Ghana

Country Operational Plan

FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

Country Context

The HIV Epidemic in Ghana

The HIV/AIDS epidemic in Ghana is a low-level generalized epidemic with pockets of high infection among female sex workers and men who have sex with men. HIV prevalence in the general population has been declining since peaking at 2.4% in 1998. In 2013, prevalence in the general population was estimated to be 1.3% in adults aged 15-49, and an estimated 224,488 persons, including 34,557 children, were living with HIV/AIDS. HIV infection rates among pregnant women attending antenatal clinics as measured by the national HIV sentinel surveillance system show a decline. Prevalence among adult females continues to be higher than among adult males (1.6% vs 1.0%).

HIV incidence has been decreasing in the general population (from 0.37 in 1996 to 0.04 in 2013 among adults 15-49 years). Estimated mother-to-child transmission (MTCT) rates decreased from 32% in 2009 to 21% in 2013. HIV incidence among persons 15 – 24 years old was estimated to be 0.03% in 2013 and two times higher among females than among males.

In 2013, the number of persons living with HIV (PLHIV) that initiated antiretroviral treatment (13,456) was higher than the estimated number of new HIV infections (7,812). Antiretroviral treatment (ART) coverage among eligible PLHIV as of December 2013 was 60%, leaving approximately 50,000 eligible PLHIV (35,000 adults; 15,000 children) still in need of ART according to the current national treatment guidelines.

HIV prevalence in key populations (11% in female sex workers and 17% in men who have sex with men) continues to be higher than that of the general population. There is evidence that prevalence among female sex workers (FSW) may be decreasing especially among the younger mobile sex workers ("roamers"), the majority type of FSW in Ghana. Recent surveys indicate that HIV testing rates among key populations (KP) continue to be quite low, especially among men who have sex with men (MSM). The proportion of HIV-infected key populations in HIV care and treatment services is unknown.

The most recent modes of transmission study (MOT) was conducted in 2008. Data sources for the MOT included the 2003 Ghana Demographic and Health Survey (GDHS) and KP surveys conducted in 2006. In the 2008 MOT, it was estimated that 9% of new adult infections occurred in FSW and their clients, 8% in MSM and their female partners, and 22% in the partners of FSW clients. Twenty-nine percent of new

infections were associated with casual heterosexual sex and their partners, and 30% were associated with low-risk heterosexual sex. Available epidemiologic data suggest that female prisoners and non-paying partners of sex workers may be at higher risk for HIV infection than the general population in Ghana. Very little is known about people who inject drugs (PWID) in Ghana and their risks of HIV infection.

Prevalence data from the 2003 GDHS and from the annual HIV sentinel surveys conducted by the Ghana Health Services' National AIDS/STI Control Program (GHS/NACP) demonstrate higher prevalence among women than among men and higher prevalence in urban areas than in rural areas. In addition, the HIV epidemic appears to be concentrated in five of the ten regions in Ghana: Greater Accra, Ashanti, Western, Eastern and Brong Ahafo regions in southern Ghana. Recent size estimate exercises indicate that higher numbers of FSW and MSM also occur in urban areas in southern Ghana.

More information about HIV in Ghana will be available in 2014-2015. The USG is supporting the 2014 GDHS which will includes HIV testing and will provide information about HIV prevalence and knowledge and behavior. Another MOT is also being conducted this year using data generated from the recent Integrated Bio-Behavioral Sentinel Surveillance (IBBSS) surveys conducted among FSW and MSM and from the GDHS. USG is also supporting formative assessment activities for PWID in Kumasi, Accra/Tema and Cape Coast to assess the social, economic and behavioral vulnerability; HIV and STI related risk behaviors; and access to HIV prevention and care services. These assessment activities will also inform the feasibility of the implementation of an IBBSS to be completed by the end of 2014 for further information about PWID.

The Ghana National Response to the HIV/AIDS Epidemic
The National HIV and AIDS Strategic Plan 2011-2015 (NSP) prioritizes HIV prevention with the aim of reducing new infections among key populations and other vulnerable populations and virtually eliminating the MTCT of HIV. The NSP 2011-15 objectives are the reduction of new HIV infections by 50% by 2015 and reduced morbidity and mortality among PLHIV.

In terms of prevention, the Government of Ghana (GOG) plans to continue expanding access to combination prevention/HIV treatment and improving linkages, engagement and retention of PLHIV in the continuum of HIV care. Ghana has been quite successful at rapidly scaling up the provision of clinical HIV services through the training of service providers and through increasing the number of sites providing HTC, PMTCT and ART services. However, this expansion began slowing down in 2013 due to inadequate funding and stockouts of antiretroviral drugs (ARV) and HIV test kits.

In the 2014 Government of Ghana budget, the National HIV/AIDS Response was increased to 55 million

Ghana Cedis ($22.9 million). In January 2014, the Ghana Government released $12 million Ghana Cedis ($5 million) for the purchase of ARVs.

U.S. Government role in the Ghana National Response

The overall PEPFAR goal is to strengthen the capacity of the GOG, including GHS/NACP, Ghana AIDS Commission (GAC) and Ghana Armed Forces (GAF), civil society organizations (CSO) and communities to finance and manage the National HIV/AIDS Response and to achieve the NSP goals of reducing new infections and morbidity and mortality of PLHIV.

PEPFAR Ghana provides technical leadership and assistance for quality improvement of HIV services in the community and those provided by the GHS by working with the GOG to ensure appropriate implementation of HIV prevention activities, including those supported by The Global Fund (GF). USG either directly or through international non-governmental organizations (NGO) has been supporting local nongovernmental organizations (NGO) and community-based organizations (CBO) with grants to provide prevention services to PLHIV and KP with the objective of strengthening local systems.

Roles of other partners in the National Response and USG coordination with other partners

The GF and PEPFAR are currently the major funders of the National HIV/AIDS Response in Ghana. The GF provides the majority of the treatment commodities. The GF also provides a grant to GAC to support NGO implementation of KP interventions and a grant to the NACP to support the National Prevention of Mother to Child Transmission (PMTCT) Program. Ghana is a GF interim funding country and received $15 million for PMTCT and antiretroviral therapy (ART) in 2014. An additional $2 million is available from the GF for health systems strengthening (HSS), specifically for supply chain reform.

For 2014, the German Society for International Cooperation (GIZ) has pledged $1.5 million to support the Country Coordinating Mechanism (CCM) for the GF. The Japanese International Cooperative Agency (JICA) has also pledged funds to support the National PMTCT Program. United Nations Agencies are providing technical support and $5 million to support the National HIV/AIDS Response.

The PEPFAR Ghana team is in ongoing discussions with GOG, GF and other key stakeholders regarding USG support for the National HIV/AIDS Response. The PEPFAR Ghana team is represented at the CCM, HIV key partners meetings, and GAC committee and Technical Working Group (TWG) meetings. The team also participates in the annual GAC Partnership Forum to review progress in the implementation of the National HIV/AIDS Response. The USG is participating in strategic planning meetings to inform the development of the New Funding Mechanism (NFM) concept note for the TB/HIV application. Moreover, USG is directly funding two inputs for the NFM concept note: 1) the development of the Investment Case for HIV/AIDS to identify national priorities for resource allocations that can be co-financed by GF and other partners; and 2) geo-spatial mapping and analysis as well as an epidemiological data review to

inform high-impact program planning and to develop long-term strategies to address HIV.

National HIV Response Funding Challenges

The National HIV Response which has seen declines in HIV prevalence and incidence rates associated with the successful expansion of access to HIV prevention and treatment services is facing serious funding challenges for several reasons. Ghana's economy is not performing as well as had been anticipated, and unfortunately due to the initial projections of Ghana's economic success, several funding partners have experienced reductions in funding availability and/or have reprogrammed support to other health areas. Although GOG funding for HIV/AIDS has been increasing, the amounts pledged to-date will not be enough to initiate new clients on ART after 2014 or to implement other critical HIV prevention interventions including HIV testing and counseling (HTC).

Planning for the 2014 COP

Based on the epidemiology of HIV in Ghana, the activities already funded by the GOG and the GF, and USG's comparative advantage points, the PEPFAR Ghana team has prioritized the following areas as core activities for its portfolio: key populations and PLHIV (institutional/technical capacity building, quality of services, policy and strategic information); stigma and discrimination; and supply chain management from 2014 onward. In addition, the PEPFAR Ghana team will focus its interventions to the five regions (Greater Accra, Eastern, Ashanti, Western, Brong Ahafo) in southern Ghana with the highest HIV prevalence and the higher numbers of FSW and MSM.

II PEPFAR Focus in FY 2014

The PEPFAR Ghana team has been regularly meeting with the GOG, including GHS, GAC, and NACP as well as with other key stakeholder groups, including civil society organizations, the Joint United Nations Program on HIV/AIDS (UNAIDS), CCM and more recently, the U.S. State Department Office of Global AIDS Coordinator (OGAC) to discuss priority areas for PEPFAR Ghana support for the National HIV/AIDS Response. Based on the epidemiology of HIV in Ghana, the activities already funded by GOG and GF, and USG's comparative advantage points, the PEPFAR Ghana team has prioritized the following areas as core activities for its portfolio: key populations and PLHIV (institutional/technical capacity building, quality of services, policy and strategic information), stigma and discrimination and supply chain management from 2014 onward.

The PEPFAR Ghana program remains closely aligned to the NSP in its focus on HIV combination prevention among KP, their clients and their intimate partners. In 2014, USG will expand efforts to improve the quality of clinical and community services and to strengthen linkages between community and health system services. Specifically, national standard operating procedures (SOP) will be introduced

to effectively design, manage and monitor the implementation of quality, evidence-based HIV interventions targeting FSW and MSM in a harmonized and coordinated manner irrespective of the funding source.

III Progress and Future

Update on Partnership Framework

The 2009-2013 Partnership Framework (PF) between the USG and the GOG supports Ghana's National HIV/AIDS Response and the USG focus for long-term sustainability of the response. During 2009-2013, significant progress was made toward reaching the prevention, treatment, care and support, HSS and community systems strengthening (CSS) goals of the PF. These PF goals included the reduction of new infections; increase in ART coverage; capacity-building of NGOs providing HIV prevention services at the community level; establishment of drop-in centers for KP and other vulnerable populations; training of health staff in stigma reduction; improved reporting of HIV program data through the national Health Management Information System (HMIS); and strengthening of the national lab network.

The USG continues to provide support to improve GOG capacity to plan, manage and monitor HIV prevention and treatment programs; deliver quality services with the participation of local civil society and communities; and ultimately, finance national HIV and other health programs.

Update on progress made on country ownership and focus/activities in 2014

PEPFAR Ghana continues to support the GAC to achieve a high-impact National HIV/AIDS Response owned by the GOG, civil society and other stakeholders. Similarly, PEPFAR Ghana continues to engage these same groups to achieve high level programmatic engagement in the COP planning process and also, in the design and implementation of PEPFAR-supported interventions.

PEPFAR Ghana fully supports the involvement of civil society as a partner in the National HIV/AIDS response through grants to CBOs and others working with PLHIV and KP. Civil society has been involved in all levels of Ghana's National HIV/AIDS Response through PLHIV associations, NGOs, the media, CBOs and faith-based organizations (FBO). At the national level, umbrella organizations and networks are involved in the national policy formulation and planning and, are responsible for building the capacity of the smaller organizations working at the community level.

Since 2013, the GAC has expanded its efforts to mobilize the private sector. As noted in the 2014 Mid-Term Evaluation (MTE) of the NSP, the private sector is still not yet fully engaged in the National HIV/AIDS Response and additional strategies are being explored to effectively reach out to this group.

Trajectory in FY 2015 and beyond: Based on the PEPFAR Ghana core priorities, the team budgeted a total of $12.5 million in existing and new funds for the FY 2015 program. As per OGAC's financial projections for PEPFAR Ghana, the PEPFAR allocation to Ghana will decrease by 20% to a total of $10.075 million by COP16.

IV PROGRAM OVERVIEW

KEY POPULATIONS

The PEPFAR Ghana program prioritizes support for the implementation of combination prevention interventions for KP because of their high risk of HIV infection and because the majority of GOG resources are focused on PMTCT and other interventions for the general population. Over the last two years, the USG has gradually transitioned its focus from funding service delivery by NGOs and CBOs to incorporate institutional strengthening in addition to technical assistance to support these organizations to deliver and manage quality services.

HIV prevalence among FSW and MSM continues to be higher than among the general population. PEPFAR Ghana also focuses on associated groups including clients and non-paying partners of FSW and MSM. In 2014, USG will be conducting formative assessment activities to determine the extent of PWID in Ghana and their level of risk to HIV infection. DOD is also planning a HIV prevalence survey for the military.

Table 2: Key Populations and Other Populations in Ghana

Population	HIV prevalence	Population size (estimate)	# reached FY 2013*	Comments
FSW	11%	51,937	11,881	Reached with prevention package
MSM	17%	30,583	5,740	Reached with prevention package
PWID	Not available	Not available	0	Formative research ongoing
FSW NPP	Not available	66,329	4,837	Reached with prevention package
PLHIV	100%	231,205	61,546	Reached with one care service
Military	Not available	-	8,218	Reached with prevention package

*PEPFAR Ghana FY 2013 APR data

In Ghana, KP are faced with many challenges that impact their engagement and retention in HIV services. The proportions of HIV-infected FSW and MSM who know their HIV status and are enrolled and retained in the HIV continuum of care in Ghana are unknown. In addition, there is inadequate information about HIV prevalence and levels of engagement in HIV prevention and care services among other at-risk populations, including MSM subgroups, persons who engage in transactional sex, and PWID.

The USG will continue to support programs and interventions targeting KP and other vulnerable populations, including direct service provision of HTC and condoms and lubricants at drop-in centers and during outreach.
Quality of services: The USG will continue its technical leadership and support for the development and implementation of national quality standards and measurements for KP program services and for PLHIV clinical services.

Linkages, engagement and retention: PEPFAR Ghana supports interventions targeting KP and other vulnerable populations that include peer-led referrals of those testing HIV+ and follow-up by PLHIV case managers from HIV testing sites to health services. The USG also supports interventions to reduce stigma and discrimination towards KP and PLHIV and interventions to increase access to services and expansion of linkages between prevention services and care, support and treatment services. This year, the USG will also intensify its emphasis on the scale up of defaulter tracing of KP clients lost to follow-up.

Protecting the rights of PLHIV and KPs: In collaboration with the GOG and civil society, the USG has supported the integration of the Positive Health Dignity and Prevention (PHDP) toolkit into PLHIV support group activities. USG will also continue its support for activities that protect the rights of PLHIV and KP, including the expansion of the M-Friends and M-Watchers social protection network; the regional rollout of the anti-stigma and discrimination reporting system at the Commission on Human Rights and Administrative Justice (CHRAJ) and Legal Aid Scheme; sensitivity trainings for the Ghana Police Service (GPS); and the strengthening of CSOs.

IBBSS and KP size estimates: In 2014, the USG is supporting an IBBSS of MSM, which is part of a full evaluation of the National KP Program that also includes a performance evaluation of KP services. In 2012, CDC and USAID were awarded a KP Challenge fund grant for $1.0 million to support formative assessment activities for PWID in Kumasi, Accra/Tema and Cape Coast to assess their social, economic and behavioral vulnerability; HIV and STI related risk behaviors; and access to HIV prevention and care services. These assessment activities will also inform the feasibility of the implementation of an IBBSS of PWID.

In 2013, CDC and USAID were awarded a KP Implementation Science grant for $1.55 million to learn more about KP engagement in the HIV continuum of care and to improve efficiencies and linkages in the HIV care cascade.

COMMUNITY SYSTEMS STRENGTHENING

The National HIV/AIDS Response is dependent on community systems, which include CBOs, FBOs, NGOs, traditional councils, women's groups, and PLHIV associations, which are engaged in the provision of a range of HIV services including prevention, treatment, care and support. Community systems have a critical role in improving access of PLHIV and KP to quality HIV services given the high levels of stigma and discrimination in Ghana and the limited geographic distribution of GOG HIV clinical services.

Over the last two years, the USG has gradually transitioned its focus from funding service delivery by NGOs and CBOs to incorporate institutional strengthening with technical assistance to these organizations to support them to independently deliver and manage quality services.

Capacity building of those managing and implementing programs at the community level: All of the USG Agencies are involved in building local organizational capacities including Peace Corps which is involved in capacity building of community members, health workers and CBOs. USAID supports the institutional strengthening of approximately 40 indigenous NGOs and CSOs in organizational development areas of human resource management, finance and administration, governance and leadership, strategic planning and organizational systems, resource development, grants management, and monitoring and evaluation. USAID also supports the technical capacity building of these organizations to manage and provide comprehensive prevention services for KP and PLHIV. Lastly, USAID supports community-based PLHIV support groups with trainings on the PHDP toolkit.

The DOS gives self-help awards and public diplomacy grants to NGOs and CSOs to provide prevention, care and support services for KP and PLHIV and to implement information education campaigns. Both Peace Corps and DOS support life skills and behavior change communication (BCC) programs for youth. CDC supports the GAC in strengthening its monitoring and evaluation (M&E) capacity of CBOs in the Brong Ahafo and Eastern regions. Overall, the USG will expand its support to improve CSO capacity to monitor, evaluate and improve the quality of their services for KP and PLHIV.

In an effort to improve engagement and retention in HIV services of KP and PLHIV, the USG will continue to support the strengthening of linkages between clinical and community programs and services and, will promote the provision of timely referrals to ensure access to critical prevention, care, support and treatment services. Along those lines, the USG will engage community-based support groups and the

Models of Hope (PLHIV who work in ART sites and provide essential links between care providers and PLHIV clients) to improve adherence to treatment; identify new HIV cases among KP and PLHIV partners and family members; trace defaulters and those lost to follow up; and provide education on reduction of risk behaviors. The USG will also continue to support peer education and IT-based interventions, including information, counseling and support services via SMS, telephone and social media.

Stigma reduction: Stigma and discrimination reduction activities are key components of the comprehensive continuum of HIV and AIDS prevention, treatment, care, and support services provided by all stakeholders in the National HIV/AIDS response (MTE, 2014). The USG will continue to support other activities to address stigma and discrimination at both clinic and community levels, including the implementation of PHDP toolkit and gender-based violence (GBV) programs.

Gender: The USG will support the scale up of the gender/GBV component of the National HIV/AIDS Response with trainings of PLHIV, KP, CBO, GHS and GPS. USG will also provide technical assistance in operation of drop-in centers in GBV screening and referrals for survivors. USG activities also support the empowerment of PLHIV females to take on leadership roles in PLHIV communities and to gain access to information and services detailed in outreach efforts.

Care and Support Services: The USG will continue to advocate for the integration of HIV and other health services including family planning, sexual and reproductive health and outpatient department services. The USG will also support PLHIV to implement income generation activities (IGA) to facilitate economic independence.

Programming for social and behavior change (SBC): The USG will continue to support KP and PLHIV communities in understanding their HIV risks; in adopting behaviors that reduce HIV risk including condom use; and supporting changes in social and gender norms. Along those lines, USG coordinates quarterly outreach programs that focus on particular issues such as GBV; human rights; and the provision of accurate information exchanges among stakeholders and at-risk populations in the five focus regions. The USG works closely with the Ghanaian media to accurately and comprehensively report on HIV/AIDS.

HEALTH SYSTEMS STRENGTHENING

The PEPFAR Ghana team will continue its partnerships with GOG to strengthen health systems and the National HIV/AIDS Response. The USG will continue to advocate for logistics reform and pre-service training. The USG will also provide support for the provision of quality HIV clinical and laboratory services; monitoring and evaluation activities; reporting and use of quality data; and surveillance and surveys.

The limitations of the national procurement and supply chain management system are having negative

impacts on the National HIV/AIDS Response. In 2013, Ghana experienced severe shortages of antiretroviral drugs, HIV test kits and quality condoms. To develop a comprehensive procurement plan for condoms and lubricants, the USG is supporting the development of the National Condom and Lubricant Strategy and is assessing the total marketing approach for inclusion of the private sector. The USG is closely working with the National Population Council and GAC to effectively take steps towards one national condom quantification and forecasting exercise to inform Ghana's procurement plan for these items. The USG will continue to strengthen the Ministry of Health (MOH)/GHS central level capacity in forecasting and procurement planning for HIV and TB commodities, e.g., training in quantification and supply chain management. The USG is also engaged in building regional level capacity in distribution and warehouse management and in improving the availability and use of logistics information at all levels for decision making, e.g., systematic drug and commodity quality control systems, use of SMS-based early warning system to eliminate ARV stockouts.

There are serious concerns regarding the quality of HIV clinical services in conjunction with rapid scale up. In 2012, only 20% of the identified HIV-exposed infants received prophylaxis in contrast to the 70% of identified HIV-infected mothers who received ARVs to prevent MTCT. This disparity could be associated with quality of care, stigma, and/or weak linkages in the continuum of services between PMTCT and MCH.

Changes in the national treatment guidelines make it even more critical that providers have access to quality laboratory services. Ghana plans to adopt the WHO Option B+ guidelines for PMTCT and the WHO Treatment Guideline Recommendations that HIV-infected persons begin antiretroviral treatment at a CD4 count = 500; that HIV-positive partners in discordant couples receive immediate treatment; and that clinicians have access to viral load testing for monitoring ART patients.

National capacity in strategic information (SI) still needs to be strengthened. The reporting of NACP clinical data has been integrated into the national District Health Information Management System (DHIMS); however, there are still concerns about the availability and the quality of the data. The GAC is responsible for maintaining a national data bank of all available HIV data, including program and research data. However, reporting to the GAC by the GHS, CBOs and internationally-funded NGOs providing HIV services and by researchers is still very incomplete.

Logistics reform: USAID will continue its technical support for improving the procurement and supply of HIV-related commodities through the implementation of logistics reform and drug-quality control systems, including early-warning systems (for drug stockouts). USG will concentrate its technical support in strengthening national capacity in forecasting, managing, monitoring and reporting on the use of program commodities and also, in improving the availability and use of logistics information at all decision making

levels.

Quality improvement of HIV clinical services: USG will continue its technical assistance to expand the quality of HIV services especially for clinical ART and PMTCT activities financed by the GF. Efforts to improve the quality of services provided by the health sector will include stigma reduction among health staff; implementation of the new Sexually Transmitted Infections (STI) guidelines for KP; strengthening linkages with the National Tuberculosis Program (NTP) and other health programs/services, and the intensification of defaulter tracing through Models of Hope. DOD will continue to support GAF to adapt national standards for HIV care and treatment programs and to improve quality of treatment and care services.

Through technical assistance and the Models of Hope program, the USG will support the strengthening of linkages between the health facilities and communities to ensure successful referrals and to maximize retention in services, including the tracking and follow-up of PLHIV not participating in care or treatment services. The USG will support NACP to expand its review of early warning indicator (EWI) data at the district and regional levels to facilitate the identification of facilities where retention of ART clients may be an issue. The USG will support GHS to strengthen linkages with the laboratory services provided by its Institutional Care Division with a focus on PLHIV in need of diagnosis and monitoring of HIV status (i.e., CD4, viral load (VL) and early infant diagnosis (EID)), and opportunistic infections, especially tuberculosis (TB), and ARV drug toxicity and to monitor ART client treatment adherence and/or treatment failure.

In the past, the USG supported pre- and post-service training for midwives using e-learning modules (open source), an effort which was directly aligned to the GOG's shift from nurses to increased midwives at the community level. Two modules have been developed on PMTCT and on anti-stigma and discrimination. A third module will be developed this year outlining HIV basics. With limited PEPFAR resources, this activity was identified as non-core and will be discontinued after this year; however, all three e-learning modules will be transferred to GHS for continued use.

Laboratory Strengthening: The USG will continue to support implementation of the National Laboratory Policy and Strategy at GAF laboratory facilities, which includes support for the National Laboratory Quality Assurance Program to implement onsite supportive supervision and proficiency testing for HIV rapid tests and other clinical tests.

In 2015, the USG will discontinue its support for the participation of national and regional level laboratories in the Stepwise Laboratory Quality Improvement Process towards Accreditation (SLIPTA) program coordinated by African Society for Laboratory Medicine (ASLM). With limited PEPFAR resources, this activity was identified as non-core. Fifteen laboratories in Ghana were enrolled in the

SLIPTA program. In 2013, three of the four laboratories audited by ASLM scored four stars and the fourth scored one star (five star maximum). To contextualize, only five other laboratories in Sub-Saharan Africa have achieved four stars. The USG will complete the ASLM audits for the remaining eleven laboratories in late 2014 and early 2015.

The USG is supporting the implementation of a standardized logbook for recording results of HIV rapid tests. Data from these logbooks will be useful for monitoring how HIV rapid test kits are being used (e.g., PMTCT, blood screening), test kit stock levels, and the quality of testing. The USG has also been supporting the development and implementation of a national laboratory information management system (LIMS) at GAF laboratory facilities which is being integrated into the national HMIS.

The USG will support a pilot decentralization initiative to expand clinician and patient access to quality HIV test results. Two regional hospital laboratories, which were awarded four stars during the WHO AFRO SLIPTA audit conducted in November 2013, will be responsible for expanding access to quality HIV laboratory services including EID, and VL, CD4, and rapid HIV testing, throughout their respective regions. Clinicians caring for ART clients will be encouraged to request VL and other clinical tests when appropriate. Interventions will also be introduced to reduce turn-around-time of EID and other laboratory testing by incorporating measures to expedite the transmission of results to health providers.

Quality data/HIV surveillance and surveys/Monitoring and Evaluation: The USG is working with the GHS and the GAC to strengthen the processes needed to expand access to and the use of quality HIV data. The USG will continue its technical assistance to strengthen the GHS District Health Information System (DHIMS 2) with an emphasis on the HIV/AIDS component of the reporting system (which has migrated fully into a web-based, real time database for all clinical- and hospital-based data). A main objective of USG SI support is to improve the quality of data generated from program, HIV surveillance and surveys, and M&E from national and community M&E activities and related information management systems. The USG will support the enhancement of DHIMS-2 to facilitate the tracking of clients between and/or through services within the same facility (i.e., antenatal care and maternal, newborn and child health (ANC/MNCH) services and short- and long-term ART services) and across health facilities to facilitate follow-up and retention in care.

More information about HIV in Ghana will be available in 2014. USG is supporting the 2014 GDHS which includes HIV testing and will provide information about HIV prevalence, knowledge and behavior. Another MOT is also being conducted this year using data generated from the recent Integrated Bio-Behavioral Sentinel Surveillance (IBBSS) surveys conducted among FSW and MSM and from the GDHS. In 2012, CDC and USAID were awarded a KP Challenge fund grant for $1.0 million to support formative assessment activities for PWID in Kumasi, Accra/Tema and Cape Coast to assess the social,

economic and behavioral vulnerability; HIV and STI related risk behaviors; and access to HIV prevention and care services. These assessment activities will also inform the feasibility of the implementation of an IBBSS among PWID.

In 2013, CDC and USAID were awarded a KP Implementation Science grant for $1.55 million to learn more about KP engagement in the HIV continuum of care and to improve efficiencies and linkages in the HIV care cascade. In 2014, the USG is supporting an IBBSS survey for MSM, which is part of a full evaluation of the National KP Program that also includes a performance evaluation.

The USG is also supporting the planning and the implementation of several studies to monitor HIV drug-resistance (HIVDR) and early warning indicators (EWI) and an assessment of the utility of PMTCT program data (e.g., data quality) for HIV surveillance.
Lastly, the USG recently supported the development of the GAC national evaluation plan for HIV prevention programs for KP and the performance evaluation of HIV prevention programs for KP. This year, the USG will support a third related activity - an evaluation plan of the national HIV prevention program for KP based on a plausibility analytical research design (or data triangulation) that synthesizes data from multiple sources including routine monitoring data, performance evaluation data, an assessment of contextual events, program costs, and IBBSS 2011 and 2014 with MSM and FSW and any other relevant data collection and analysis efforts. The evaluation findings will provide information about the effectiveness of the national KP strategy and operational plan to inform the next strategic planning cycle in 2016 (GAC NSP update).

V GHI, Program Integration, Central Initiatives and other Considerations

GHI Strategy: The PEPFAR Ghana approach aligns with the USG Ghana Global Health Initiative Strategy (GHI) which focuses on three cross-cutting issues: access to quality of services; improved use of strategic information; and governance and accountability in the health sector.

Collaboration/engagement strategies with multilateral partners: PEPFAR Ghana participated in the development of and signing of the 2014 Partnership Forum Aide Memoire and is in ongoing discussions with GOG and key stakeholders regarding USG support for the National HIV/AIDS Response. The USG is heavily engaged in the TB-HIV Global Fund concept note development. Upon request from the CCM, the USG is funding the development of the Ghana Investment Case using the GOALS model, geospatial mapping and analysis and, an epidemiological data review. UNAIDS is funding the two consultants to conduct the costing analysis and to write the proposal.

PEPFAR Ghana regularly participates in the CCM and interacts with HIV Key Partners, and GAC

committees and TWGs.

Additional PEPFAR funds that are programmed through Central Initiatives
DOS is supporting the Human Rights Advocacy Centre (HRAC) to implement a Post Exposure Prophylaxis (PEP) project that will scale up PEP for HIV infection prevention with emphasis on KP and PLHIV. Interventions will include extending referral systems for PEP cases to police and judicial services and trainings of providers engaged in rape cases.

In 2013, USAID received a Local Capacity Initiative award ($710,000) to implement a civil society driven governance and accountability project. The project will build the capacity of local Ghanaian NGOs and CSOs to monitor the quality and ease of access to health services and, to strengthen community structures in advocacy for patients' rights and client-centered care. The project will support government, community, and service provider dialogues to improve the quality and responsiveness of health services and also, to promote a customer service orientation among health providers.

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

What are the intended outcomes of this enhanced collaboration with multilateral partners (e.g. better anticipation of TA needs or service interruptions, identification of duplication, adjustments to USG programming to increase coverage, achieve efficiencies, etc.)? Additionally, please describe how the USG will leverage partnerships with the Global Fund, UNAIDS, and other partners to advance larger policy issues at the national level.

USG strategically and continuously engages the GF and other multilateral partners in planning and implementing HIV/AIDS interventions. PEPFAR Ghana maintains constant contact with the Geneva-based GF secretariat to exchange views and to ensure its full awareness of conditions on the ground. Programs are closely coordinated and USG plays a key role in developing and supporting new interventions that can be further developed as new funding opportunities for GF arise. Over the years, the USG has provided tailored support to the CCM to increase its effectiveness, especially in the areas of governance, oversight and costing. These engagements have stimulated healthy harmonization of response and reduced duplication of activities, while ensuring efficiency. Additionally, USG has been able to strategically refine its program approaches to complement GF efforts and ensure synergy in planning and implementation.

For instance, in an effort to reduce duplication, refine HIV interventions and improve quality, the USG, GF and OGAC conducted a joint visit to Ghana earlier this year to come to a consensus on the following

issues: a core KP combination prevention package and implementation methods and processes required for its effective delivery; mapping and geographic coverage of KP interventions for the next five years; a quality assurance system for KP interventions; and the division of labor between GOG, GF and PEPFAR Ghana to achieve sufficient coverage and quality of KP programs. This visit reaffirmed that PEPFAR Ghana is supporting the implementation of a mature FSW program and has demonstrated strong political (GOG and CSO) commitment to and community engagement in the public health approach to KPs with intense emphasis on human rights and anti-stigma and discrimination. Moreover, the USG supported work coordinated by the GAC on the development of KP SOPs to provide effective quality management of all interventions for KP and to ensure quality and uniformity of KP programming irrespective of funding source.

One critical challenge in Ghana is HIV commodity procurement delays, which occur mainly due to inadequate funding and internal bureaucratic bottlenecks, which have resulted in stockouts of key HIV commodities including ARVs, rapid test kits, and lab reagents. In 2013, the Government of Ghana procured substandard condoms that had a negative impact on program performance. The USG continues to work closely with GF and other partners to operationalize a national Procurement and Supply Chain Master Plan to create a viable supply chain and to strengthen health commodity security

How is the USG engaging with partners in Global Fund concept note development under the New Funding Model (NFM) and UNAIDS Investment Approach/Investment Case development?

The USG is heavily engaged in the TB-HIV Global Fund concept note development. Upon request from the CCM, the USG is funding the development of the Ghana Investment Case using the GOALS model. UNAIDS is funding the two consultants to conduct the costing analysis and to write the proposal. Finally, the USG is supporting geospatial mapping and analysis as well as an epidemiological data review.

How will these processes (Global Fund NFM and Investment Approach development) affect COP planning and USG programming? How has the NFM and/or the Investment Approach created space for strategic discussions with stakeholders about the investment of Global Fund and donor resources? At which national entry point (i.e. NSP, Phase 2, GF concept note, national program evaluation)?

The Global Fund NFM proposal is due October 15, 2014, and the Ghana Investment Case will serve as reference for the resource allocations quoted therein. Both components will impact the implementation of the rest of COP14 USG programming and also, the planning for COP15. The USG anticipates that with the strategic directions already defined, it will result in meaningful dialogue with national stakeholders on the key drivers of the epidemic and the appropriate resources needed to effectively dent the spread. Going forward, the USG projects a stronger collaboration with the GF to strategically plan for long-term

priorities as outlined in the NFM application.

We recognize that procurement and supply chain management issues are regular challenges in Global Fund implementation and performance; please elaborate specifically if and how this is an obstacle in your country. In addition, what are 2-3 other primary challenges facing Global Fund grant implementation or investment case development? How are you planning to address these challenges through your COP, partners, or any other activities?

Health commodity security in Ghana is weak and needs to be strengthened. Aside from inadequate human resources as the central level, the procurement processes are inefficient and fragmented. Delivery of supplies is still limited, and management procedures at all levels are highly variable and overall and not up to modern standards. Supply chain management information systems and capacity is still weak. Lastly, Ghana repeatedly experiences frequent stockouts of HIV commodities. The USG is supporting the following reform efforts: building technical and managerial capacity to improve skills in forecasting and quantifications for health commodities at all levels; improving governance and developing clear policies on selection of medicines and other health commodities; and strengthening supervision and M&E of procurement and supply chain. Another critical challenge stunting Global Fund implementation is quality improvement within community and clinical settings. In response, the USG is in dialogue with partners to strengthen quality assurance/quality improvement (QA/QI) models for use within the program. The USG has also been working with GAC on the development of the KP SOPs to provide effective quality management of all interventions for KP and to ensure quality and uniformity of KP programming irrespective of funding source.

Are you a recipient of Country Collaboration Initiative funds and/or do you have a Global Fund liaison? If yes, please describe what has worked well and any lessons learned you may have. How have you tailored the placement and responsibilities of the Global Fund Liaison to your program needs? Do you have plans to incorporate any of these activities into your COP?

No