintained
 - Programmatic coordination by the Ghana AIDS Commission (GAC) will be ensured
 - Resource mobilization by the GAC will continue at 2003 levels or higher
 - Global Fund targets will be met and successive year resources will be received
 - The GOG will be able to procure (Global Fund) or manufacture ARV drugs

Comment: Much of the current strategy is based on USAID's ability to complement other donors' activities, provide strategically directed technical assistance and/or financial support, and leverage resources for priority areas. Should political and/or financial support wane, USAID's focus will necessarily be re-directed to those program areas for which we have more direct management oversight, i.e., prevention, monitoring and evaluation, and, to a lesser extent, institutional capacity development. Advocacy efforts would also be continued.

- Status of the epidemic will be consistent with current data (sentinel surveillance). Should this be found to not be the case (sero-prevalence testing is planned for the 2003 DHS), USAID will revise its strategic emphases as appropriate.
- The sub-region will maintain its present level of stability. Given the links between population movements and HIV/AIDS, should Ghana become affected by regional instability, the program will redirect resources toward such populations and concentrate on areas of turmoil.
- The Food for Peace Program will continue at FY2002 levels and progressively increase its focus on the needs of people affected by HIV/AIDS. Should this not evolve as anticipated, USAID will need to lower programmatic expectations of support particularly for PLWHA and OVCs

In addition to the critical assumptions, there are also several special concerns regarding the political, social and economic environment that may affect the implementation of this HIV/AIDS strategy.

Stigma and Discrimination: Stigma remains very strong in relation to PLWHA. Diagnosis as HIV positive means losing one's means of employment and being ostracized by family and community. This feeds the culture of silence driving the disease underground and fueling its spread. The involvement of religious groups and the potentially increased availability of ARV should contribute to individuals' willingness to recognize their HIV status.

Youth-Parent relationships: Although parents may be aware that their teenage children are sexually active, most parents are either not able to talk openly and frankly to their children about sex, and parents often scold their children rather than educate them on sexual matters. Some parents oppose sex education in schools.

Involvement of PLWHA: Ghana currently does not have a spokesperson for PLWHA. There are now more than 15 known associations of PLWHA. These associations provide psychosocial support and a few are able to provide economic support to PLWHA. Association leadership of these is still weak though. There is a need to strengthen leadership, effectively represent and improve the livelihood of association members.

Capacity of NGO and MOH staff to provide care and support: Care and support to PLWHAs and those affected requires skills that are new to all categories of personnel. Unless new skills are developed the response capacity of the HIV/AIDS program will be jeopardized.

Follow up on quality care: Most care and support activities will take place at community level. There is no evidence that programs are in place that would follow up on and supervise NGOs, CBOs etc. to ensure quality of care.

Ability of the system to manage ART: The management of persons on ART is very intense and time consuming. Preparations are underway to introduce ART into the country; some are already being imported by the private sector. Although treatment guidelines have been developed and approved, skills development for management of ARTs has not kept pace and the potential for managing ART drug resistance is not assured. Cost recovery remains an issue.

3. Results and Reporting

As an intensive focus country, USAID/Ghana will be reporting on performance as follows (*italics indicates reporting indicator*):

What	Indicators	Source
Strategic Objective	National HIV prevalence HIV prevalence among 15-19 and 20-24 year olds HIV prevalence amongst sex workers PLWHA receiving ARV treatment	National sero-surveillance system Selected sex workers clinics/MOH Public & private sector monitoring
Changes in sexual risk reduction behaviors in most at-risk groups	Higher-risk sex* in the last year among target groups Condom use at last higher-risk sex <i>Median age at first sex among young men and women</i> Number of sex workers and other most at-risk groups reached through prevention programs * sex with non-marital, non-cohabiting partner in the last 12 months	Second generation surveillance DHS, GAS Implementing partners reports
STIs	Percentage of STI clients in targeted areas that are accurately diagnoses and treated <i>Number of clients provided services at STI clinics</i>	PI6 & 7 survey* MOH quarterly reports *instrument will be adjusted for female vaginal discharge
VCT	Numbers of clients seen at VCT centers Number of VCT centers with USAID support Number VCT centers with test-kit stock-out in the last 3 months	VCT center reports Partner reports Logistics reports
PMTCT	Number of USAID-supported facilities offering PMTCT services <i>Number of women who attended PMTCT sites for a new pregnancy in the past 12 months</i> <i>Percent of HIV+ women attending antenatal clinics receiving a complete course of ARV therapy</i>	Partner reports MTCT center reports
ARV	Number of HIV-positive persons receiving ARV treatment Number of USAID supported ARV treatment sites	ARV center reports MOH and partner reports
OVC	Number of OVCs enrolled in scholarship programs <i>Number of USAID-supported OVC programs</i> <i>Number OVCs receiving care and support</i>	Education SO Partner reports GAC
Care & support	Number of HIV positive individuals and OVC receiving basic care and psychosocial support <i>Number of USAID-assisted basic care and psychological support programs</i> Number of TB cases among HIV+ persons detected through VCT referral Number of PLWHA receiving food supplements	Treatment center reports National TB program Program reports Program reports
Condom sales	Condoms sold in non-traditional outlets <i>Total condoms sold</i>	MOH and social marketing reports

What	Indicators	Source
Enabling environment	Number of public-private partnerships Percent of enterprises/companies employing 30 or more employees that have HIV/AIDS workplace prevention and care policies and programs Percent of women and men age 15-24 who believe that HIV can be transmitted by sharing meals with an infected person Number of districts spending one percent of their common fund for HIV/AIDS activities Number of CSOs advocating on HIV/AIDS issues	Partners reports Ghana Employers Association DHS and Ghana AIDS Survey Ministry of Local Government reports Democracy and Gov SO
Institution strengthening	Number of NGOs trained in HIV/AIDS programming Number of districts who develop work-plans using participatory methods	Partner reports Ghana AIDS Commission

N.B. Additional indicators may be proposed.

3.1 Planned surveillance, surveys and other M&E activities

Annex 2 summarizes Ghana's overall indicators framework for the National M&E plan. USAID plays a key role in supporting the overall system design, data collection, analyses and information dissemination, spearheaded by the GAC. The national M&E Plan is designed to measure progress toward the following international and expanded response goals:

- National/Global Fund targets;
- National/United Nations General Assembly Special Session on HIV/AIDS (UNGASS) targets; and
- USAID Expanded Response targets.

GAC and USAID/Ghana have adopted the UNAIDS and UNGASS standards for the Agency reporting system so that most data are compatible with all three systems. Data collection methods for the monitoring of both USAID's and the National Strategy include:

- HIV, STI and behavioral surveillance: Ghana currently has no second-generation surveillance system in place, even though it is essential for the monitoring of overall behavior and sero-status of the general population and most at-risk groups. In collaboration with partners, USAID will provide technical input in developing these systems. Sentinel HIV and STI surveillance are functional and the quality of the HIV-surveillance system has been confirmed by independent WHO and CDC reports. Quality assurance mechanisms are in place and the number of sites (now 26) is being expanded each year.
- National sample survey studies: USAID plays a major role in providing financial and technical support for the Ghana Demographic and Health Survey (DHS) every five years. Within two DHS's, USAID plans to support a stand-alone HIV survey, based on the DHS module. Planning is ongoing to include an HIV testing module in such surveys.
- PI 6 & 7: USAID will continue financing the STI diagnosis, treatment and counseling survey, known as Performance Indicator 6 & 7 survey, which focuses on the quality of STI management in the public and private sector. The USAID funded Service Provision Assessment will contain modules focusing on HIV/AIDS related treatment, VCT and PMTCT.

- Sector-specific reporting systems such as in the MOE and the MOH: The MOH has satisfactory routine reporting systems, especially those elements related to sector-wide indicators and MCH-related reporting. As with all larger reporting systems, they are under continuous revision and improvement, and USAID will provide selected TA to develop and improve HIV/AIDS related elements, most in particular for VCT, ARV and PMTCT activity reporting. USAID will also provide technical assistance to the MOE to develop and improve HIV/AIDS related reporting.
- District-wide reporting systems, supervised by a District M&E Focal Point: District-level reporting is still in its infancy. USAID will continue providing the GAC with technical assistance to develop and improve those systems.

USAID/Ghana HIV/AIDS Results Framework

Critical Assumptions:

- Global fund targets met & resources continue
- Donor commitments will be met
- GAC coordination effective
- High-level political support maintained
- ARV drugs available and affordable
- Epidemic consistent with current data
- Sub-region stability will be maintained
- FFP program will increase PLWHA focus

SO: HIV Transmission Reduced & HIV/AIDS Impact Mitigated

Performance indicators: HIV prevalence rate among adults, among 15-24 year olds and among sex workers; PLWHA receiving ARV treatment

Outcome: Prevention and Care Practices Increased

Performance indicators: Higher-risk sex in the last year among target groups; Condom use at last higher-risk sex among target groups; food supplementation for PLWHA

Reporting Indicators

SO: HIV prevalence rate among 15-19 and 20-24 years old
 IR: Higher risk sex in the last year; condom use at last higher-risk sex; Median age at first sex among young men and women; # of women visiting ante-natal clinics receiving a full course of ARV therapy to prevent PMTCT; # of women who attended PMTCT sites for a new pregnancy; total condoms sold; number of STI clients; number USAID-supported STI clinics; number USAID-supported OVC programs

IR 1

Improved prevention programs

Indicators:

- number of sex workers and other most at-risk groups reached through prevention programs
- number of clients seen at VCT centers
- percent STI clients accurately diagnosed/treated
- condom use among youth
- number of condoms sold, non-traditional outlets

IR 2

Improved treatment, care and support programs

Indicators:

- number of USAID supported ARV treatment sites
- number of USAID supported PLWHA basic care and psychosocial support programs
- number of USAID supported health facilities providing PMTCT services
- number of OVCs enrolled in scholarship programs
- number of TB cases among HIV+ persons detected through VCT referral

IR 3

Improved enabling environment for HIV/AIDS programs

Indicators:

- Percent of women and men age 15-25 who believe that HIV can be transmitted by sharing needs with infected person
- Percent of enterprises/companies employing 30 or more employees that have HIV/AIDS workplace prevention and care policies/programs
- number of district spending one percent of their common fund for HIV/AIDS activities
- public/private partnerships
- number of CSOs advocating on HIV/AIDS issues

IR 4

Institutions strengthened for HIV/AIDS programming

Indicators:

- number of districts that developed district work plans using participatory planning methods
- number of NGOs trained
- percent of VCT centers with test-kit stock out last 3 months

Illustrative Activities

- Most at-risk group strategy development
- Behavior change communication for most at-risk and bridging groups
- VCT, PMTCT services, high prevalence areas
- General behavior change communication and information, education and communication
- Social marketing of condoms and STI and VCT services
- Most at-risk group STI case management
- Workplace programs, private and public sector

- Increased access to a range of support services for PLWHA and to OI treatment
- Strengthened linkages between TB and HIV treatment programs
- Food distribution for PLWHA and OVC
- Private sector service provision of ARV, PMTCT and OI
- Monitoring of decentralized VCT and PMTCT linked to quality improvement
- Orphans scholarship program

- Policy and advocacy
- dialogue sessions among leaders to discuss emerging issues
- Document legal and social barriers to effective HIV/AIDS prevention and care activities
- Develop or adapt existing program development tools for use in workplace-based HIV/AIDS programs
- Ensure dissemination of surveillance data to opinion leaders for advocacy and policy issues

- Institutional capacity building selected district level institutions, NGOs, faith-based institution, community organizations
- support groups for people living with or affected by HIV/AIDS
- Support for Global Fund implementation.
- Commodity security/supply chain management
- M&E systems strengthening, surveillance, research and assessments

Annex 1 – Behavioral information on key most at-risk groups

Comparison of some key most at-risk populations (BSS 2002 & baseline commercial drivers, 2000)	Miners	Police	Profess. Drivers	Female Sex Workers	
	<i>Obuasi</i>	Accra	Accra, Kumasi, Takoradi, Tamale, Techimaan	Accra	Obuasi
Comprehensive correct knowledge about AIDS	42 %	66%	N/D	23%	39%
Higher risk sex in the last year	17 %	67%	42%		
Condom use at last higher risk sex	66%	83%	56%		
Sexual relations with a sex worker in the last 12 months	7%	9%	11%		
Condom use at last commercial sex, reported by client	78%	98%	78%		
Condom use at last commercial sex, reported by sex worker				97%	78 %

Annex 1 – Behavioral information on key most at-risk groups - continued

Comparison of some key youth populations (BSS)	Young Males (median age 22)			Young Females (median age 20)		
	<i>Accra</i>	Agomenya	Kumasi	<i>Accra</i>	Agomenya	Kumasi
Ever had sex?	93% %	83%	75%	63%	75%	76%
Median age at first sex	18	17	17	18	17	16
Median age of first sex partner	16	16	16	22	20	20
First partner 5 or more years older?	6 %	4%	7%	47%	23%	43%
Ever condom use?	90%	84%	81%	53%	50%	73%
Sex during last 6 months?	77%	56%	70%	95%	95%	99%
Condom use during last sex	74%	54%	63%	41%	43%	61%
Sexual relations with a sex worker in the last 6 months	17%	21%	17%	7%	10%	5%
Condom use at last commercial sex, reported by client	95%	82%	81%	54%	62%	64%
Genital ulcer or discharge in last twelve months (categories added up)	13%	27%	5%	65%	37%	33%

Annex 1 – Behavioral information on key most at-risk groups - continued

Preliminary findings student population (SHAPE)	<i>Males (median age 16)</i>	<i>Females (median age 17)</i>	<i>JSS</i>	<i>SSS</i>
Ever had sex?	20%	7%	8%	20%
Median age at first sex	17 (est.)	18 (est.)		
Forced or raped during first sex	31%	46%		
One or two partners during the last 12 months	92%	75%		
Ever condom use?	70%			
Condom use during last sex	40%			
STI knowledge	Knowledge is low. Info too confused to be captured with one indicator.			

Annex 1 – Behavioral information on key most at-risk groups - continued

Workplace HIV/AIDS Programme

Comparison of some indicators	Brewery Accra N=134	Brewery Kumasi N= 86	<u>Manufacturing</u> Tema N= 282	Manufacturing Juapong N=268	Farm Workers N=104
Mode of Transmission	83%	83	83	82	74
No cure of AIDS	75	76	74	76	82
Knows someone who has died of AIDS	39	45	33	42	22
Compassion for PLWHA	85	86	84	76	66
Support for condom use	84	77	82	84	86
Support for abstinence	73	79	72	72	68
Willingness to Test	74	70	74	79	85
Knowledge of HIV Test Center	58	67	69	64	34
Perceived risk					
High	11	11	9	4	1
Moderate	2	5	2	5	1
Low	21	16	25	27	40
None	66	64	63	58	56
Sex with non-regular partner	10	7	7	6	14
Sex with commercial partner	2	4	2	1	2
Contracted STI in last 12 months	6	4	1	2	2
Freq. of condom use with NR partners					
Always	58	83	33	46	64
Sometimes	17	-	22	10	21
Never	25	17	28	37	14
Frequency of Condom use with commercial partners					
Always	50	100	33	N/A	--
Sometimes	--	--	--	N/A	--
Never	50	--	33	N/A	100
	134	86	282	268	104

Annex 2 - Ghana National Monitoring and Evaluation Plan Indicators

(UNGASS indicators in italics)

I. REDUCTION OF HIV PREVALENCE IN GHANA

A. Monitoring and tracking the epidemic			
Indicator	Data Collection Method	Data Source	Frequency of Reporting
Impact			
Percent of blood samples taken from women aged 15-24 years that test positive for HIV during routine sentinel surveillance at selected antenatal clinics	Sentinel surveillance at ANC clinics	NACP/ MOH	Annual
Percent of blood samples taken from female commercial sex workers that test positive for HIV on their first visit to selected sentinel sites	Targeted surveillance at specific sentinel sites	WAPTCAS/CIDA	Annual
Percent of women that test positive to syphilis during routine sentinel surveillance at selected antenatal clinics	Sentinel surveillance at ANC clinics	WAPTCAS/CIDA	Annual
Percent of infants born to HIV infected mothers who are infected	Program reports and estimation	MOH	Annual
<i>B. Promoting safer sexual behavior</i>			
The age at which one half of young men or young women aged 15-24 years have had penetrative sex (median age), of all young people surveyed	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database ¹	3-5 years
Percent of women and men aged 15-24 who have had sex with more than one partner in the last 12 months, of all young people surveyed.	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database	3-5 years
Percent of young people 15-24 years reporting the use of a condom at last sexual intercourse with a non-regular partner	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database	3-5 years
C. Knowledge and attitudes			
Percent of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmissiong	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database	3-5 years
Percent of respondents who have knowledge of mother to child transmission of HIV.	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database	3-5 years

Percent of schools with teachers trained in life-skills based HIV/AIDS education and who taught it during the last academic year.	School reports/survey	MOE	Bi-annual
E. Managing STIs			
Percent of patients with STIs at selected health care facilities who are appropriately diagnosed, treated and counseled according to national guidelines, of all STI patients at those centers	Health Facility Survey	MOH	Annual
F. Promoting Blood Safety			
Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	HMIS, Special survey	Ghana Blood Bank Services	Annual
G. Reducing Mother to Child Transmission			
Number of centers providing PMTCT services	PMTCT records	MOH	Annual
Percent of HIV positive pregnant women who receive a complete course of anti-retroviral therapy to prevent mother to child transmission in the last 12 months.	Program reports and estimation	MOH, GSS	Annual
H. Promoting VCT Services			
Number of centers that have at least one staff trained as a counselor providing specialized HIV counseling and testing services free or at affordable rates.	VCT records	MOH	Annual
Indicator	Data Collection Method	Data Source	Frequency of Reporting
Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	Program records	MOH/FHI	Annual

II. CARE AND SUPPORT

A. Providing home-based care			
Number of NGOs receiving financial support from GAC providing home-based care and support services to PLWHA	Program Reports	District Reporting Form	Annual
B. Providing Care for Orphans and Vulnerable Children			
Ratio of orphaned to non-orphaned children aged 10-14 who are currently attending school	National population-based survey (GDHS)	DHS HIV/AIDS Indicator Database	3-5 years
Number of NGOs receiving financial assistance from GAC for giving care and support to orphans and vulnerable children	Program Reports	District Reporting Form	Annual

III. CREATE AN ENABLING ENVIRONMENT FOR NATIONAL RESPONSE

A. Stigmatisation and Discrimination			
Percent of women and men age 15-24 who believe that HIV can be transmitted by sharing meals with an infected person.	GDHS	DHS HIV/AIDS indicator database	3-5 years
B. Supporting a legal, ethical and policy environment			
Percentage of large enterprises/companies employing 30 or more people that have HIV/AIDS workplace prevention and care policies and programs	Workplace survey	Ghana Employment Association (GEA)	Bi-annual
Percentage of sector ministries with HIV/AIDS work plans and budgets approved and funded by GAC and being implemented	Review of MDAs sector plans	GAC	Bi-annual
Number of published reports and HIV/AIDS informational documents distributed to districts.	GAC records	GAC	Annual

IV. DECENTRALISED IMPLEMENTATION AND INSTITUTIONAL ARRANGEMENT

Indicator	Data Collection Method	Data Source	Frequency of Reporting
A. District level response			
The percentage of districts with HIV/AIDS workplans and budgets approved and funded by GAC	District sector reports	District Assemblies	Annual
B. Community level response			
The percent of donor funds awarded to CBOs.	GAC records	GAC	Annual

V. RESEARCH, MONITORING AND EVALUATION

<i>A. Research</i>			
Number of studies endorsed or funded and disseminated in each of the five intervention areas	Review of GAC records	GAC	Annual
B. M & E Capacity			
Percentage of regions that submit quarterly monitoring reports to GAC	Program reporting forms	GAC	Annual
Number of regional and district focal persons trained on M&E	Program reports	GAC	Annual