

GHANA FINAL REPORT

September 1998—June 2004

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



FINAL REPORT

for the

**Implementing AIDS Prevention
and Care (IMPACT) Project in**

GHANA

September 1998 to June 2004

Ghana Final Report

*Submitted to USAID
By Family Health International*

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201
TEL 703-516-9779
FAX 703-516-9781

In partnership with

**Institute for Tropical Medicine
Management Sciences for Health
Population Services International
Program for Appropriate Technology in Health
University of North Carolina at Chapel Hill**

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TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS	1
EXECUTIVE SUMMARY	3
COUNTRY CONTEXT	5
The Burden of HIV/AIDS in Ghana	5
Factors Contributing to the Epidemic in Ghana	6
Assessing Health Care Settings	7
Policy Response to HIV/AIDS in Ghana	7
THE IMPACT PROGRAM IN GHANA	10
Implementation and Management	10
Program Evolution: A Chronology	13
PROGRAM IMPLEMENTATION AND RESULTS	15
Interventions with Uniformed Services	15
Workplace Programs	18
Interventions with Sex Workers	20
Developing Antiretroviral Treatment and Voluntary Counseling and Testing Programs	23
Youth-focused Programs	27
Care and Support for People Living with HIV/AIDS and Orphans and Vulnerable Children	31
LESSONS LEARNED AND RECOMMENDATIONS	32
HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITY	37
Implementing Partner Matrix	37
Subproject Highlights	38
ATTACHMENTS	40
Attachment A: Data on Condom Use in the Police Services	40
Attachment B: Summary Data on Program Performance	42
Attachment C: Activities of Faith-based Projects	43
Attachment D: Activities of Nongovernmental and Community-based Organizations	49
Attachment E: Annotated Bibliography of Resources Published with Support from FHI	56

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune efficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretrovirals
BCC	Behavior change communication
BSS	Behavioral surveillance survey
CA	Cooperating agency
CBOs	Community-based organizations
CEPS	Customs, Excise and Preventive Services
CEDPA	Centre for Development and Population Activities
COP	Church of the Pentecost
DFID	Department for International Development
DRI	District Response Initiative
FBO	Faith-based organization
FHI	Family Health International
FOWA	Fire Officers' Wives' Association
GAC	Ghana AIDS Commission
GAF	Ghana Armed Forces
GAFCO	Ghana Agro-Food Company Limited
GARFUND	Ghana AIDS Response Fund
GDHS	Ghana Demographic and Health Survey
GGGA	Ghana Girl Guides Association
GHACEM	Ghana Cement Manufacturing Company
GIS	Ghana Immigration Service
GNFS	Ghana National Fire Service
GPoS	Ghana Police Service
GRCS	Ghana Red Cross Society
GSMF	Ghana Social Marketing Foundation
GSPA	Ghana Service Provision Assessment
HBC	Home-based care
HIV	Human immunodeficiency virus
HMIS	Health management information system
IMPACT	Implementing AIDS Prevention and Care Project
IEC	Information, education and communication
IR	Intermediate Results
ISSER	Institute of Statistical, Social and Economic Research
JHU	Johns Hopkins University
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
M&E	Monitoring and evaluation
MKQMA	Manya Krobo Queen Mothers Association
MOH	Ministry of Health
MURAG	Muslim Relief Association of Ghana
NACA	National Advisory Council on AIDS
NACP	National AIDS Control Program
NGO	Nongovernmental organizations
NPHRL	National Public Health Reference Laboratory

OIs	Opportunistic infections
OVC	Orphans and vulnerable children
PCG	Presbyterian Church of Ghana
PE	Peer educator
PEF	Private Enterprise Foundation
PEP	Post-exposure prophylaxis
PLHA	Persons living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PPP	Participatory planning process
PROWA	Prison Officers' Wives' Association
SA	Salvation Army
SO	Strategic objective
SOP	Standard operating procedure
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TOR	Tema Oil Refinery
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WAPCAS	West African Project to Combat AIDS and STIs
WVG	World Vision Ghana

EXECUTIVE SUMMARY

In July 1998, Family Health International, under its USAID-funded Implementing AIDS Prevention and Care (IMPACT) Project, initiated a program of activities in Ghana to strengthen the Ghana National AIDS/STI Control Program (NACP), the National Public Health Reference Laboratory and the Ghana Police Service. IMPACT's program strategy complemented Ghana's national program, with its emphasis on reducing risk behaviors, strengthening care and support, improving the quality of sexually transmitted infection (STI) services and expanding the availability and use of data for decision making.

During the program, IMPACT/Ghana used the subagreement process to support the behavior change, care and support programs of a wide variety of community-based organizations, including faith-based organizations (FBOs) and churches, nongovernmental organizations (NGOs), youth groups and groups for people living with HIV and AIDS (PLHA). Within a short time, IMPACT became a recognized and respected partner among the donor and NGO communities working in Ghana, in large part because of the range of expertise within its staff.

Over time, IMPACT/Ghana expanded its activities with the NACP to include training of more than 400 health providers in syndromic management of STIs, STI studies and two rounds of behavioral surveillance surveys (BSS) among the same targeted groups in 2000 and 2003, and voluntary counseling and testing (VCT) activities. IMPACT/Ghana also expanded its police program to include the Ghana Armed Forces and other branches of the uniformed services and moved beyond peer education to counseling and STI services. The program also began to support behavior change activities initiated by community-based organizations.

IMPACT/Ghana's work with the uniformed services has evolved into a global model. Starting as a peer education activity for the police, the program has grown to include six uniformed services partners (Ghana Armed Forces, Ghana Prisons, Immigration, Police Services, Customs Excise and Preventive Service, and Ghana National Fire Service). In addition to peer education training, IMPACT's technical assistance to the uniformed services has included advocacy, strategic planning and materials development.

In 2001, IMPACT/Ghana supported the Private Enterprise Foundation (PEF) in implementing workplace programs for six economically strategic companies, as well as programs for informal entrepreneurs. These efforts included policy development, community outreach and development of behavior change communication (BCC) materials.

IMPACT also supported an extensive array of youth-focused programs, implemented by four FBOs and other NGOs. These programs, which have reached an estimated one million people, incorporated peer education and training of peer educators, counseling and house-to-house visits, community education and establishing "AIDS committees" in houses of worship.

After IMPACT conducted behavioral surveillance surveys among female sex workers in 2000 and 2002, IMPACT-supported subprojects targeted this vulnerable group with

outreach and peer education, programs to increase use of STI treatment services, a BCC strategy and condom promotion and distribution.

Care and treatment were also focal points for IMPACT activities. Through the subagreement process, IMPACT supported the creation of VCT centers for the uniformed services, pregnant women and the general public. In 2003, IMPACT was a leader in helping develop new antiretroviral therapy (ART) programs at two of Ghana's teaching hospitals. In addition to ART services, these programs offered VCT, services to prevent mother-to-child HIV transmission services and clinical care.

COUNTRY CONTEXT

Ghana's population is estimated at more than 18,412,500, with a growth rate of 2.5 percent, according to preliminary results of the 2000 Population and Housing Census. Life expectancy stands at 57 years.

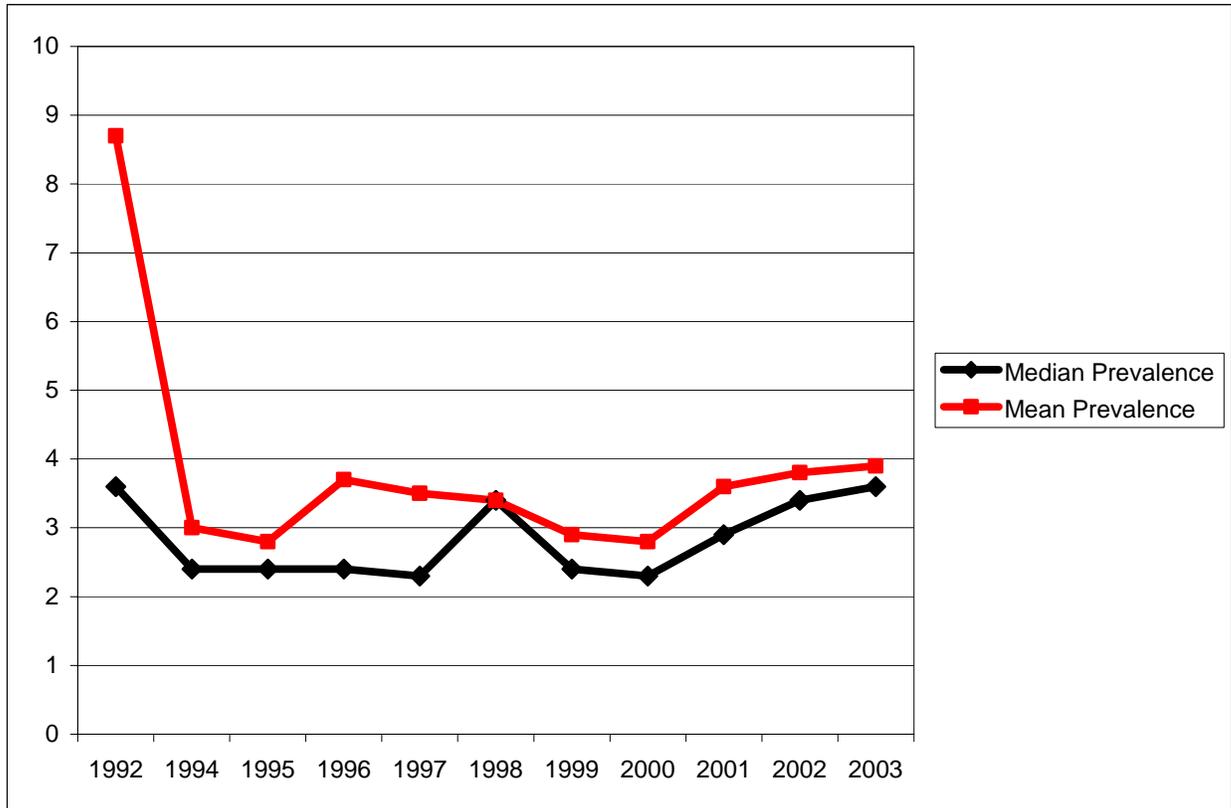
The Burden of HIV/AIDS in Ghana

In 2000, an estimated 350,000 persons living with HIV and AIDS (PLHA) lived in Ghana.¹ By 2002, there were an estimated 42,000 new AIDS cases and a cumulative total of 326,780 deaths. At the end of 2002, median HIV prevalence in Ghana was 3.4 percent, or 335,000 adults living with HIV and AIDS. The number of PLHA will reach between 560,000 and 1,200,000 by 2014; by then, AIDS will be responsible for 28 percent of all deaths in the country.²

In Ghana, the mode of HIV transmission is predominantly heterosexual sex (80 to 85 percent). Mother-to-child transmission reportedly accounts for 12 to 15 percent of transmission, while transfusion of blood and blood products accounts for less than 2 percent. Between 94 and 96 percent of HIV infections are caused by the HIV-1 strain.

Based on sentinel surveillance of seroprevalence among women attending antenatal care clinics, median HIV prevalence between 1992 and 2003 shows three peaks at the beginning, midpoint and end of this time period.³ HIV prevalence declined slowly over most of the 1990s but has steadily increased since 2000. Although the median 2003 adult HIV prevalence of 3.6 percent was the same as in 1992, there is much concern that, despite intensive prevention efforts, prevalence has increased about 50 percent since 2000 (Figure 1). At Ghana's sentinel surveillance sites—which increased from eight in 1992 to 30 in 2003—prevalence rose between 1999 and 2004 by 50 percent at 11 sites, 100 percent at six sites and more than 200 percent at two sites. At one site, Kumasi, HIV prevalence in 2003 among clients seeking care for sexually transmitted infections (STIs) was 9.6 percent. On the other hand, HIV prevalence in the 15- to 19-year-old age group has declined since 2001; in 2003 it was 1.9 percent.

Figure 1: Median and Mean Adult HIV Prevalence in Ghana, 1992-2003



Data for 1993 were not collected.

The epidemic will continue to impact development in Ghana. In the health sector alone, HIV/AIDS is placing increasing demand on health care facilities for such services as palliative care, management of opportunistic infections (OIs) and antiretroviral treatment (ART). In some hospitals in Ghana, HIV/AIDS is already the leading cause of adult mortality. HIV/AIDS could lead to increases in mortality for both adults and for children under five, rising numbers of orphans and vulnerable children and a reduced labor force with a consequent loss in productivity.

Factors Contributing to the Epidemic in Ghana

Several factors affect HIV/STI transmission in general and high-risk behavior in Ghana. As in much of West Africa, Ghana has a young population (41 percent of the population is under 15), as well as increasing urbanization, high rates of migration and travel, low literacy and widespread poverty. Women have low status in Ghanaian society, which increases their vulnerability. Although adult HIV prevalence in West Africa has generally remained under 5 percent, prevalence in the three countries surrounding Ghana (Côte d'Ivoire, Burkina Faso and Togo) exceeds 5 percent.

Cultural factors also affect the course of the epidemic in Ghana. Male circumcision, which may protect men from HIV transmission, is widely practiced in Ghana. According to the Ghana Demographic and Health Survey (GDHS) 2003, 95 percent of males 15 to 59 years old were circumcised.⁴ Such potentially harmful sociocultural practices as

polygamy, widowhood rites, female genital mutilation and tattooing appear to be declining.

Overall, AIDS awareness has increased remarkably over the past decade. In the GDHS 2003, 98 percent of women and 99 percent of men had heard of AIDS; 96 percent of women and 98 percent of men believed there was a way to avoid HIV infection.⁵ Information from both routine reports and surveys shows that the use of condoms has been increasing but is still relatively low. In the GDHS 2003, 28 percent of sexually active females 15 to 49 years old and 44 percent of males 15 to 59 years old reported using a condom during their last sexual encounter with a non-cohabiting partner. The use of condoms among men was associated with young age, unmarried status, urban residence, secondary education and residence in the Greater Accra and Volta regions.

Assessing Health Care Settings

In 2002, Ghana and USAID funded the Ghana Service Provision Assessment (GSPA) survey in a representative sample of 428 health facilities (hospitals, polyclinics, health centers, public clinics, private maternity homes and private clinics) throughout Ghana.⁶ Its purpose was to assess the infrastructure and quality of care relating to child health, family planning, maternal health and STI and HIV/AIDS services. The study found that soap was available in all assessed service delivery areas in 70 percent of facilities, and water in 68 percent of facilities. Gloves were available in all relevant service areas in 54 percent of facilities, but disinfectant solution was available in all relevant service areas in only 24 percent of facilities. While 67 percent of facilities had functioning equipment for either high-level disinfecting or sterilizing, only 51 percent of facilities had both the equipment as well as staff who knew the correct processing time.

Universal precautions against infection in health facilities are inadequately followed. While disposable syringes and needles are widely used, health workers frequently recap needles and reuse them.

Policy Response to HIV/AIDS in Ghana

In 1985, the Government of Ghana established the National Advisory Committee on AIDS (NACA). The National AIDS Control Programme (NACP) was established under the Ministry of Health (MOH) in 1987 to implement and coordinate the national HIV program. At the time, a separate National STI Control Programme was also established. The National HIV/AIDS and STI Policy was developed to guide the national response, addressing safe sexual behavior, condom promotion, safe blood and blood products, syndromic management of STIs, counseling and community care of persons living with HIV/AIDS.

By 2000, heeding the growing global realization that HIV presents one of the greatest threats to national development, the Ghanaian government shifted its response from a medical approach to a development approach. The Ghana AIDS Commission (GAC), modeled on the Ugandan experience, was established in September 2000 under the Office of the President. The GAC was responsible for developing, coordinating, monitoring and evaluating the national response plan to HIV/AIDS, including strategies for:

- Preventing new infections: behavior change communication (BCC), voluntary counseling and testing (VCT), preventing mother-to-child transmission (PMTCT) of HIV and managing STIs.
- Clinical management of PLHA: managing and treating OIs, providing antiretroviral therapy and home-based care (HBC), and strengthening surveillance, research, monitoring and evaluation.
- Psychosocial care and support of PLHA.
- Creating an enabling environment through advocacy.
- Building the capacity of civil society organizations to respond effectively to the epidemic.

In 1997, the District Response Initiative (DRI) was implemented to decentralize the response from the national level to local levels and to create a rallying point for AIDS activities at the district level. In the same year, Regional AIDS Committees were set up in all 10 regions, while District AIDS Committees were created in 110 districts. These committees have been hampered by limited funding, high personnel attrition rates, weak capacity and limited involvement of CBOs and other civil society stakeholders.

A national HIV/AIDS Strategic Framework and a Monitoring and Evaluation Plan were developed in 2001 to provide goals and indicators for monitoring the national response to the disease.^{7,8} Also that year, the GAC established the Ghana AIDS Response Fund (GARFUND) to support governmental and nongovernmental organizations conducting research and implementing HIV/AIDS/STI interventions. Between January and June 2003, the GAC reported that 43,554 beneficiaries had received support from GARFUND for interventions in advocacy, capacity building, condom distribution, counseling, communications and education, peer education, social support, training and technical support.

Political commitment to HIV/AIDS remains high in Ghana. The GAC, with funding from the UK's Department for International Development (DFID) and USAID, is commissioning studies to assess the socioeconomic impact of AIDS in Ghana. A national HIV/AIDS policy has been drafted with GAC's support and awaits approval from the Cabinet. The policy seeks to create a favorable environment for all aspects of HIV/AIDS/STI programming in prevention, care and support.

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THE IMPACT PROJECT IN GHANA

In September 1997, USAID awarded Family Health International (FHI) and its partners a five-year cooperative agreement for the Implementing AIDS Prevention and Care (IMPACT) Project. IMPACT's mission is to help countries expand and improve HIV/AIDS prevention and care.

In July 1998, FHI initiated the country program in Ghana to focus on strengthening the NACP, the National Public Health Reference Laboratory (NPHRL) and the Ghana Police Service. IMPACT/Ghana's program strategy complemented Ghana's national program, with its emphasis on reducing risk behaviors, strengthening care and support, improving the quality of STI services and increasing the availability and use of data for decision making. IMPACT's activities were designed to contribute to USAID/Ghana's Strategic Objective 3 (SO3), *Improving Family Health*, through the following Intermediate and Sub-Intermediate Results (IRs and Sub-IRs):

- IR 3.1.1: Increased demand for reproductive health services
- Sub-IR 3.1.3: Improved quality of reproductive health services
- Sub-IR 3.1.2.1: Data available for decision making

Implementation and Management

IMPACT/Ghana was one of the key USAID instruments for funding the HIV/AIDS programs of the Government of Ghana and NGO partners. Within a short time, it became a recognized and respected partner among the donor and partner communities working in HIV/AIDS, in part because of the range of expertise that the program brought to the country. IMPACT country office staff served on many committees, including the UNAIDS Technical Working Group, the Ghana AIDS Commission's Orphans and Vulnerable Children Subcommittee, the World AIDS Day Planning Committee and the WHO-led Surveillance Task Force.

Most of the support for IMPACT's implementing partners was arranged through subagreements. Although partners were expected to develop the proposals themselves, it became apparent that most lacked the capacity to do so. To resolve this, the country office team worked closely with partners to determine the activities that would go into the proposals.

Staffing and Management

In September 1998, FHI hired an in-country coordinator to manage IMPACT/Ghana; she initially worked out of her home. In response to increased funding and the growing responsibilities of the program, an office opened in March 1999 in Accra. A resident advisor came on board, and by the end of August of the same year a program officer, an accountant, a secretary, a driver and an office clerk had joined the country office team. In late 2001, an additional program officer and a driver were hired, bringing the total IMPACT/Ghana staff to eight. In 2001, FHI redesignated all resident advisors as country directors, in line with the growing portfolios and multiple funding sources of country programs. In January 2002, and following discussions with USAID/Ghana, a regional

senior technical advisor was placed in country, devoting 25 percent of his time to care and support activities.

The country office was responsible for the day-to-day coordination of technical assistance and programmatic support to the implementing partners; for collaboration with national-level institutions such as the GAC, the NACP and the Ghana Health Service; for liaison with USAID/Ghana; and for achieving program objectives. The country office worked with the FHI/Arlington team responsible for backstopping IMPACT/Ghana's programs.

Coordination with USAID/Ghana and Other Cooperating Agencies

IMPACT/Ghana enjoyed the full support of the USAID Mission. The Health, Population and Nutrition office was easily accessible to the country office team for meetings with the country director and consultants and frequently participated in such IMPACT activities as training and capacity building, report disseminations and program launches. IMPACT was often selected to showcase its program activities to visiting U.S. dignitaries, which the implementing partners appreciated.

IMPACT/Ghana, represented by the country director, participated in the regular quarterly meetings of all USAID partners as well as the quarterly meetings of the SO3 (Health) partners. Whenever possible, IMPACT/Ghana collaborated with other USAID cooperating agencies (CAs) in implementing its programs. As an example, Johns Hopkins/Population Communication Services were closely involved in designing behavior change communication (BCC) materials for the IMPACT partners. In September 2002, IMPACT/Ghana worked closely with the Mission to revise IMPACT's workplan to fit the emerging USAID/Ghana country support strategy (2004-2010).

Technical Assistance

At the core of IMPACT/Ghana's programs was providing technical assistance to the partners for key activities. Most of this assistance was provided by consultants from outside Ghana. The challenge was to arrange for technical assistance at a time that was both appropriate for the program and convenient for the partners. By developing technical assistance plans at the beginning of the fiscal year, IMPACT/Ghana was able to better coordinate assistance.

Monitoring and Evaluation

One weakness within the country program was the lack of an effective monitoring and evaluation (M&E) system to track program implementation. With technical assistance from FHI in Arlington, the Ghana office developed an M&E country strategy. Implementing partners received training in M&E in the later phase of the program.

Capacity Building and Sustainability

Over the life of the program, IMPACT/Ghana provided technical assistance to its partners to better implement and sustain HIV/AIDS interventions. Training and capacity building were integral to the programs implemented with the partners. Representatives of

IMPACT partners and country office program staff participated in such international conferences as the World AIDS Conference and the International Conference on AIDS and STIs in Africa. In 2002, two IMPACT program officers undertook a training program in AIDS and STIs at the London School of Hygiene and Tropical Medicine. The country director participated in the country directors' meetings and global management meetings organized by FHI.

Non-subagreement Activities

- “Support and Capacity Building to the National Public Health Reference Laboratory (NPHRL)”: Starting in 1998, at the request of USAID/Ghana, IMPACT provided technical assistance and capacity building to NPHRL, with the overall goal of ensuring accurate diagnosis of HIV, STIs and other diseases for improved reporting. FHI helped to develop, produce and disseminate Standard Operating Procedures (SOP) manuals and laminated desktop sheets for laboratories. The NPHRL program manager later trained all of the regional lab technicians and staff in the new SOPs; they were then able to train the district lab personnel. They also helped to establish a baseline for proficiency tests in 10 regional labs. This technical assistance strengthened the skills of the lab technicians and staff at both the regional and national levels.
- “Support to the National AIDS/STD Control Program (NACP)”: In December 1998, a national symposium convened to discuss the findings of an assessment, “Review of the National Response to the HIV Epidemic in Ghana.” IMPACT supported this activity, which was aimed at ensuring greater coordination among key stakeholders in Ghana. Partners at the workshop included donor agencies, ministries, religious organizations, the private sector, traditional healers, uniformed services, NGOs and the media. At this meeting, participants determined that IMPACT’s role was to support the strengthening of STI services and surveillance activities of the NACP, as well as the training of nurse/counselors in HIV counseling and testing. IMPACT provided technical assistance to the NACP to strengthen coordination of the national HIV/AIDS response in Ghana.

Strengthening STI Services and Surveillance/Monitoring

IMPACT’s support to the NACP for sentinel surveillance began in early 2001 with a consensus meeting of key stakeholders drawn from the NACP, the Disease Surveillance Unit and sentinel health institutions from all 10 regions. Discussions covered selection criteria for sites, responsibilities of health institutions and health personnel, case definitions, reporting forms and systems. Other key regional health staff received an orientation to sensitize them to the STI sentinel surveillance concept.

In October 2002, staff at the 18 selected sites participated in a one-day on-site orientation to the newly designed STI forms. Staff were then asked to send completed forms to NACP by a predetermined deadline for analysis. Once the data were collected and analyzed, health institutions and clinics received a report detailing the key findings. The findings showed that 75 percent of clients seen were female; vaginal discharge was the most common syndrome reported, and urethral discharge was the most common presentation among the male clients. Although support for this activity ended in February

2003, the NACP secured alternative funding to hold a stakeholders' meeting to discuss initial results from the sentinel surveillance.

Improving the Quality of STI Case Management at Public Health Clinics in Ghana

In early 1999, IMPACT coordinated and facilitated training of 15 core trainers from Ghana's 10 regions in the syndromic approach to STI treatment. Additionally, 246 medical officers/doctors throughout the 10 regions were trained by this core group of trainers and FHI staff in 1999 and 2000. Also in 2000, 225 medical assistants from nine of the 10 regions received training in syndromic management.

VCT Assessment, National VCT Guidelines and VCT Counselors' Training Manual

Between 2002 and 2004, IMPACT/Ghana, in collaboration with the Ghana AIDS Commission and the NACP, assumed the leading role in developing the National Voluntary Counseling and Testing Guidelines and in revising the *Counselors' Training Manual*. These two key documents helped guide the establishment of VCT centers as well as the training of counselors for these centers. The first draft of the national guidelines went through several reviews by a team put together by the GAC, NACP and FHI. A wider stakeholders' meeting was held in April 2003 to review the document, after which it was presented to the NACP and GAC for broad distribution.

Program Evolution: A Chronology

As part of the program start-up process, implementing agencies conducted various needs assessments and related formative research. In collaboration with the Ministry of Health, an STI study was conducted between July 2000 and January 2001 to establish a standard for appropriate diagnosis and treatment of STIs and to evaluate how many people were receiving appropriate STI treatment throughout Ghana. The PI 6 & 7 study also evaluated the counseling of clients on the preventing STIs, condom use and partner referral, which are all important components of STI case management.

In 1999 and 2000, IMPACT/Ghana expanded its activities to include training of health providers in syndromic management of STIs and in conducting STI studies and behavioral surveillance surveys (BSS). The Ghana Police Service program was expanded to include other sectors of the country's uniformed services: the Ghana Armed Forces, prison officers, the Ghana National Fire Service, the Ghana Immigration Service and Customs, Excise and Preventive Services (CEPS). Services were also expanded beyond peer education to include counseling and STI services.

In 2000 and 2001, IMPACT began supporting BCC activities with local NGOs and faith-based organizations (FBOs). In 2001, IMPACT also provided support to the Private Enterprise Foundation (PEF) to develop a workplace program, targeting seven businesses critical to the national economy in the energy, food processing, wood processing and manufacturing sectors, as well as 410 small businesses in the informal sector.

In February 2002, FHI conducted a program review of IMPACT/Ghana. A key objective was to determine how the current program was contributing to Ghana's national

HIV/AIDS strategy and meeting USAID's SO3 objectives. Based on the findings and the recommendations from the review, IMPACT/Ghana revised its program strategy and activities to focus on specific technical areas, including establishing VCT centers, a second round of the BSS, sex worker interventions, STI management and services, supporting FBO care and support programs and evaluating the effectiveness of the uniformed services program.

With support from the West African Project to Combat AIDS and STIs (WAPCAS), the Salvation Army and the Red Cross, IMPACT targeted interventions to female sex workers to promote health-seeking behavior and condom use among itinerant sex workers ("roamers") in Accra/Tema—where sex with sex workers may be responsible for 84 percent of adult HIV prevalence—and Secondi-Takoradi. IMPACT also supported a GAC-affiliated Transactional Sex Working Group that included groups working with sex workers and groups working with men mainly through the private sector. Its purpose was to ensure uniform approaches to STI management and VCT, share materials, standardize data collection where possible and ensure that programming gaps were covered.

FHI launched the Start Program in February 2002 as a collaborative effort with the government to provide comprehensive prevention, care and treatment services for PLHA and their families in two districts of the Eastern Region, where regional HIV prevalence has been among the highest in country (14 percent at the time). The Start Program addresses the unmet medical and psychosocial needs of people infected and affected by HIV and reduces the impact of the epidemic. The program has established "learning sites" to manage HIV disease and provide comprehensive care. As a result of discussions with USAID/Ghana in 2003, IMPACT/Ghana funding supported expansion to two sites: Korle Bu Teaching Hospital and Komfo Anokye Teaching Hospital. ART began at the Korle Bu site in October 2003 and at the Komfo Anokye site in January 2004.

To support the national HIV/AIDS surveillance system, IMPACT conducted two rounds of BSS in 2000 and 2002 among policemen, female sex workers, miners and male and female youth. Following the 2002 BSS, IMPACT conducted a qualitative study to complement the BSS and further explore issues pertaining to the findings of the study.

The Institute of Statistical Social and Economic Research (ISSER) conducted a formative assessment of roamers in Tema, Takoradi and Accra. The study described the settings in which sex workers live and work and the culture of sex work, identified barriers to lowering risk and proposed solutions to improve targeted behaviors, including condom use and use of VCT and care and support services. ISSER also conducted a size estimation study of this sex worker population, after which a qualitative assessment was conducted among the sex workers to further explore issues revealed in the findings of the size estimation study.

PROGRAM IMPLEMENTATION AND RESULTS

IMPACT targeted the following populations in Ghana:

- Uniformed services personnel
- Men and women in the workplace
- Members of FBOs
- Male and female youth, both in and out of school
- Female sex workers
- PLHA
- STI clients
- Adult men and women seeking VCT
- Adult men and women involved in CBOs

Interventions with Uniformed Services

In July 1998, IMPACT initiated activities to strengthen HIV/AIDS programming for the Ghana Police Service (GPoS). The main objectives of the program included establishing a reliable and high-quality STI/HIV testing facility at the Police Hospital, producing a database on police risk for HIV and implementing a behavior change program among police personnel. Activities included conducting peer one-on-one and group HIV/AIDS education; sensitizing the top hierarchy of the police; providing in-service training for middle rank and senior police officers; developing, producing and distributing targeted IEC materials; and promoting and distributing condoms. All condoms distributed under the IMPACT Project were provided by the Ghana Social Marketing Foundation and not purchased by FHI or IMPACT.

In 2001, IMPACT expanded activities to cover Ghana National Fire (GNFS) Services, Ghana Immigration Services (GIS), and Ghana Customs, Excise and Prison Services (CEPS). The goal of the expanded intervention was to strengthen the capacity of the different services to design and implement HIV/AIDS/STI behavior change programs to prevent HIV and other STIs and build supportive attitudes about PLHA. Program implementation strategies included advocacy, training and capacity building in several technical areas, including diagnosing and managing STIs, developing a BCC strategy and materials relevant to the uniformed services, peer education and VCT. IMPACT developed training-of-trainers' manuals and instructor's guides for each category of personnel. Based on the findings of needs assessments conducted within the uniformed services, the program expanded activities to reach the wives of uniformed service personnel and other civilians. Through prevention-focused BCC activities, 2,015 persons received training and were then able to reach 32,500 uniformed services personnel. Another major achievement was sensitizing top-ranking officials, which has been credited as a major factor in successful program implementation.

IMPACT/Ghana's work with the uniformed services is seen as a model on the African continent and globally. Representatives of the uniformed services in Eritrea, Kenya and Nigeria have visited Ghana to learn about the program. IMPACT/Ghana has also provided technical assistance in developing a BCC strategy for the Nigerian Police Service. IMPACT/Ghana has played an important role in the Uniformed Services Working Group, a global, FHI-led initiative. As part of the group's activities, peer

education tools and an in-service training curriculum have been developed and field-tested in Ghana.

Intervention Activities

The interventions with all six uniformed services partners followed a systematic pattern of activities to ensure understanding of key issues in HIV/AIDS and STIs and participation of service personnel in program activities, with some variation in activities for specific services. The common activities were:

- *Advocacy sessions for management* to facilitate program development and create a favorable environment for program implementation. Top leadership of the uniformed services participated actively in advocacy and program launch activities, provided office space, participated in discussions of the program at management meetings and helped promote condom use.
- *An official program launch* conducted by the highest-ranking official of each service.
- *Formative research* to provide insight on such issues as current sexual behaviors, STI experience, attitudes about condoms, condom use, profiles of sexual partners and communication among peers. Information collected from this research was used for program rollout, including developing BCC strategies and materials, training peer educators and producing training manuals.
- *Capacity building for program sustainability* to enable services to develop proposals for alternate funding to further expand their programs. To this end, national teams within each service were set up to coordinate activities for program sustainability.
- *Peer education training*, the key activity of the behavior change intervention. “The Uniformed Services HIV/AIDS Peer Leadership Guide,” produced by the Uniformed Services Task Force on HIV/AIDS, was adapted for peer education training. Training methodologies included film shows to increase knowledge about HIV/AIDS/STI in general, facilitator presentations, role-plays, group discussions and group work.
- *A condom availability program*, closely linked to the peer educational activities. Promotional materials were designed to boost condom sales.
- *BCC materials* were developed for the peer education activities and other components of the program.
- *Adding a “condom wallet”* to the official military uniform as part of peer education activities.
- *Developing basic and in-service training curriculum* to help structure the training provided at the uniformed services training schools and integrate HIV/AIDS into regular in-service training.
- *Monitoring of activities* by national and regional team members of each service, which held quarterly and monthly regional meetings, respectively, to discuss accomplishments and challenges as part of routine feedback and information sharing.

Additional Service-specific Activities

- *Civilian Employees Program, Ghana Armed Forces*: 100 representatives of the civilian employees were provided with HIV/AIDS/STI education emphasizing key information, attitude change and condom negotiation skills. These activities were targeted to 15,000 civilian employees (who outnumber GAF personnel) who also live within the barracks.

- *HIV/AIDS counseling skills training for religious leaders (priests and Islamic clerics/imams), Ghana Armed Forces:* 25 religious leaders within the seven battalions were trained during a four-day HIV/AIDS education and counseling training session. The aim was to improve their counseling skills and enable them to provide support to HIV-positive members of the armed forces.
- *Training in condom promotion and sales for “mess boys” (working in mess halls), Ghana Armed Forces:* Condom promotion and use training was conducted for 91 mess boys, after which they were linked up with the Ghana Social Marketing Foundation for condom supply and sales.
- *HIV/AIDS training for laboratory technicians, Ghana Armed Forces and Ghana Police Service:* Three laboratory technicians from the Military Hospital and two from the Ghana Police Hospital were trained in quality assurance for STI/HIV testing at the Public Health Reference Laboratory using standard operating manuals developed under a subagreement with the NPHRL.
- *Training for HIV/AIDS counselors, Ghana Armed Forces and Ghana Police Service:* 83 health providers within the military and police hospitals were trained in HIV/AIDS counseling.
- *STI training for physicians, Ghana Police Service:* Seven physicians and five medical assistants at the Police Hospital were trained in the syndromic approach to the STI treatment of STIs. A one-page bench review/referral sheet of the approach was also developed and distributed to the physicians for reference during case management.
- *Establishing a VCT center, Ghana Police Service:* Twenty additional counselors and three senior counselors were trained to use rapid test kits to support services at the center. Nearly 1,000 clients were seen at the center.
- *Support for TB program, Ghana Prison Service:* A program to identify and manage tuberculosis within the prison setting, in collaboration with the National Tuberculosis Program of the Ministry of Health. Linkages were developed with the National Tuberculosis Program for this activity.
- *Choir-Music Band Program, Ghana Immigration Service and Ghana National Fire Service:* Both services have vibrant choir and music bands for regimental activities and recreational purposes. After both groups received training, they were encouraged to compose songs about AIDS prevention.

Behavioral Outcomes: Ghana Police Force

Data from the 2000 and 2002 BSS show changes in some HIV/AIDS-related knowledge and behavior indicators among the program’s target population in the Ghana Police Force. For instance, awareness of HIV/AIDS increased from 93.7 percent in 2000 to 100 percent by the end of 2002. The data also show a significant increase between 2000 (25.2 percent) and 2002 (84.1 percent) among those who had attended a meeting or had been visited to discuss HIV/AIDS, an indication that HIV/AIDS information was being more widely disseminated.

Unfortunately, while HIV prevention and transmission knowledge increased dramatically between survey rounds, so did reported high-risk sexual contact and STIs. For example, the percent of respondents reporting sex with a commercial partner in the last 12 months increased from 3.4 percent in round one to 9.2 percent in round two; reports of urethral discharge, an STI symptom, within the previous 12 months also increased, from 6 percent

to 11.2 percent. The seeming contradiction between higher levels of knowledge and behavior are difficult to interpret and may reflect an unwillingness to report “bad” behavior during round one to interviewers, who were introduced to informants through the police hierarchy.

Despite this, the data show notable improvements in several behavioral indicators, particularly condom use. (For more details, see Figures A and B and accompanying analysis in Attachment A.) Some indicators of health-seeking behaviors also improved between the rounds: 97 percent of men who had suffered STI symptoms in the previous 12 months said at the second round that they had sought care from a health worker, compared to only 36 percent at the first round

Workplace Programs

The Private Enterprise Foundation (PEF), a private-sector umbrella association covering businesses in both the private and informal sectors, implemented IMPACT’s workplace programs in Ghana. PEF’s objective was to help establish workplace HIV/AIDS programs at six participating companies, as well as to promote prevention activities among informal entrepreneurs. To plan for implementation of activities, PEF conducted a project initiation needs assessment and other research to locate and map existing workplace programs as well as to obtain baseline information.

The six companies were strategically placed within the economy (see Table 1):

- The energy sector: Tema Oil Refinery (TOR)
- The food sector: Ghana Agro-Foods Company Limited (GAFCO)
- The industrial sector: Crocodile Matchets and Ghana Cement Company (GHACEM) at its sites in Tema and Takoradi
- The wood-processing sector: SCANSTYLE and Ayim Timbers

Table 1: Summary of Workplace-based Peer Education/Sensitization Program

Company/Institution	Program	Year	No. of persons trained	No. of people reached
Tema Oil Refinery	Peer education and refresher course	2002/2003	42	2,500
GHACEM (Tema)	"	2002/2003	26	1,500
GHACEM (Takoradi)	"	2002/2003	22	1,500
GAFCO	"	2002/2003	24	3,000
Crocodile Matchets	"	2002/2003	22	1,500
SCANSTYLE – MIM	"	2002/2003	22	1,800
AYUM Timber Products	"	2003	40	2,000
Informal sector executives of trade associations and small businesses	Sensitization	2002/2003	410	5,000
TOTAL			608	18,800

Program Activities

The following activities were key components of the workplace program:

- *Employee educational workshops:* A cross-section of employees at all participating companies attended obligatory three-hour workshops to raise HIV awareness and to learn how to protect themselves and their families. Reducing stigma and discrimination was an important goal of these workshops.
- *Voluntary counseling and testing:* Peer educators in the workplace programs emphasize the importance of VCT to workers.
- *Peer education:* 198 staff members—both employees and managers—of the six participating companies were trained as peer educators; over time, many of them also received refresher training. To counter complaints by management about taking time away from production activities, the peer educators frequently used a “low cost, no cost” approach by scheduling activities during break periods, bus rides, funerals and company gatherings. Among program participants in the informal sector, 410 leaders of business associations also received training. Both groups were able to reach 18,800 workers, managers, company clients or members of the larger community with HIV/AIDS messages. Routine monitoring visits to program areas were organized to oversee the activities of peer educators.
- *Sensitization workshops and other types of training for managers, union officials and other leaders:* More than 70 executives and managers in the six companies participated in workshops and other activities to sensitize them to the impact of HIV/AIDS on the operations and profitability of their companies and to educate them about how they and their employees can practice lower-risk behaviors. Dozens of union officials and other leaders of employee organizations also participated. In addition, 20 nurses received training as counselors; 16 more were trained in the syndromic management of STIs, while 10 human resources officers were trained in public relations and community messages and activities on HIV/AIDS.
- *Developing BCC materials:* By the end of the subproject, 4,400 posters and 5,000 stickers displaying HIV/AIDS messages for the workplace had been produced and distributed to the six participating businesses. Giant billboards and posters were also erected at the premises of the businesses. Audiovisual materials on HIV/AIDS were produced and distributed to the companies for use by peer educators. Each company received copies of the videos “It Is Not Easy,” “The Silent Epidemic” and “Drive Protected.”
- *Policy development:* Two representatives of each participating company attended a policy development workshop to facilitate the design and development of workplace policies for their respective companies. The policies outline the company’s response to HIV/AIDS, describe strategies for combating workplace stigma and discrimination and ensure the continuation of the education programs for prevention. All policies developed thus far address the issues of discrimination, gender equality, confidentiality, prevention, care and support, continuation of employment, health care and sick leave.
- *Creating workplace committees:* To ensure effective program implementation, companies were encouraged to form HIV/AIDS committees that include members from management and staff, including some peer educators. These committees were the contact points for all HIV/AIDS programs in the workplace. Since management

and union leaders were represented on these committees, organizing education programs at the company level became easier.

- *Media dissemination*: PEF arranged to discuss workplace programming on four radio stations – JOY FM, ADOM FM, CHOICE FM and PEACE FM—and two TV stations: GTV and TV3. One major component of the workplace HIV/AIDS program was the development, pre-testing and airing of two different jingles for a period of four weeks on five radio stations in the Greater Accra, Western and Ashanti regions. Because of the important role they play in the disseminating information on HIV/AIDS, 40 senior editors and reporters attended a media sensitization program to build knowledge and skills for reporting on HIV/AIDS, particularly on workplace interventions.
- *Community outreach*: Valuable time and resources were spent to expand the general education program to the surrounding communities; approximately 3,000 community members benefited. This aspect of the program was more successful in the communities surrounding the timber companies in the Brong Ahafo Region.
- *STI treatment*: Because treatment of STIs reduces vulnerability to HIV infection, clinics at each of the participating companies were encouraged to promptly treat all STI cases reported to them. Some of the company clinics instituted a free treatment program for STIs.
- *Awareness and sensitization workshops for the informal sector (trade associations and small businesses)*: These one-day workshops reached a total of 410 managers, executives and small businesspersons in Accra, Tema/Ashaiman, Kumasi, Takoradi and Tamale; these participants then passed on what they'd learned about HIV to approximately 5,000 apprentices, workers and association members.

Interventions with Sex Workers

IMPACT targeted female sex workers through three subprojects: the Salvation Army “Roamers” (itinerant sex workers) Project in Accra and Tema, the Red Cross Drop-in Center for Roamers in Agbobloshie/Accra, and the West Africa Project Against AIDS and STIs (WAPCAS) in Accra, Tema/Ashaiman and Sekondi/Takoradi.

Baseline Findings

Two rounds of the BSS were conducted among female sex workers in 2000 and 2002. The data they generated produced baseline information for the program.

The 2002 BSS study about condom use found:

- Condom use varied by type of partner: 68 percent used condoms every time with paying clients, while only 30.4 percent used them every time with non-paying clients.
- The four major reasons given for not using condoms were:
 - “Partner doesn’t like it”: 36.8 percent with paying clients and 37.8 percent with non-paying clients.
 - “Partner objected”: 26.3 percent with paying clients and 30 percent with non-paying clients.
 - “Didn’t think of it”: 21.1 percent with paying clients and 23 percent with non-paying clients.

- “Didn’t think it was necessary”: 23.9 percent with paying clients and 22.2 percent with non-paying clients.

These findings suggest that many female sex workers were unable to negotiate safer sex, had a low perception of risk and/or had received inadequate education about HIV/AIDS and condoms.

IMPACT/Ghana’s programs for female “roamers” (itinerant sex workers) therefore focused on increasing awareness, perception of risk and willingness to use condoms during every sexual activity, as well as to make condoms more accessible. Other objectives included the following:

- Reducing gonococcal infection among roamers in three cities.
- Increasing condom use in the last sexual activity among roamers.
- Increasing the proportion of roamers who adopt primary prevention and health-seeking behaviors.

While post-intervention behavioral studies were not conducted, proxy and direct indicators have been used to illustrate program effect among female sex workers at the program sites.

Program Activities

The following major activities were carried out:

- *Baseline data collection*: ISSER conducted geographic mapping of sites, size estimation studies at all sites and formative research to identify key determinants of risk and effective messages.
- *Participatory planning process (PPP)*: A PPP meeting took place in Accra in May 2003, attended by WAPCAS, FHI, sex workers, the Salvation Army, the Red Cross Society, NACP and ISSER. The discussion focused on priorities and concerns, defining the roles of various stakeholders and determining lines of communications and coordination.
- *Developing a BCC strategy*: FHI and WAPCAS conducted a workshop of stakeholders and partners to design a BCC strategy and identify existing materials that could be adapted for use, as well as to determine what new materials needed to be developed.
- *Training of outreach workers and nurses*: Orientation activities, including meetings and preparatory field trips, helped sensitize outreach staff and nurses to sex workers. Training workshops took place in June and November 2003 for all outreach workers and nurses.
- *Outreach and peer education*: These included guided small group discussions on HIV/STIs and other health issues, as well as interpersonal communications between (1) community outreach workers and their peers and (2) community outreach workers and peer educators. Peer educators promoted and distributed male and female condoms and water-based lubricants. More than 12,000 female sex workers were reached.
- *Increased use of STI services*: During outreach visits, 1,795 referral cards were issued to female sex workers to invite them to visit STI clinics in Accra, Tema and Sekondi-Takoradi. All clinics received sensitization training on program activities and the role

they were expected to play. During the program, 111 sex workers reported to these clinics for STI management.

- *Promoting and distributing male and female condoms and water-based lubricants.* At WAPCAS, sales of male condoms almost doubled, while sales of female condoms increased by 500 percent between 2001 and 2003.

I benefited tremendously from the program. Before the program, due to ignorance and embarrassment, I used to self-medicate any time I got infected. Now, I can confidently walk into any STI clinic for effective treatment of my STI. What's more, I now have the capacity to educate my colleagues on the dangers of self-medication.

Female sex worker, community 8, Tema

I am so happy about the project. I used to think the disease was not real but only happens as a result of juju from your colleagues when they are jealous of your numerous customers. Now I know a lot about the disease. It is real and I now use a lot of protection. I use condoms now or I let my customers use condoms.

Female sex worker, Agbobloshie

Developing ART and VCT Programs

In 2002, IMPACT helped the Ghana Police Service AIDS Control Program establish a high-quality voluntary counseling and testing (VCT) center at the Police Hospital as part of a comprehensive HIV/AIDS care program for the uniformed services and for the general public. In 2003, FHI developed a subagreement with the Salvation Army/Ghana to establish a VCT center for the general public at the Anidaso Fie clinic in Accra, aiming to serve an average of 75 clients per week. The main goal of both subagreements was to provide VCT services for those who want to know their serostatus, for pregnant women accessing VCT in the within PMTCT interventions and for those with medical indications.

IMPACT/Ghana played a leading role in developing and implementing new antiretroviral therapy programs, including VCT services, at the Korle Bu Teaching Hospital (KBTH) in October 2003 and at the Komfo Anokye Teaching Hospital (KATH) in January 2004. The main goal of the subagreement with KBTH was to provide VCT services for the general public, for pregnant women seeking PMTCT services and for those with medical indications, and to provide clinical care as needed, including ART. The main goal of the KATH subagreement was to provide start-up support for new clinical services to PLHA in the Ashanti region and adjoining areas by strengthening the hospital's capacity for diagnosis, treatment and prophylaxis of AIDS-related illnesses.

Main Strategies for VCT and Clinical Care

The VCT and HIV/AIDS clinical care strategies specified in the sub-agreements for the program sites included the following:

- Sensitizing 11 VCT staff—service providers, counselors, receptionist, custodians—to reduce stigma.
- Training staff (see Table 2).
- Creating Programme Management Committees and PMTCT support networks.
- Periodic health worker meetings.
- Refurbishing VCT sites.
- Procuring equipment, test kits and supplies.
- Improving STI services.

- Blood chemistry and CD4 investigations of ART patients.
- Ensuring continuous availability of drugs.
- Instituting a post-exposure prophylaxis (PEP) program.
- Strengthening referral systems and other linkages.
- Monitoring and evaluation, including quality assurance of VCT.
- Initiating PMTCT programming.

Major achievements of the VCT services include:

- During the launch of the new VCT services, public awareness campaigns used advertisements, radio programs, brochure distribution, billboards and targeted education programs with selected target groups. The single most effective campaign provided free VCT services in the weeks before and after World AIDS Day 2003.
- Laboratory equipment and some supplies for HIV testing were provided at KATH and Police Hospital.
- Given that services had not been systematically organized or in some cases were nonexistent, VCT, ART and to a lesser extent, PMTCT services improved remarkably. The Salvation Army VCT Centre served 528 clients during the program period, while the Police Hospital VCT Centre counseled 1,253 clients between January 2003 and March 2004.
- Reports from client exit surveys and mystery client interviews suggested that clients were also generally satisfied with the quality of VCT services.
- The quality assurance programs put in place to ensure quality of care were of real value. At the Police Hospital, counselors supported each other and reviewed the quality of their counseling sessions using self-assessment questionnaires during their monthly meetings. The Police Hospital also distributed client-administered exit questionnaires on client satisfaction. Three full-time counselors at the Salvation Army's Anidaso Fie VCT Center provided VCT services for 474 clients between April 2003 and March 2004.
- The Police Hospital trained all doctors, medical assistants and other clinicians at their own and regional facilities in STI clinical care, with the aim of integrating STI management into routine outpatient care delivery. Awareness of STIs among the police services rose: The proportion of policemen in Accra who could identify two or more STI symptoms in women increased from 47 percent in 2000 to 71 percent in 2002.

Some of the achievements of the ART program are as follows:

- Institutional capacity has been built for program implementation and continuity. Many health workers have been trained in counseling (VCT, PMTCT, adherence) and in clinical care (managing opportunistic infections and ART), infrastructure has improved and some computers and laboratory equipment have been provided. Program staff have gained experience in program management overall.
- Infrastructure has been refurbished to ensure that services take place in a more congenial environment. Rooms were painted and televisions, videocassette recorders, computers and accessories, photocopiers, air conditioners, filing cabinets, furniture and other items were supplied. At KATH and KBTH, new counseling rooms were built within open spaces in existing buildings.

- KBTH and KATH enrolled 659 and 149 new HIV clients, respectively, as of April 30, 2004. They started 389 and 75 patients on ART, respectively, over the same period.
- Both KATH and KBTH actively promoted client adherence to ART through counseling to ensure that prospective ART clients clearly understand the goals of clinical care, the expectations of the program and their roles and responsibilities. In addition, clients choose a close relative as an adherence monitor before they are started on the ART drugs. Once this is achieved, compliance with therapy is very high.
- Perhaps the single most impressive achievement is the dramatic reported effect of ART on clients. Service providers and patients themselves attested to gains in body weight and CD4 counts, as well as improvement in their opportunistic infections and overall clinical conditions. As one clinician put it, “It’s as if you have flipped on a switch.”
- Weekly and monthly clinical meetings were held at KBTH and KATH to review the progress of patients on ART and OI management. In addition to providing pre-therapy counseling, adherence counselors ensured that patients on ART had community-based adherence monitors to observe the clients taking their drugs at home. They also monitored compliance through pill counts. National protocols for VCT counseling and ART were used at the program sites.
- On their own initiative, ART staff at KATH developed a nurse-led system for streamlining patient flow and reducing case loads through a triage system.
- Both KATH and KBTH set up a PEP program for health care providers. At KATH, about 650 health workers received training and sensitization on PEP in February 2004, and the hospital has developed a laminated poster of the hospital’s PEP protocol. KBTH’s ART team is reviewing a draft PEP policy document. Training also took place at the Police Hospital and Salvation Army sites (see Table 2).

Table 2: Training Programs Undertaken in Intervention Areas

Description of training	KATH	KBTH	Police Hospital	Salvation Army
VCT counseling	29 (NACP)	99	29	17
PMTCT counseling	-	96	N/A	N/A
Management of OIs and ART	20	89	N/A	N/A
Adherence counseling	20 (as for ART)	35	N/A	N/A
Other training in HIV testing	0	0	3	1
<i>Total</i>	49	319	32	18

From a 42-year-old male TB and ART client at KATH ...

“I was diagnosed HIV-positive in 2000, when I was asked to do a medical check-up as a requirement for the application of a visa to travel outside the country. I was very much surprised because I felt very healthy and strong at the time. A year later my wife fell ill and died of what was diagnosed as AIDS. I was very apprehensive and wondered if I would also go the same way. It took me three years before I started coughing. I overlooked my ailment until one morning when I coughed up phlegm with blood. Initially, I went to a drug store, where I was given some worm treatment without improvement. Later I felt something in my chest and when I coughed, I brought out pure blood with a clot. I immediately went to the hospital where they did X-rays and examined my phlegm. I was then told I had TB and it was reconfirmed that I was HIV-positive. I was started on TB treatment on the 25th September 2003. My fears were somewhat allayed when I was assured that some HIV drugs were expected this year for the HIV patients.

“After I started the TB treatment, the cough stopped and I did not see any blood again. I slimmed down very much and my weight, which had been around 100kg, dropped to 80kg. I started on the ARVs one month ago after a series of lab tests and I have come for my second month’s supply. I went through counseling three times to make sure that I understood everything about the drugs and that I have someone to help me before I was put on the drugs. At first, I did not understand but now I am happy about the counseling.

“Now I can feel my immune system is improving because I don’t feel the weakness I use to feel with the TB drugs. When I wake up in the morning, I feel stronger daily. I used to feel weak with some pains here and there but I am now OK. I now weigh 92 kg. The only thing with these drugs is that they make you eat very well. If you don’t eat well, you feel it.

“I like everything about the clinic. You could see there is a lot of pressure on the staff but the doctor tries to see everybody and the nurses are nice and approachable and they try their best to explain everything to us.

“The problems I have are that even though we are told the drugs have been subsidized, the ₦50,000 is still too much for some of us because I am not working. At times, you may be given a prescription to buy blood tonic or some other drugs for which you have to pay since they are not free. With TB treatment, we are given some tea but I have not seen anything like that with the ARVs. Most of the problems I have concerns our behavior as patients; some of us are not patient at all and we fail to comply with the directives of the nurses, which is bad.”

From a 56-year-old female former dispensary technician on ART...

“This is the tenth time I have attended this clinic. In fact it is the only clinic I am attending.

“I had a boyfriend who was positive and I did not know. Later, I started having rashes all over my body with sores and started growing lean. I went to PPAG at Laterbiokoshie. They received me very well, counseled me, took my blood and asked me to report back in three days’ time. When I went back, I was told I was HIV- positive. The staff of PPAG brought me to the Fevers’ Unit and introduced me to the sisters about two years ago. I started having treatment for the skin condition and was occasionally seen by a dermatologist. I was given drugs such as flucloxacillin, Piriton, Septrin and blood tonic. Anytime I came, I went to the lab then I’m counseled and given the routine drugs. I later started having some vaginal infection. I started using potassium permanganate and the doctor advised me to continue. There was not much improvement on these treatments as my condition continued to deteriorate.

“In January this year I had my CD4 count measured and was put on ART since February. I was counseled, told what to eat and what not to eat. After I started treatment, I got more rashes and the itching got worse. I had the vaginal thrush again and I was put on drugs. I came back to report to the doctor but he advised me to continue. This went on until last month when I realized I was getting better. Now the skin rashes are all gone and I have started putting on some weight.

“The staff here is doing well. Whenever you go to the consulting room, the doctor receives you, asks questions about your health—they are good to me. The nurses are also good to us. I’ve worked with nurses for many years but these nurses here—they are better. They are sensitive to our needs. Some clients don’t have the patience and start shouting at the nurses over there. The nurses cope very well with the insults.

“The place is comfortable to me but there is congestion. There are a lot of places around the facility that can be used as waiting rooms and maybe they should look into that. There is a lot of confidentiality here. When they are on break, they lock up everything so that nobody can get access to our records. The files are kept better than they were kept at the other side.”

Youth-focused Programs

The youth subprojects were implemented by four FBOs—the Presbyterian Church of Ghana (PCG), the Church of Pentecost (COP), the Muslim Relief Association of Ghana (MURAG) and the Salvation Army (SA)—and other organizations and NGOs, such as the Ghana Red Cross Society (GRCS), the Girl Guides Association, Rural Watch and World Vision Ghana (WVG).

The key role played by churches and FBOs reflected IMPACT’s growing realization—based on needs assessments and program experience—that the support of the adult population within the faith-based communities was critical to successfully launch and sustain a youth program. Subproject amendments therefore included the clergy and other elders and influential FBO leaders. Programs for adults in FBO communities were created at the same time, which led to broader community understanding of the epidemic,

community-wide awareness of the need to practice safer behaviors and increased support for sustainable youth programs.

Program Activities

IMPACT/Ghana's youth-focused programs have reached an estimated one million people. Activities common to many or all of the programs include the following:

- Peer education.
- Training of approximately 1,332 people as peer educators, counselors and other types of community-based educators.
- Counseling and house-to-house visits.
- Community educational sessions.
- AIDS education at special events, such as weddings.
- Creating of "action clubs" for youth.
- Establishing HIV/AIDS committees in many places of worship.
- Integrating HIV/AIDS messages and presentations into sermons and other religious activities by religious leaders.

Program Activities at Christian Churches and FBOs

Special HIV/AIDS programs have now been established within COP and PCG at the national level, with full-time staff to focus on HIV/AIDS-related issues and with resource mobilization to continue activities initiated through IMPACT, including training of peer educators. Related activities include the following:

- Establishing HIV/AIDS committees in each church.
- Counseling for members of COP and PCG.
- Opening a youth-friendly resource center in Tema with a full-time coordinator, with the full backing of the COP.
- Developing and disseminating a PGC church policy on HIV/AIDS.
- Producing a counselor's training manual by PCG that can be used by other Christian denominations.

The COP project trained more than 626 persons—including pastors, Sunday school teachers, youth leaders and church elders—to counsel church members and others in the community on HIV/AIDS, marriage and abstinence before marriage, as well as to counter stigmatizing attitudes about PLHA. A significant COP achievement has been the youth-friendly drop-in center in Tema. This center is staffed with a full-time youth coordinator, has a library, is planning skills development among unemployed youth and has an outreach counseling service with 40 trained counselors as well as a counseling service through the internet. In addition, confidential diagnosis and free treatment for STIs are now provided at COP's six medical facilities.

These activities led to significant contextual changes for COP:

- An office with a program manager and an assistant has been established at headquarters to initiate programs for pastoral care and support, education, prevention and VCT.
- Youth are receiving counseling and other services at the youth drop-in center in Tema.

- PLHA are gradually being accepted.
- Congregants who are HIV-positive are increasing looking to the church for care and support, including help paying for medicine.
- The attitudes of most leaders and church members are improving. Most pastors are more tolerant about discussing AIDS with youth.
- Some pastors have delivered sermons that include information about HIV.
- An NGO has been formed to help PLHA.
- Plans are being developed for the care of orphans and vulnerable children.
- Confidential diagnosis and free treatment for STDs are provided at the Church's medical facilities.
- The Church continues to promote HIV testing before marriage but does not pressure congregants to get tested.
- Sex and sexuality are no longer taboo topics.
- The COP now recommends use of condoms for married couples in situations when one or both spouses are infected with the disease.

The PCG implemented all major planned activities. A total of 724 persons, including ministers, district officers, peer educators and nurses, as well as 31 university students, received training and were able to reach out to a total of 142,760 persons. The 60 trained counselors who worked within the youth program counseled a total of 2,950 youth. To guide the church's response to the HIV/AIDS epidemic, a pastoral policy was developed with the help of FHI and a consultant. The moderator of the General Assembly of PCG, who is also the chairman of the AIDS Committee, released the 28-page policy document in February 2002.

Important contextual changes have resulted from PCG's activities:

- Many ministers and pastors are including AIDS content in their sermons.
- HIV/AIDS is no longer a taboo subject among youth.
- There are known PLHA in the congregations who appear to be accepted by other congregants. Some presbyteries have developed care and support proposals and are approaching the GAC for funding.
- PLHA from the congregation are coming to the program to seek help voluntarily.
- Negative attitudes about condom use are less apparent.
- Churches are contributing funds to support PLHA.
- Presbyteries have intensified AIDS education.
- Three presbyteries have established committees to facilitate to help implement HIV programs.

Program Activities of the Muslim Relief Association of Ghana (MURAG)

MURAG's target population was primarily out-of-school youth. The organization developed a unique program to reach youths at places—called “bases”—where they gather socially. MURAG identified 102 such bases and sent 259 trained peer educators, male and female, to reach approximately 23,500 youth, who were predominantly Muslim.

Other MURAG activities include:

- Identifying outreach prevention strategies acceptable to Muslim communities (e.g., educating traditional healers and birth attendants to observe universal precautions).
- Broader involvement of religious and community leaders, including imams, ulamas, magajiahs and market queens.
- Integrating HIV/AIDS themes into the sermons of Islamic clerics.
- Developing and translating BCC materials, such as “A Guide to Islam and AIDS.”

Other Islamic communities outside IMPACT-supported areas have adopted many of these strategies and are also using BCC materials developed during the program.

It is reasonable to expect that if behaviors changed within this community as a result of the interventions, there would be a reduction in the incidence and eventual prevalence of HIV/AIDS within the Muslim communities of Nima and Maamobi. At the Maamobi polyclinic, there was a dramatic decline in reported STI cases, from 21 in month one to zero in month twelve. This low incidence of STIs was maintained almost until the program ended.

Program Activities of NGOs and Associations

The Ghana Girl Guides Association worked with 55 schools and trained 176 peer educators (an average of three peer educators per school), who were able to reach out directly to 2,800 students.

Rural Watch worked with 15 beneficiary schools, helping to establish reproductive health clubs. In addition, 525 peer educators were trained, and they in turn were able to directly reach 6,000 other students, 1,000 more than the original target number. Seminars, quiz competitions and symposia were organized for the participating schools.

The Ghana Red Cross exceeded its planned training target by training 128 peer educators (instead of the original target of 36) in three districts of the Ashanti Region: Kumasi, Amansie East and Kwabre. These peer educators reached 15,640 students, about 70 percent more than the original goal of 9,200.

Care and Support for PLHA and Orphans and Vulnerable Children (OVC)

As part of efforts to support the West and Central Africa Regional Workshop on Orphans and other Vulnerable Children in Yamoussoukro, Côte d'Ivoire, IMPACT/Ghana provided funding for a local consultant to write a report entitled "Status of Care for Children That Are Orphaned and/or Vulnerable due to HIV and AIDS in Ghana." IMPACT also sponsored the participation of an implementing partner, the Manya Krobo Queen Mothers Association, to participate in a workshop where the report would be presented.

The aim of the workshop was to build capacity and commitment throughout West and Central Africa and to respond to the enormous challenges posed by the HIV/AIDS pandemic, particularly to the children of Africa. The workshop also sought to help participants formulate country-specific action plans and give the regional and global planners some idea of the resources needed to support country-level actions. Ghana's five-member delegation, led by the Ghana AIDS Commission, included a representative from the Ministry of Social Welfare, two NGO representatives (a PLHA association and Manya Krobo Queen Mothers Association/HIV/AIDS program) and a representative from UNAIDS.

LESSONS LEARNED AND RECOMMENDATIONS

The IMPACT Project in Ghana gained many insights into comprehensive HIV/AIDS programming. One of the most important elements of a successful intervention is ongoing support from top management. Peer education and counseling are effective tools for behavior change communication (BCC) activities, as are training and capacity-building efforts.

Overall Program Management

Integrating projects into existing management structures: Program management structure should be integrated into the overall management structure of participating institutions to attract support from institutional authorities. Institutional strategic HIV/AIDS plans should be developed to guide HIV/AIDS interventions.

Improving service quality, affordability and uptake: Quality assurance mechanisms, including clinical review meetings, counselors' meetings, adherence monitoring and client exit interviews, should be institutionalized. HMIS should be strengthened and program activities adequately documented. Cost of services should be reviewed to determine whether they're affordable for clients. Finally, linkages between implementing agencies and PLHA groups as well as with the Ghana Health Service should be actively pursued to improve care of PLHA and community-based follow-up services. The mix of staff skills can be improved by involving sociologists, psychologists, religious leaders and public health practitioners. Awareness campaigns among the general public ensure high service uptake.

Workplace Programs

Reaching out to management: Senior management or business owners need to be "on board" before HIV/AIDS workplace programs begin so they understand the value of such programs for their work force. Management concerns (e.g., loss of productivity if workers take off time to attend program activities) need to be addressed as early as possible. Actively engage line managers and supervisors through briefings and staff meetings and as part of advocacy activities; their commitment is also critical to the success of the program.

Countering stigma and discrimination: Stigma can easily derail a workplace prevention and care program by discouraging employees from seeking access to services. Some African companies that offer treatment are now facing lower-than-expected uptake of ART because potential clients fear stigma. Research indicates that some workers may be more comfortable using services and attending PLHA support groups that are based in the community, rather than on site, to maintain anonymity.

Reaching out to families and the community: Offering HIV/AIDS services to company workers but not to family and community members can have a negative impact on the program. It is critically important to establish inclusive HIV/AIDS workplace policies, strengthen care and support services in the community as well as on site, and ensure buy-in and involvement of both workplace staff and the greater community. Management

must encourage the formation of workplace HIV/AIDS committees and/or support groups for PLHA.

Sex Worker Interventions

Starting interventions early: Because sex work is illegal and highly stigmatized in Ghana, it takes time to gain the trust of sex workers. Once that trust is achieved, though, sex workers can become very active in prevention programs. Some services, including VCT, may thus have slow initial uptake among stigmatized populations and take a long time to achieve full patronage.

Gaining access: It is often difficult to gain and maintain access to sex workers. Periodic police harassment and the occasional closure of hotels where some sex work takes place contribute to the difficulty in maintaining contact. To overcome these barriers, community outreach workers often had to work late at night.

Using peer education to reach itinerant sex workers: Peer educators are particularly skilled at reaching hard-to-reach mobile sex workers (“roamers”) because they are trusted and know where their counterparts operate. That trust is particularly important in overcoming competitiveness among roamers, which can make it difficult to bring them together for peer education activities. Peer education sessions also helped make the program widely known to the target group.

Promoting condoms: To maximize condom promotion and sales among roamers, program implementers should make condoms and lubricating gels available, accessible and affordable. Issues such as condom availability, training for correct usage and record keeping of distribution are all important components of sex worker interventions.

Benefiting from partnerships: All the partners involved in the sex worker program (Red Cross, WAPCAS and the Salvation Army) felt that collaboration with other agencies ensured wider program coverage. Many felt that WAPCAS, which has much experience working with sex workers, was an invaluable mentor to the other organizations. Bimonthly partner meetings provided a forum for sharing challenges.

Youth-focused Programs

Getting early approval and buy-in from national and local educational agencies and from students: For youth-centered activities, seek required approval from the Ghana Education Service (GES) and the relevant local school authorities before the program starts. The approval process helped gain early support, cooperation and involvement of educators and administrators. Additionally, sensitizing students before programs begin ensures their sustained interest in reproductive health and related HIV/AIDS activities.

Enlisting teachers to lead activities: Teachers in the Rural Watch program volunteered to be Reproductive Health Club Patrons, which made it much easier to include the activities in the regular school schedule and to organize such off-campus activities as symposia and quiz competitions.

Helping youth understand AIDS by exposing them to PLHA: Implementing agencies found that young people learn better when they can see firsthand what they're learning about – in this case, the reality of HIV disease. Interactive sessions with PLHA made a strong impression on the youth and helped draw them in to the program's activities. Additionally, young people enjoyed such activities as symposia and interschool quiz competitions, which proved successful in sustaining their interest.

Interventions with Faith-based Organizations

Involving religious leaders: As for any program, but perhaps even more so in a faith-based setting, the commitment of the minister, imam or other religious leaders is critical to the success of HIV/AIDS projects, particularly behavior change activities. A necessary first step to prepare religious leaders for this role is often intensive education about HIV and AIDS and reproductive health. The spouses of religious leaders should also be included in educational activities because some youth find it easier to talk to them about sexuality.

Tailoring the program to the congregation: The Presbyterian Church, which implemented one of IMPACT's programs, found that developing custom-made programs relevant to specific presbyteries takes a lot of energy and time but pays off in the end.

Confronting faith-based misconceptions: The Presbyterian Church found that some church members believe that anyone who is an active churchgoer is not vulnerable to HIV infection. This dangerous misconception prevented many PLHA from disclosing their status and seeking much-needed care and support from their fellow congregants.

Using drama as an educational tool: Many faith-based programs found that drama was a powerful way to teach people about AIDS.

Discussing difficult issues: Talking frankly about such topics as sexual relations, contraception and multiple partners can be very difficult for both faith-based leaders and their congregants. While it's extremely important to involve religious leaders in message development and delivery, they may not be best at leading discussions on reproductive and sexual health. Peer-led interventions can be much more effective, especially for young church members. Sometimes unemployed youth become involved as peer educators and may demand financial "motivation." In these cases, programs can develop innovative non-monetary incentives to keep such youth active.

Sustaining the impact: Future faith-based programs should incorporate follow-up schedules and strategies to provide sustained HIV/AIDS preventive education and care and support for PLHA. More faith-based organizations should become involved in home-based care, a service they are well-suited to organize and deliver.

Programs for the Uniformed Services

Involving top officials in advocacy: Advocacy for HIV/AIDS interventions is essential when working with uniformed services. Advocacy should be an ongoing rather than a one-time or sporadic activity, for the top officials among the key players in HIV/AIDS in-country as well as for core team members.

Tailoring BCC interventions to the uniformed services: BCC activities for the uniformed services should include drug and alcohol abuse and its role in HIV/AIDS/STI. Future interventions with the uniformed services should also focus on stigma reduction. Nurses and doctors in prison infirmaries should be included in BCC training process because they are always available to follow-up, supervise and reinforce messages.

Preparing promotional and educational materials: Peer educators need to be equipped with such BCC materials as promotional handouts (leaflets, keychains and videos about STIs, HIV/AIDS, VCT and PLHA). Videos were very popular among members of the uniformed services members, and peer educators should have access to equipment for showing films.

Choosing and training peer educators: The criteria for selecting peer educators in the uniformed services should include good communication skills, competence, desire to do the work and positive attitudes about AIDS-related issues. Some involved in the program feel that the three-day training course for peer educators was insufficient and recommend that it be extended to at least five days, with a one-day refresher course offered every three to six months. Stigma reduction should be incorporated into the training.

Improving peer education for the uniformed services: The peer education components of the uniformed services program need to be intensified at the sites where the program has been implemented and scaled up to other regions. Additionally, the peer education training manual should be reviewed and updated to incorporate alcohol and drug abuse. Peer education activities in the prisons should incorporate messages and discussion about the risk of HIV infection through same-sex sexual activities. Programs for the uniformed services should include informative field trips, such as visits to a PLHA association or VCT and STI clinics, to facilitate referrals to these services.

Promoting condom use: Demonstrating condom use and distributing condoms were an integral part of the uniform services program. Selling condoms rather than distributing them for free was considered a much better strategy for uniformed services programs because it made them more valuable to those who bought them. However, as demand for condoms increased, supply was often insufficient. To combat this, regional core teams should monitor supplies carefully and restock efficiently. In future programs, female condoms should also be promoted and sold.

Keeping careful records: All staff and volunteers involved in uniformed services interventions should be involved in data collection and record keeping, including regional core team members, peer educators and overall program managers. Extensive training on how to collect information monthly on all the different activities of peer educators should be organized for core team members. Peer educators should submit monthly reports on their activities to regional core team members for quarterly summaries. Core team members should collect completed forms every three months when they go for supervision; a checklist for this task would have been extremely useful. Monitoring and evaluation (M&E) plans should be created for each implementing agency. Selection and training of an M&E officer from core teams from each agency would greatly improve monitoring, data management and general record keeping.

VCT, PMTCT and Clinical Care Services

Building strong management: Active program management committees have proved invaluable to implementing well-managed HIV preventive and clinical care programs. This is particularly important in the overall guidance and monitoring of nascent or innovative projects. Examples of this are the projects at KATH and the Police Hospital, where well-organized management structures integrated new activities into existing institutional structures and solicited support from the central administration.

Ensuring service quality and increasing uptake: Some of the critical factors for a successful HIV clinical care program are availability of ARVs, providing services at affordable costs, dedicated and well-trained staff, a well-functioning laboratory, a good referral system, an effective quality assurance system and good leadership. Quality assurance mechanisms, including clinical review meetings, counselors' meetings, adherence monitoring and client exit interviews, should be implemented. In addition to ART services, managing OIs effectively reduces HIV-related morbidity and improves quality of life for PLHA. All of these services should be promoted through mass media campaigns and VCT services.

Improving VCT services: VCT facilities should provide one-stop services that include counseling, HIV testing, adherence counseling and pharmacies, all within a reasonable distance from each other. Such an arrangement would, for example, help clients get their test results. Improved design of counseling rooms should ease congestion, making them more comfortable for clients.

HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITY

I. Implementing Partner Matrix

Contracts and Subagreements: IMPACT (Award Number HRN-A-00-97-00017-00)
(from General Ledger as of August 2004)

Current FCO #	Recipient Name	Completion Date	Start Date	Life of Project Budget US \$	Total Funding US\$
85353	Korle Bu Teaching Hospital	06/30/04	10/01/03	159,146	151,361
84592	Komfo Anokye Teaching Hospital	04/30/04	01/15/04	70,478	69,846
84594	Centre Hospitalier Universitaire	04/30/04	03/15/03	159,965	175,241
84598	Red Cross Society	04/30/04	03/15/03	19,875	21,719
84599	Salvation Army	04/30/04	03/15/03	27,757	27,319
85358	Salvation Army	03/31/04	02/01/03	63,373	63,337
85754	Ghana Police Service	03/31/04	09/09/02	51,208	50,852
84597	Private Enterprise Foundation	12/31/03	10/01/01	137,049	140,158
84593	ISSER: CSW Project	11/30/03	05/01/03	107,824	104,926
85753	Fire Service HIV/AIDS Programme	10/31/03	11/01/02	116,655	117,342
85636	Rural Watch	09/30/03	01/01/02	34,545	33,600
85355	Presbyterian Church/Youth Project	08/31/03	01/01/01	148,661	148,592
85756	Queen Mothers	08/31/03	03/12/01	75,539	72,579
85757	Muslim Relief Association Ghana	07/31/03	06/01/01	81,502	81,670
84803	Prison Services	06/30/03	03/01/01	91,504	89,886
85637	Ghana Armed Forces	04/30/03	01/01/02	75,417	66,386
85639	Ghana Customs Service	04/30/03	01/01/02	88,773	82,918
85755	Church Pentecost: HIV/AIDS Ed.	04/30/03	12/01/00	114,609	114,610
85758	Red Cross	04/30/03	03/01/01	80,717	67,257
85759	World Vision HIV/AIDS Programme	04/30/03	05/01/02	78,600	78,526
85357	Research Int'l: BSS2	04/15/03	06/01/02	105,321	101,313
84596	Salvation Army	03/31/03	10/01/01	65,437	57,909
84936	Ministry of Health	02/28/03	03/01/01	32,325	18,057
84801	Ghana Girls Guides	05/31/02	02/15/01	73,789	69,645
85638	Ghana Immigration Service	04/30/02	01/01/02	64,886	58,729
84802	Police Services	03/31/02	03/01/01	78,349	66,751
84804	African-Caribbean Institute	10/31/01	02/05/01	34,126	29,599
84935	Red Cross: Youth HIV/AIDS Project	08/31/01	01/24/00	41,563	38,990
84825	GAFACP (Ghana Armed Forces	07/27/01	02/28/00	39,977	32,639
	AIDS Control Program)				
85015	Research Int'l.: BSS1	07/15/01	07/15/00	96,929	95,330
84925	Salvation Army - Capacity. Strengthening in HIV/AIDS Activities	06/30/01	02/03/00	39,867	31,107

84595	PEF (Private Enterprise Foundation)	05/31/01	01/01/01	19,237	15,670
84605	HRU (Health Research Unit)/PI 6& 7	01/31/01	06/01/00	55,469	54,669
84815	Ghana Police - Police Services	08/31/00	11/01/98	64,642	52,651
	AIDS Control Program.				
84820	NACP (National AIDS/STD Control Program) - AIDS/STD Control	07/31/00	11/01/98	167,121	117,128
85025	Pediatric: Seminar on Pediatric HIV/AIDS	07/31/00	05/10/00	1,500	1,296
84805	Nat'l Labs - TA to Ghana PH Labs	05/31/00	11/01/98	53,703	52,342

II. Summary of All Subprojects Supported by IMPACT/Ghana

IA Name	Project Title	Effective	Expires
Salvation Army	Outreach and Peer Education Among Young "Roamers" in Accra - Tema	3/15/2003	6/30/2004
Red Cross (Drop-in Center)	Drop In Center for Roamers in Agbobloshie, Accra	3/13/2003	6/30/2004
ISSER (mapping)	Roamers Census and Formative Assessment: CSW Project in Ghana	4/15/2003	8/15/2003
Salvation Army	Salvation Army HIV/AIDS Program	10/1/2001	2/28/2003
Ghana Red Cross Society	GRCS Youth with Youth HIV/AIDS Peer Education Program	3/1/2001	2/28/2003
World Vision International	WV/Ghana HIV/AIDS Program	5/1/2002	4/30/2003
Immigration Services	Ghana Immigration Services HIV/AIDS Program	1/1/2002	12/31/2002
Customs, Excise and Preventive Service	Customs, Excise and Preventive Service HIV/AIDS Program	1/1/2002	12/31/2002
Ghana Police Service	Ghana Police VCT	9/9/2002	9/8/2003
Ghana Fire Service	Ghana Fire Service HIV/AIDS Program	11/1/2002	10/31/2003
Ghana Armed Forces	Ghana Armed Forces HIV/AIDS Program	1/1/2002	12/2/2002
Church of Pentecost	Church of Pentecost HIV/AIDS Education/Counseling Program	12/1/2000	12/31/2002
Muslim Relief Assoc. of Ghana (MURAG)	Youth HIV/AIDS Peer Education Project at Nima and Maamobi	6/1/2001	7/31/2003
Private Enterprise Foundation (PEF)	Support to PEF Workplace HIV/AIDS Program	10/01/2001	9/30/2003
Presbyterian Church of Ghana	Presbyterian Church of Ghana HIV/AIDS Project	1/1/2001	12/30/2002
Rural Watch	Support to In School Youth	1/1/2002	12/31/2002
Manya Krobo Queen Mothers Association	Support to Queen Mothers Association of Manya Krobo	3/12/2001	8/31/2003
Research International	BSS2	6/1/2002	12/15/2002
Salvation Army (VCT)	Salvation Army Voluntary Counseling		
WAPCAS (Univ. of Sherbrooke)/Centre Hospitalier Universitaire	Female Sex Workers Intervention	3/15/2003	6/30/2004
Korle Bu Teaching Hospital	Clinical Care (ART, VCT, PMTCT)	10/01/03	06/30/04
Komfo Anokye Teaching Hospital	Clinical Care (ART, VCT, PMTCT)	01/15/04	04/30/04
ISSER	Size estimation study of female sex workers in selected sites in Ghana	05/01/03	11/30/03
Ministry of Health	Support for technical assistance (non-subproject based)	03/01/01	02/28/03
Ghana Girls Guides		02/15/01	05/31/02

IA Name	Project Title	Effective	Expires
Ghana Police Services	Police Services AIDS Control Program	03/01/01	03/31/02
Ghana Red Cross	Youth HIV/AIDS Project	01/24/00	08/31/01
GAF	Ghana Armed Forces AIDS Control Program	02/28/00	07/27/01
Research International	Implementation of Behavioral Surveillance Surveys	07/15/00	07/15/01
Salvation Army	Capacity Strengthening in HIV/AIDS Activities	02/03/00	06/30/01
PEF (Private Enterprise Foundation)	Workplace Program	01/01/01	05/31/01
HRU (Health Research Unit)	Support for Implementation of STI PI 6 & 7 studies	06/01/00	01/31/01
Ghana Police	Police Services AIDS Control Program	11/01/98	08/31/00
Pediatric centers	Seminar on Pediatric HIV/AIDS	05/10/00	07/31/00
NACP	Strengthening AIDS/STD Control	11/01/98	07/31/00
National Public Health Laboratory Nat'l Labs	Technical Assistance and Capacity Building	11/01/98	05/31/00

ATTACHMENTS

ATTACHMENT A: Data on Condom Use in the Uniformed Services

About 36 percent of policemen identified police stations as a source of condoms in 2002, compared to 0.6 percent in 2000, a reflection of the success of condom promotion activities and the enabling environment created by the program (see Figure A). Other positive indications of increased condom use among the police are shown in Figure B. For example, the percentage of police respondents reporting that they used a condom with non-regular, noncommercial sexual partners every time in the past 12 months increased from 20.8 percent at round one to 50.8 percent at round two; for every-time condom use with commercial partners, the percentage rose from 80 percent to 92.7 percent between rounds.

Figure A: Sources of Condoms Reported by Police

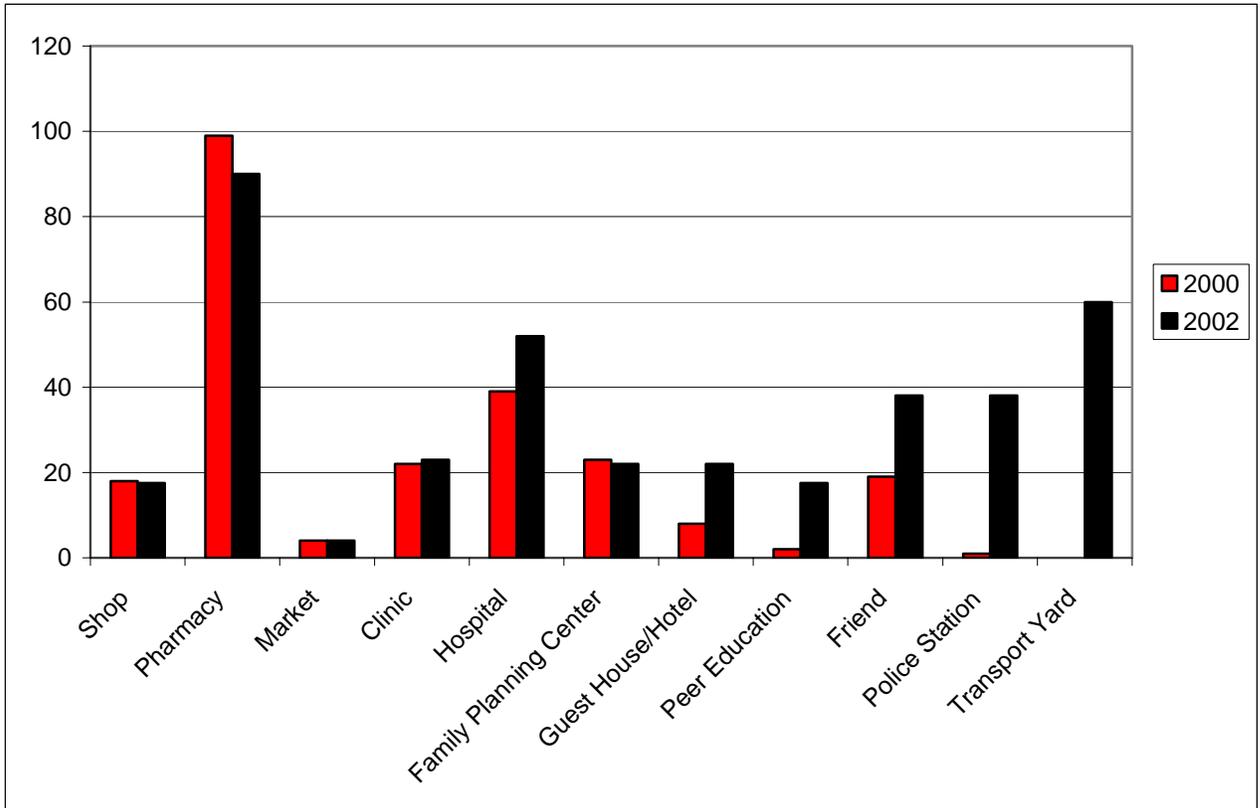
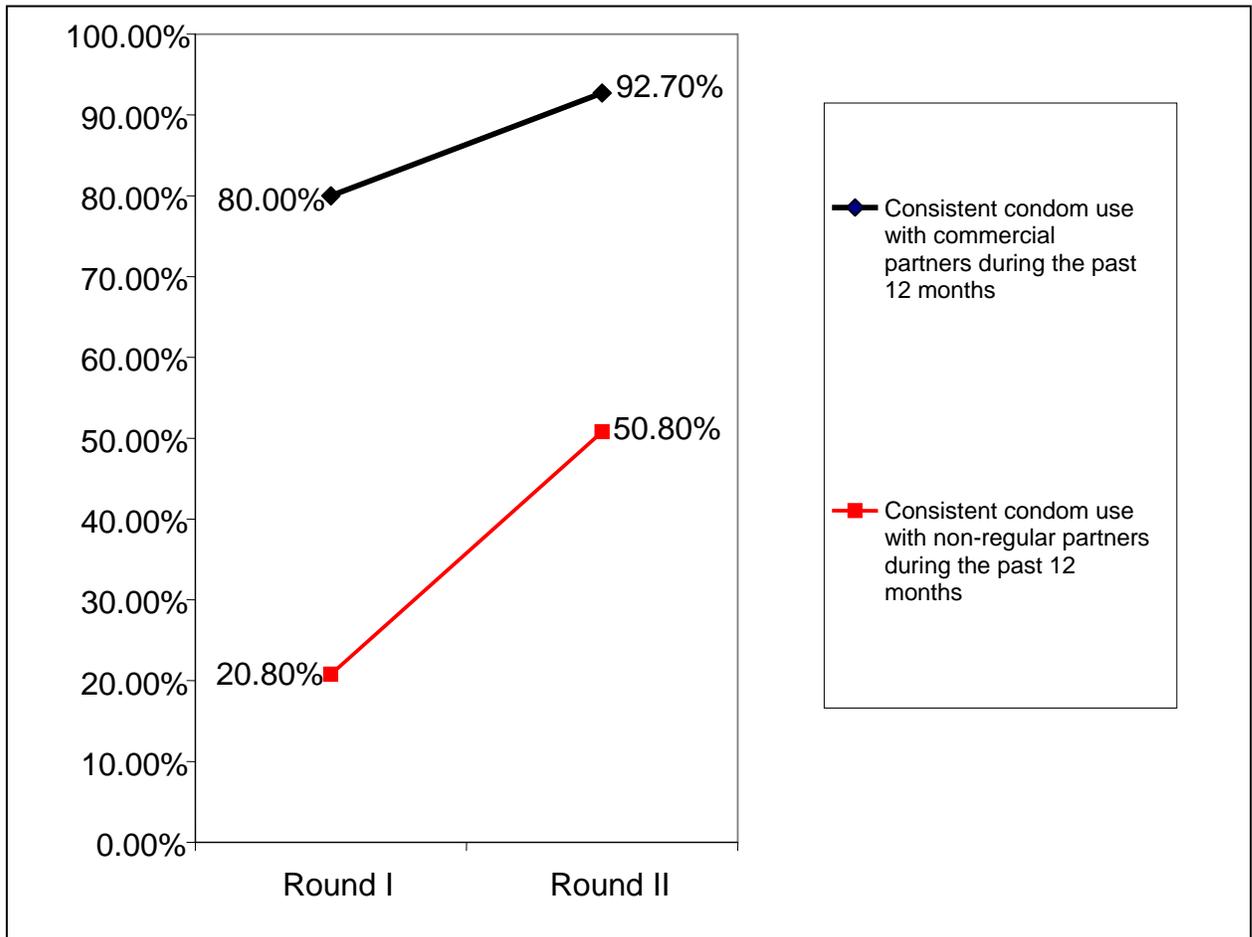


Figure B: Police Reporting Consistent (100%) Condom Use with Regular and Commercial Partners over the Past 12 Months



ATTACHMENT B: Summary Data on Program Performance

I. Number of Persons Trained and Reached by Subprojects

SUBPROJECT	No. of Persons Trained			No. of Persons Reached.
	Male	Female	Total	
Uniformed Services				
Ghana Armed Forces			359	10,000
Ghana Police Service			0	0
Ghana Prisons Service			992	15,000
Ghana National Fire Service			196	4,500
Ghana Customs, Excise and Preventive Svc.			171	3,000
Ghana Immigration Service			297	0
			2,015	32,500
Faith-based Organizations				
Presbyterian Church of Ghana (PCG)	612	22	634	142,760+
Muslim Relieve Association of Ghana	130	129	259	27,300+
Church of Pentecost (COP)			429	100,000+
Salvation Army (SA)				
			1,322	270,060
Workplace Programs				
Tema Oil Refinery (TOR)			42	2,500
Ghana Cement Man. Co. Ltd. – Tema			26	1,500
Ghana Cement Man. Co. Ltd – Takoradi			22	1,500
Ghana Agro-Food Company Ltd.			24	3,000
Crocodile Matchets			22	1,500
SCANSTYLE			22	1,800
AYUM Timber			40	2,000
Informal Sector Executives of Small Trade Associations and Small Businesses			410	5,000
			608	18,800
Youth NGOs				
Rural Watch			525	6,000
Red Cross			128	15,914
Salvation Army			234	24,600
World Vision Ghana			355	267,000
Ghana Girl Guides			176	2,800
			938	316,314
Female Sex Workers				
Salvation Army			15	3,013
WAPCAS (Tema & Sekondi-Takoradi)			36	1,297
Ghana Red Cross Society			15	2,361
			66	6,671
Community				
Manya Krobo Queen Mothers			291	No records

ATTACHMENT C: Activities of Faith-based Projects

I. Activities under Presbyterian Church of Ghana Youth Project

MAJOR PLANNED ACTIVITIES	EXPECTED OUTCOME	KEY COLLABORATORS	ACHIEVEMENTS
Support salary for project assistant	Project well managed	PCG elders and FHI	Full-time project assistant in place
Equip/refurbish office of project assistant	Managed and documented		
<ul style="list-style-type: none"> Air conditioner 		PCG and FHI	HIV/AIDS secretariat in place
<ul style="list-style-type: none"> Printer 			Information system in its infancy
<ul style="list-style-type: none"> Photocopier 			
Development and pretest of logo	Project easily identified		Project logo on all documents, t-shirts, caps, etc.
Provide HIV/AIDS education/counseling training for: <ul style="list-style-type: none"> 13 youth coordinators 1 national coordinator 1 project assistant 	Trained coordinators facilitating the peer educators at each presbytery to provide outreach	<ul style="list-style-type: none"> PCG national coordinator Peer educators Project assistant Pastors NACP 	Youth coordinator at each presbytery. Project assistant trained and in place.
Conduct six 5-day HIV/STI peer education residential workshops for all 184 District Officers within the country	Peer educators know the relationship between HIV/AIDS, how to teach basic facts on AIDS its transmission, prevention, care and support	FHI, NACP, PCG	184 district officers from the 13 presbyteries trained and functioning.
Carry out educational sermons by peer educators in churches in the districts	Youth listen to their peers and are influenced to change behavior.	Pastors, peer educators, coordinators	Peer educators conducting health education in Churches, societies and the larger community.
<ul style="list-style-type: none"> Linkage of youth-friendly doctors, medical assistants and nurses to the National Youth Council (NYC) of PCG 	Youth motivated to seek VCT	Doctors and nurses at Presbyterian Hospitals	Youth-friendly health services established in the 4 health institutions run by the Church. Youth seeking VCT, cannot however be deciphered from existing records.
<ul style="list-style-type: none"> Select 60 nurses for PCG clinics for training 	Nurses better equipped to do counseling and VCT	Presbyterian Health Services	
Formation of HIV/AIDS/STI action clubs with the youth ministry of the church	Formation of Action Clubs	GES, NACP PCG, FHI	60 AIDS Action clubs formed. The main activities promoted consult of self-esteem and confidence building for promoting

MAJOR PLANNED ACTIVITIES	EXPECTED OUTCOME	KEY COLLABORATORS	ACHIEVEMENTS
			<p>abstinence as well as other reproductive health issues.</p> <p>They are also engaged in house-to- house and person-to-person awareness campaigns. Some move from congregation to congregation in towns and villages showing videotapes on STIs/HIV/AIDS, organize talks, football matches, etc., during which they distribute STD/HIV/AIDS materials.</p>
Organize a national quiz on HIV/AIDS/STI as part of a national youth conference in 2001	Youth motivated to understand and adopt healthy sexual behavior	GES, NACP PCG, FHI	Done (August 2 to 5, 2001)
Collaborate with the “Christian Messenger” to feature special issue in its monthly publications and networking.	Outreach of information to community members on a monthly basis.	PCG, Christian Monitor, World Council of Churches, Christian Council of Ghana, Bank of Ghana, COP, WAPCAS, MOH, GAC, NACP	Articles on HIV/AIDS now appear in issues of the “Christian Messenger” and “The Presbyterian,” the two main PCG monthly newspapers.
Establish linkages with other IMPACT/Ghana implementing agencies	Shared knowledge and skills	FHI/PCG/COP	Worked closely with COP on policy development
Get technical assistance and educational materials from the NACP	All acceptable messages available to PCG congregants	NACP, PCG	Materials identified and made available

II. Activities under Amendments 1, 2, and 3 of Presbyterian Church of Ghana HIV/AIDS Project

MAJOR PLANNED ACTIVITIES	EXPECTED OUTCOME	KEY COLLABORATORS	ACHIEVEMENTS
<ul style="list-style-type: none"> Developing church HIV/AIDS policy 	Policy to guide church's interventions	FHI/MAP International.	Policy developed in a participatory manner and more than 5,000 copies distributed to all presbyteries nationwide.
<ul style="list-style-type: none"> Evaluating Presbyterian Church of Ghana HIV/AIDS Project through evaluation forum to all who benefited 	Grassroots input in the project	All Presbyterians, FHI consultants	Participants from the 13 Presbyteries were involved as well as from the National Union of Presbyterian students guild all project facilitators and consultants, nurses and FH
<ul style="list-style-type: none"> HIV education for PCG ministers in Ghana 	All ministers knowledgeable about HIV/AIDS; able to show compassion and work against stigma and discrimination	FHI/NACP	A total of ____ Ministers, Presbytery Chairpersons and heads of department were trained.
<ul style="list-style-type: none"> Developing teaching manuals for HIV/AIDS education in PCG congregation 	Standard teaching manual consistent with the teaching of the church		A training-of-trainers manual for counselors developed

III. Training Conducted by Presbyterian Church of Ghana

TRAINING TYPE	NUMBER TRAINED		INTENDED TARGET	ACTUAL TARGET TRAINED	NUMBERS REACHED
	M	F			
	Sex				
	M	F			
Peer education and counseling training					
• Presbytery coordinators	13	0	All 13 coordinators	13	Not given
• District organizers	174	0	All 174 district organizers	174	95,900
• Presbyterian Church teachers	0	31	All 31 Presbyterian Church students	31	310
Counseling training (nurses in PCG clinics)	0	59	All 59 health staff	59	2,950
Presbyterian chairpersons and heads of departments at the head office, by presbytery:	36	0	All 36 head office staff	36	3,600
• Akuapem	24			24	2,400
• Dangme, Tongu and West Akim	45	4		49	4,700
• West and Central	43	4		47	4,500
• Northern and Kwahu	33	4		37	3,500
• Brong Ahafo	41	3		44	4,250
• Akyem Abuakwa and Volta	53	4		57	5,500
• Asante	60	1		61	6,050
• Ga	50	2		52	5,100
• Asante Akyem Scholarship and Centres	40	0		40	4,000
<i>Total persons trained and reached</i>	612	22		724	142,760

IV. Major Activities Planned and Implemented by Muslim Relief Association of Ghana (MURAG)

MAJOR ACTIVITIES PLANNED	EXPECTED OUTCOME	KEY COLLABORATORS	KEY ACHIEVEMENTS
Organizing advocacy and sensitization program for community leaders	<ul style="list-style-type: none"> • Leaders educated on HIV/AIDS • Leaders support education campaign 	Imams, opinion leaders, Muslim chiefs, market queens, women leaders, traditional healers	Three-day workshop held. Pledge of support obtained from 61 chiefs, imams/ulamas, women and youth leaders
Launch of HIV/AIDS Program	<ul style="list-style-type: none"> • Collaborators and stakeholders support project • Project launched 	MURAG, FHI, Ghana AIDS Commission, stakeholders	Launched on July 18, 2001, by the Presidential Advisor on HIV/AIDS
Conduct a baseline survey	<ul style="list-style-type: none"> • Youth groups identified. • Stakeholders identified. 	Youth leaders, opinion leaders, other stakeholders	Conducted August 2001 <ul style="list-style-type: none"> • 122 youth bases identified • 2,344 members in bases • Each base well-organized with leaders and regular meetings • Bases had strong influence on the youth in their areas • Decision made to use bases and train leaders as peer educators
Training peer educators and identified stakeholders	<ul style="list-style-type: none"> • Peer educators trained • Other stakeholders trained 	<ul style="list-style-type: none"> • MURAG • FHI 	100 peer educators from 50 bases selected and trained
Organizing HIV/AIDS education program	<ul style="list-style-type: none"> • Peer groups educated on HIV/AIDS • Peer groups undertake outreach programs 	Peer leaders, imams, women leaders	15 community education sessions: <ul style="list-style-type: none"> • Outreach programs using games such as “ludu” and card games; invited the public to watch and gave intermittent messages on HIV/AIDS; reached more than 15,600 persons • Referred 130 persons for counseling and 50 persons to STD clinic • House-to-house visits • Educational dramas
Public education during festivals	Festival celebrants educated	Peer leaders, imams, women leaders, ulamas, opinion leaders	HIV/AIDS education during Eid Ul-Fitr and Eid-Ul-Adha
Strengthen MURAG office	MURAG office equipped	FHI	Computer, printer procured.
Develop BCC	BCC materials	MURAG, FHI,	<ul style="list-style-type: none"> • Video clips – “The Pain of

MAJOR ACTIVITIES PLANNED	EXPECTED OUTCOME	KEY COLLABORATORS	KEY ACHIEVEMENTS
materials	developed	advertising agent	HIV/AIDS and the Need For Compassion” <ul style="list-style-type: none"> • 200 T shirts for peer educators • A Guide to Islam and AIDS: collection of sermons and lectures translated into English about AIDS prevention, communication education, care and support, and interfaith collaboration
Establish a drama and role play team	<ul style="list-style-type: none"> • Clip produced. • Role play/ drama team put in place 	<ul style="list-style-type: none"> • MURAG • Peer educators 	Group established and in demand at festivals and other community events.
Monitoring and evaluation	Continual monitoring and evaluation started.	<ul style="list-style-type: none"> • FHI • MURAG 	Monthly intra-project leaders’ meetings and quarterly reports submitted to FHI

V. Training Conducted by MURAG

TYPE	NO. TRAINED		POSITION IN COMMUNITY	INTENDED TARGET	TOTAL TARGET TRAINED	OUTREACH
	M	F				
Youth HIV/AIDS Peer education (3 sessions)	65	36	Youth group leaders	All youth group leaders (100)	101	15,600
Training, advocacy and sensitization	35		Imams/ulamas	Community leaders	35	3,600
Training on HIV/AIDS		22	Magajiahs	All magajiahs (25)	22	2,700
Training on HIV/AIDS		46	Market queens	All market queens (43)	46	4,050
Training on HIV/AIDS	30		Traditional healers/TBAs	All traditional healers/TBAs (27)	30	900
Training on HIV/AIDS		25	Traditional healers/TBAs	All traditional healers/TBAs (25)	25	450
Total Trained	130	129			259	27,300

ATTACHMENT D: Activities of Nongovernmental and Community-based Organizations

I. Activities of the Salvation Army Community-based HIV/AIDS Volunteer Project

ACTIVITIES PLANNED	EXPECTED OUTCOME	KEY COLLABORATORSs	ACHIEVEMENTS
Support salary for project assistant	Project well managed	SA managers and FHI	Full-time project manager employed
Equip refurbish office of project assistant	Office managed and activities documented		
Provide HIV/AIDS education counseling training for 45 church members	Trained coordinators facilitating the peer educators at each division to provide outreach	<ul style="list-style-type: none"> • SA national coordinator • Peer educators • Project assistant • Pastors • NACP 	Divisional Resource Team members trained.
Conduct six 5-day HIV/STI community-based workshops	Community-based HIV/AIDS volunteers trained	<ul style="list-style-type: none"> • FHI, NACP, SA 	234 volunteers from 6 divisions where SA operates were trained.
IEC materials from the NACP	All acceptable messages available to PCG congregants	<ul style="list-style-type: none"> • NACP, SA 	Materials identified and made available

II. Number of People Reached by Salvation Army

DISTRICT	TARGET GROUP	TOTAL
Accra	Adults	4,000
Ashanti	Adults	6,300
Central	Adults	4,000
Nkwakwa	Adults	4000
Akim Central	Adults	1,800
West Akim	Adults	4,500
TOTAL		24,600

III. Training Conducted by World Vision

TYPE	BENEFICIARIES	NUMBER TRAINED	NUMBER REACHED
HIV/AIDS education and counseling	WVG HIV/AIDS core team members	26	
HIV/AIDS education and counseling	District assemblies and decentralized departments	71	
Peer education training	In-school youth, Ahanta West District	134	
Peer education training	Ahanta West District	30	45,700
Peer education training	Adults, Ahanta West District	94	

IV. Number of People Reached by World Vision

DISTRICT	TARGET GROUP	NUMBER OF MALES	NUMBER OF FEMALES	TOTAL
Ahanta West	Youth	19,500	21,000	40,500
	Adults	12,200	13,000	25,200
	Total	31,700	34,000	45,700
Dangme West	Youth	10,000	10,500	22,500
	Adults	6,500	7,000	13,500
	Total	16,500	17,500	36,000
Ejura	Youth	10,300	10,500	20,800
	Adults	8,000	8,500	16,500
	Total	18,300	19,000	37,300
Mfantsiman	Youth	4,200	4,800	9,000
Total		70,700	75,300	267,000

V. Achievements of the Ghana Red Cross Society

NUMBERS	Apr 03	May 03	Jun 03	Jul 03	Aug 03	Sept 03	Oct 03	Nov 03	Dec 03	Jan 04	Feb 04	Mar 04	Apr 04	Total
Male condoms sold in pieces				32	1,700	1,900	11,700	8,400	6,000	7,600	34,100	5,500	8,500	85,432
Female condoms sold in pieces						13	13	2		26		0	0	54
BCC materials distributed				102				469	978	7,600	10,100	850	450	20,547
One-on-one sessions held				32	71	96	56	82	136	152	203	210	345	1,383
Referrals				25		16	16	2	3	0	5	3	6	51
PEs recruited	10	10	11	10	14	10	13	10	10	15	10	20		153
Contacts				73	105	96	136	309	434	478	730	552	709	2,361

VI. Activities of the Ghana Red Cross Society

ACTIVITIES CARRIED OUT	OUTCOME
Pre-intervention baseline survey	Number of roamers in specific sites in Accra estimated
Participatory project planning process	<ul style="list-style-type: none"> • Pre-intervention survey results validated • Intervention goals and objectives reviewed • BCC strategy designed • Process, output and outcome indicators reviewed
Staffing	Recruiting staff <ul style="list-style-type: none"> • 1 social worker • 1 project coordinator • 2 community outreach workers
Training	153 PE identified and trained STI case management training workshop for outreach and social workers held
Outreach activities to encourage STI treatment and behavior change	<ul style="list-style-type: none"> • Outreach services conducted • Interpersonal communications conducted • Facilitator-led group discussions conducted
STI services	Regular STI screening of female sex workers
Condom promotion and distribution	Accomplished
Distribution of IEC materials	Leaflets, posters and booklets distributed (20,547)
Monitoring and evaluation	<ul style="list-style-type: none"> • Program monitoring was an ongoing process • Quarterly and annual progress assessment undertaken • Internal evaluation undertaken

VII. Program Performance of Salvation Army Intervention with Female Sex Workers

Numbers of:	RESULTS							Total
	Aug. 2003	Sept. 2003	Oct. 2003	Nov. 2003	Dec. 2003	Jan. 2003	Feb. 2003	
PE trained	0	0	77	0	50	11	75	213
Group talks held with PE	0	0	60	0	26	53	53	192
Sex workers receiving outreach	22	18	1,200	0	793	187	80	2,300
Males reached out to	0	0	322	0	392	0	0	714
Sex workers contacted	0	0	0	0	461	0	0	461
Male condoms sold	1,000	800	14,908	5,597	6,240	3,637	2,968	35,150
Female condoms sold	10	0	231	33	137	0	0	411
Tubes of lubricant gel sold	3	0	24	12	5	0	0	455
Posters distributed	0	0	250	154	45	68	15	532
Leaflets distributed	0	6	1,100	533	242	0	324	2,199
Booklets distributed	0	0	50	0	32	0	3	85
Referrals made to STI clinic	4	3	93	38	8	22	0	168
Treated cases	0	0	10	0	1	0	0	11

VIII. Activities Conducted by the Queen Mothers Association

MAJOR ACTIVITY	OUTCOME	KEY COLLABORATORS
Identifying women leaders for training	Women leaders identified	Program manager
Launching of program activities for chiefs	Program was launched and witnessed by the elders, chiefs and the people of Krobo land	Traditional Council, queen mothers, health workers, FHI
Training and retraining identified women leaders (capacity-building training workshop in HIV/AIDS education and counseling)	Training was held for queen mothers and selected women leaders	Doctors and counselors of St. Martins Hospital at Agormanya and at Atua Government Hospital
Establishing secretariat for the association, including staff recruitment and office refurbishment	<ul style="list-style-type: none"> Office established with the help of FHI and USAID Staff recruited 	Queen mothers, FHI, USAID, Dangme/Tongu Presbytery
Developing locally appropriate materials	Materials produced	<ul style="list-style-type: none"> FHI queen mothers Selected School Girls
Community education of target groups by queen mothers during: <ul style="list-style-type: none"> Dipo Festival Funerals Ngmayem Festival Christmas Eve 	Series of community education activities for target groups accomplished	Queen mothers, community members and health workers
Drama performance on HIV/AIDS and STIs	Queen mothers set up role play in the local language	Queen mothers, FHI
Condom supplies and promotion	Condom supplies and promotion done	Queen mothers, MOH, DHMT
Monitoring and evaluation	Monthly monitoring	Program manager, 71 queen mothers, staff
Peer education training for Dipo girls	Peer education training for Dipo girls done	Health workers, program manager and FHI
Queen mothers monthly meeting	Monthly meetings held every Monday of the month	Program manager, queen mothers
HIV/AIDS education training for undertakers	HIV/AIDS education training for undertakers carried out	Health workers, program manager and FHI
HIV/AIDS education training for traditional birth attendants	Training carried out	<ul style="list-style-type: none"> Health workers, Program manager FHI
Formating Manya Krobo Smart Ladies Club <ul style="list-style-type: none"> Launching of HIV/AIDS program Implementation of outreach activities 	Club formed	<ul style="list-style-type: none"> FHI Program manager Queen mothers Health workers
BCC training for Smart Ladies Club	Training conducted	Smart Ladies Club
Producing, airing documentary drama	Drama produced and aired	<ul style="list-style-type: none"> Queen mothers Smart Ladies Club Production agency FHI

IX. Training Conducted by Queen Mothers Association

TYPE	NO. OF PARTICIPANTS
Capacity-building workshop for Queen Mothers in Lower Manya	71
Workshop for Dipo girls on peer education on HIV infection	60
Infection prevention workshop for undertakers in Manya Krobo	65
TBA training program	65
Behavior and communication change training for Smart Ladies Club	50

ATTACHMENT E: Annotated Bibliography of Resources Published with Support from FHI

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- “Working with Uniformed Services: Issues and Recommendations (An Evaluation Report of the Ghana Uniformed Services HIV/AIDS Program),” Implementing AIDS Prevention and Care (IMPACT) Project, Family Health International (FHI); Ghana, September 2003.

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Family Health International
Institute for HIV/AIDS
2101 Wilson Blvd.
Suite 700
Arlington, VA 22201 USA
Tel: 703.516.9779
Fax: 703.516.9781
www.fhi.org

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