

**PEPFAR Ghana
Country Operational Plan (COP) 2016**

Strategic Direction Summary

June 15, 2016

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Goal Statement

PEPFAR Ghana is committed to working with the Government of Ghana (GoG) and other stakeholders including the Global Fund to fight AIDS, Tuberculosis, and Malaria (GF), UNAIDS, and civil society organizations to achieve sustained epidemic control. There will be an estimated 262,606 PLHIV in 2020. The achievement of 90-90-90 among the general population in Ghana requires that 236,345 persons living with HIV (PLHIV) know their status and that 212,710¹ of them are receiving treatment services by 2020. Female sex workers (FSW) and men who have sex with men (MSM) are disproportionately affected by HIV. Although national data does not reference Key Population Living with HIV (KPLHIV), the prevalence rate is significantly higher in KPs (11% in FSW, and 17% in MSM) compared to 1.5% (IBBSS, 2011) in the general population. Consequently, it is imperative to intensify interventions to reach, test and link MSM and FSW into care and treatment services. By the end of FY17, PEPFAR Ghana will reach 12,500 (MSM) and 32,000 (FSW) with a comprehensive package of prevention services; and 5,000 (MSM), 21,000 (FSW) with HIV testing services in the five southern regions of Ghana (Greater Accra, Ashanti, Western, Brong Ahafo, and Eastern).

COP16 builds off the Office of the Global AIDS Coordinator (OGAC) -directed geographic prioritization as planned in COP15. This pivot reduced PEPFAR's intervention zone to the mentioned 5 regions of Ghana. In COP15, PEPFAR Ghana supported 33 districts and 1 site (Cape Coast) to better focus our efforts. COP16 proposes a further reduction to 21 districts pending discussion with GF and Ghana's National AIDS Control Program (NACP). Depending on the outcome of these discussions, PEPFAR will transition out of 12 districts and Cape Coast before September 30, 2017.

The GoG committed to adopting Test and Start for all populations as mentioned in the draft National HIV/AIDS Strategic Plan for 2016-2020, and also included in the GoG's request for supplemental funding to scale-up treatment. Adoption of Test and Start will require the GoG to address the lack of systems to track and ensure that persons who test positive are immediately put on treatment and attain viral suppression. Accurate data is not made available to monitor the care cascade for PLHIV and specifically for KPLHIV; therefore, estimates for disease burden and treatment needs are either under or over-reported. NACP received funding from GF to conduct a cohort analysis of persons on treatment to provide an accurate report on the number of persons on treatment and to determine retention rates. Preliminary results released by NACP on April 1 2016 are yet to be validated and the final results will be released by June 2016. Currently, for the 89,113 persons on treatment there is no data on retention rates and number of persons who have attained viral suppression (NACP Service Data, 2015). This poses a major challenge in determining the level of support needed to ensure that PLHIV have access to quality care and treatment services, and it impedes accurate quantification and forecasting of ARVs, other drugs, and commodities.

Based on decisions from the COP16 Management Meeting (held March 2016 in Washington, D.C.), PEPFAR Ghana will focus efforts on achieving the first and second 90 of the UNAIDS Fast Track Strategy, and will also focus on strengthening systems needed to support the third 90.

¹Estimation based on the 2014 HIV Status Report by Ghana AIDS Commission

PEPFAR Ghana will support the GoG to develop and or revise national policies and systems needed to implement Test and Start. The interventions planned in COP16 will intensify case finding and linkage to care and retention for key populations; increase data availability and use; and improve laboratory systems by developing or revising policies to increase viral load testing and to improve quality assurance/quality improvement on HIV rapid testing and HIV-related diagnostic testing to improve clinical monitoring and accuracy of results related to the HIV cascade. Through its collaboration with the GoG and Global Fund, the team will provide technical assistance for the: 1) revision of HIV guidelines for the effective adoption of current WHO guidelines; 2) improvement of linkage to quality care and treatment services by piloting innovative and/or new evidence based models of linkage to care; 3) revision of laboratory policies along with development of a viral load scale-up plan; and 4) improvement of strategic information systems for better collection and analysis of clinical cascade data.

PEPFAR Ghana is unwavering in its commitment to build a model KP program for Ghana. To be successful, the team will strengthen its partnership with the GoG, specifically NACP and the Ghana AIDS Commission (GAC). There will be increased engagement with civil society to strengthen community systems to increase KP case finding and linkage to care, and to reduce stigma and discrimination of KPLHIV. In COP16, PEPFAR Ghana activities are focused on increasing reach and testing among KP, linking KP into care and treatment services, and increasing the availability and use of data for programming.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Ghana is a lower-middle income country with a population of 27,043,093 and a per capita income of \$1,426 (Ghana Statistical Services 2015)². Ghana is currently going through fiscal deficit challenges and is part of an International Monetary Fund (IMF) program targeting fiscal deficit reduction from 7.3% in 2015 to 3.5% in 2017 (2015 Budget Highlight Commentary, PwHC). Fiscal tightening could adversely affect government spending in the health and education sectors.

The HIV and AIDS epidemic in Ghana is mixed with low-level generalized epidemic (1.47% among the general population) and a disproportionately high prevalence among female sex workers (11.1%) and men who have sex with men (17.5%) (GAC HIV Status Report, 2014). The 2014 Ghana Demographic Health Survey (GDHS) identified regional variation in HIV infection with the highest prevalence in Eastern (2.8%), Western (2.7%), and Greater Accra (2.5%) regions, and lowest in the three northern regions (Northern, Upper East and Upper West) with less than 1%. By the end of 2014, an estimated 250,232 persons were living with HIV (8% - children and 59% - women). It is projected that the number of PLHIV will increase to 262,606 by 2020, with an expected decline in prevalence from 1.47% to 1.26% by 2020. There were an estimated 11,356 new HIV infections, 9,248 AIDS-related deaths, and 133,582 adults needing ART annually (2014 Status Report, Ghana AIDS Commission). Table 1.1.1 shows key national demographic and epidemiological data for Ghana.

² <http://www.statsghana.gov.gh>

The 2015 HIV service data from NACP indicate a total of 89,113 PLHIV currently on treatment (84,179 adults and 4,934 children). These data are being verified by NACP with support from Global Fund, and technical assistance from CDC and WHO. In 2015, 955,674 persons were tested for HIV with 45,863 (4.7%) testing positive. Of those testing positive, 24,203 (53%) were enrolled in care and 16,968 (37%) initiated on ART. Pregnant women form 73% (694,329) of clients tested for HIV. Of the 694,329 pregnant women who tested for HIV, 12,236 (1.8%) tested positive. Of these, 64% (7,813) were linked to care and placed on ART. Table 1.1.2 shows the cascade of HIV diagnosis, care and treatment in Ghana

The NSP 2011-2015 identified FSW, MSM, People Who Inject Drugs (PWID), and prison inmates as KP in Ghana; but there are limited data on the population size, behaviors and needs of PWID. Results of formative studies conducted in 2014 and 2015 in Accra ($n=100$) and Kumasi ($n=35$) found low testing rates and low perceptions of risk even though PWID reported needle sharing and high risk sexual behaviors³. The modes of transmission study (MOT, 2014) indicated that among adults (15-49 years of age), 48% of new HIV infections were associated with heterosexual sex; 28% with KPs and their sexual partners; and 24% were associated with stable heterosexual couples. New infections have continued to decline among adults, from 0.13% in 2006 to 0.06% in 2014.

The Global Fund and PEPFAR are the primary funders of KP interventions in Ghana. Both entities have prioritized working in the five regions with high disease burden, namely: Ashanti, Western, Brong Ahafo, Eastern and Greater Accra. However, Global Fund supports interventions in all 10 regions, with the larger portion of their investments are in Ashanti, Western, Eastern and Greater Accra. There are an estimated 44,289 FSWs and 20,921 MSMs in the five priority regions and an estimated 4,916 and 3,661 FSWs and MSM, respectively, living with HIV. To achieve the 90-90-90 targets, 4,424 FSWs and 3,295 MSM will need to know their status with 3,982 FSW and 2,966 MSM linked to care⁴.

In FY 15, PEPFAR reached 8,267 MSMs and 15,767 FSWs with a package of prevention services and identified 1,006 KPLHIV (523 MSM and 483 FSW)⁵. Testing was provided to 2,893 MSMs and 10,286 FSWs, and of these, 18% and 4.7%, respectively, were HIV positive. The actual number of KPLHIV who are linked to care and treatment services is currently unknown. Ghana Health Services (GHS) only disaggregates treatment data by age, sex and geographical location making it challenging to track KP linked to care and treatment. There are however a number of ongoing efforts and programs to obtain data on KP. The GAC is piloting an electronic-based unique identifier code (UIC) system to track KP through the HIV care continuum. Likewise, LINKAGES, a USAID prevention program, is also piloting a manual UIC system to facilitate KP tracking from reach through referral to care and treatment. CDC is supporting GHS to harmonize and integrate the UICs into an HIV E-tracker module in DHIMS2 to capture and track patient level data across the continuum of care. Additionally, data use agreements are being put in place with NACP to facilitate data sharing.

Under the GoG's current HIV treatment guidelines priority populations who test positive are

³Lisa Messersmith, Jennifer Beard, et al: HIV Vulnerability of Men and Women Who Inject Drugs in Kumasi, Ghana. 2014

⁴ COP 15 projected estimates based on estimated KP Population from IBBSS 2011

⁵Ghana AIDS Commission values are not yet available

immediately put on treatment. These groups include pregnant women, children under 5 years of age, HIV/TB co-infected persons, and discordant couples (GHS HIV Treatment Guidelines, 5th Edition 2014). In March 2016, the Ghana Health Service Technical Working Group on HIV Treatment approved the revision of the treatment guidelines to align with the recent WHO guidelines on Test and Start, which requires that everyone with known HIV positive status receive treatment.

As Ghana prepares to implement Test and Start, the country needs to address major programmatic and policy gaps to achieve epidemic control, including viral load testing, ARV shortage, and integration of community systems and clinical services. In 2015, only 53% of persons who tested positive were linked to care and 37% placed on ART (NACP Service Data 2015). With regards to ARVs, the Global Fund is the only assured source of ARVs procurement and forecasts indicate that 2016 and 2017 targets cannot be met without additional procurement to cover the GoG cohort. Other challenges that would delay the implementation of Test and Start are weak commodities management, quantification and forecasting, inadequate laboratory and clinical capacity; lack of institutional capacity to link clients to care, and high out-of-pocket costs and other opportunity costs for patients.

The current national treatment guidelines recommend the monitoring of treatment effectiveness and adherence through viral load (VL) testing at least once a year. It is envisaged that the implementation of Test and Start would markedly increase the demand for VL testing. Although Ghana currently has nine (Roche®) VL machines in nine of the ten geographical regions, coverage of VL testing is low (10-14%), and there are no policies or scale-up plans in place to support Test and Start. Specimen referral systems are weak and there are no official national guidelines on sample collection, analysis, results transmission, and tracking to enable a measure of VL suppression. The limited data systems for documenting retention and viral load levels pose a significant challenge to tracking the achievement of the second and third 90s.

The implementation of Test and Start requires strong linkages between community outreach strategies and access to clinical services. Ghana's KP program is civil society and outreach-focused with clinical services provided by GHS. However, the interface between community and facility is weak, which results in inadequate linkages between community-based prevention and facility-based care and treatment for KP. Although the Models of Hope program is an effective service delivery model for linking PLHIV into care, it is unsustainable unless there is an established incentive structure for peer educators and formal recognition by the GHS. In addition, a more robust integrated data system is needed to support community- and facility-based service delivery and monitor and address gaps in the HIV care cascade.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year	
			Female		Male		Female		Male			
	N	%	N	%	N	%	N	%	N	%		
Total Population	27,043,093	NA	5,111,145	18.9	5,138,188	19	8,680,833	32.1	8,112,928	30	Ghana Statistical Service 2015	
HIV Prevalence (%)		1.47		NA		NA		NA		NA	2014 HIV Status Report, GAC	
AIDS Deaths (per year)	9,248		635		659		3,858		4,095		2014 HIV Status Report, GAC	
# PLHIV	250,232		10,322		10,902		137,916		91,093		2014 HIV Status Report, GAC	
Incidence Rate (Yr)		0.07		NA		NA		NA		NA	2014 HIV Status Report, GAC	
New Infections (Yr)	11,356		1,889 (16.6%)				9,467 (83.4%)					2014 HIV Status Report, GAC
Annual/Registered births	652,730	2.41									DHIMS2 generated on 02/23/2016	

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
% of Pregnant Women with at least one ANC visit	NA	97.3	NA								MICS 2011
Pregnant women needing ARVs	10,226	7.6	NA								2014 HIV Status Report, GAC
Orphans (maternal, paternal, double)	124,869		NA								2014 HIV Status Report, GAC
Notified TB cases (2014)	14,999		NA								NTP Annual Report 2015
% of TB cases that are HIV infected	2,662		304 (N), and 11.4% for both male and female				2,358 (N) and 88.6% for both male and female				NTP Annual Report 2015
% of Males Circumcised	NA	96									GDHS 2014
Estimated Population Size of MSM*	30,579	0.48									IBBSS 2011
MSM HIV Prevalence	6,032	17.5									IBBSS 2011

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		N
	N	%	N	%	N	%	N	%	N	%	
Estimated Population Size of FSW	51,937	0.80									IBBSS 2012
FSW HIV Prevalence	5,765	11.1									IBBSS 2011
Estimated Population Size of PWID	NA	NA									NA
PWID HIV Prevalence	NA	NA									NA
Estimated Size of Priority Populations (Pregnant women)	1,003,162	4	NA	NA	NA	NA	NA	NA	NA	NA	NACP Service data Report 2014
Estimated Size of Priority Populations Prevalence (pregnant women)	NA	1.6	NA	NA	NA	NA	NA	NA	NA	NA	NACP HSS Report 2014

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate	HIV Prevalence	Total PLHIV	On ART	Retained on ART 12 Months	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	27,043,093 ³	1.5 ²	250,232 ²	89,113 ¹			955,674 ¹	45,863 ¹	16,968 ¹
Population less than 15 years	9,761,626 ³	NA	21,223 ²	4,934 ¹			NA	NA	1,093 ¹
Pregnant Women	1,003,162 ¹	1.6 ⁴	10,226 ¹	7,813 ¹			694,239 ¹	12,236 ¹	7,813 ¹
MSM	30,579 ⁵	17.5 ⁵							
FSW	51,937 ⁵	11.1 ⁵							
PWID	NA	NA							

* Sources of data: ¹2015 NACP Service Data Report, ²2014 HIV Status Report, ³2014 Statistical Service Population estimate, ⁴2014 HIV Sentinel Survey, ⁵2011 IBBSS

1.2 Investment Profile

In 2011, the GoG pledged about US \$1 million as additional funding to reduce the resource gap between the GoG budget allocations and donor funding for the National HIV and AIDS Response. This high level commitment was to have been released over the period of the NSP 2011-2015. However, the annual release of these and other GoG funds allocated for the procurement of ARVs were often delayed due to the difficult economic situations⁶. Cutting spending is a critical component of the GoG response to the current economic situation, and spending by the Ministry of Finance has markedly decreased over the years. As a result, the funding that was released was not enough to initiate new clients on ART or to implement other important HIV prevention interventions, including HIV Testing Services (HTS). Due to the growing financial crisis and budget deficit, it is unlikely there will be substantial increase in funding for HIV in the next fiscal year.

The major sources of funding for the \$444 million NSP 2011-2015, which ended in December 2015, were the Global Fund, PEPFAR, and the GoG. The UN System provided technical assistance (TA), especially for HIV and AIDS systems strengthening and monitoring and evaluation. Prevention of new HIV infections made up the largest share of the NSP budget, representing 47% of the entire budget, and was driven mainly by funding for KP (\$82 million). Treatment, care, and support accounted for 18% of the NSP budget (\$79 million).

The 2016 budget allocation for the Ministry of Health (MoH) is approximately US \$1.2 billion in the 2016 FY budget⁷. The National AIDS Spending Assessment (NASA) estimates⁸ that the total expenditure on HIV and AIDS related activities decreased by 39% from 2012 to 2013, from \$109 million to \$67 million. International funding also decreased during these two years: from 80% of expenditures in 2012 and 60% in 2013. The GoG covered 4% in 2012 and 10% in 2013. Conversely, private funding has seen consistent increases over the same period; increasing from 16% in 2012 to 29% in 2013, and finally to 47% in 2014. In 2012 and 2013, household funds accounted for almost all of the private funds spent on HIV and AIDS related expenses. Despite a decline, donor funds are essential to HIV and AIDS programming. In 2015, the GoG's parliamentary appropriation for the health sector was \$334 million⁹; however, the overall required total financing was \$1.2 billion. Other expected sources of financing are the National Health Insurance (\$348 million), internally generated funds (\$249 million) and donor support (\$1.7 million) (2015 Health Summit presentations, Ghana Ministry of Health).

The Global Fund is by far the largest external source of funding for the HIV sector. Ghana has been the recipient of three HIV and AIDS Global Fund grants. Rounds 1 and 5 funding (2002-2011) were awarded to the MoH/GHS for clinical service provision, and

⁶GHC 35 million (23.3%) of the committed GHC 150 million had been released by the end of 2013

⁷2016 Budget Statement and Economic Policy of the Government of Ghana

⁸The NASA report for 2014/2015 is yet to be published

⁹Interbank Exchange rate: ₵1 = \$4.0117 for June 2015;

https://www.bog.gov.gh/index.php?option=com_wrapper&view=wrapper&Itemid=89

focused on health system strengthening and the scale-up of prevention, treatment, and care. To-date, Ghana has signed with Global Fund for a cumulative total of \$597 million to address HIV/AIDS, TB and malaria, of which \$261 million (44%) has been used to address HIV and AIDS.

For the 2015-2017 Concept Note, Ghana requires \$110 million¹⁰ to respond to the HIV and TB epidemics. The budget is allocated primarily toward ART (39%), 14% for PMTCT, 14% for TB care and prevention and TB/HIV, 7% for HIV prevention among FSWs, and 3% for HIV prevention among MSM. Almost 20% of the entire budget is for laboratory commodities, including HIV rapid test kits and commodities needed for CD4, EID, and VL testing. The NSP investment profile by intervention area and by funding agent type in 2013 is included in Table 1.2.1. The procurement profile for key commodities by program area, expenditure, and by funding agent type from 2014 is included as Table 1.2.2. Non-PEPFAR funded investments and integration by funding source, number of co-funded implementing mechanisms and objectives are detailed in Table 1.2.3. Table 1.2.4 lists USG non-PEPFAR Funded Investments and Integration.

¹⁰ The full request amount from Ghana was for \$123.7 million - \$ 109.5 million within the allocation set by Global Fund and \$14.3 million for incentive funding. Ghana was not awarded the incentive funding.

Table 1.2.1: Investment Profile by Intervention Area and by Funding Agent Type, 2013¹¹

NSP Intervention Area	Public	Private	International Organizations	Grand Total
Prevention	1,872,328	54,571	13,682,767	15,609,666
Care and treatment	1,771	19,592,484	10,418,544	30,012,799
Orphans and vulnerable children (OVC)	-	-	98,208	98,208
Programme management and administration	3,762,861	84,223	5,512,803	9,359,887
Human resources	872,632	6,735	7,110,999	7,990,366
Social protection and social services (excluding OVC)	-	-	2,653,735	2,653,735
Enabling environment	321,216	-	190,396	511,612
HIV and AIDS-related research	-	-	790,392	790,392
Total	6,830,808	19,738,013	40,457,844	67,026,665

¹¹ NASA 2013

Table 1.2.2 Procurement Profile for Key commodities by expenditure, and by funding agent type, 2014

Program Area	Total Expenditure	% PEPFAR	% GF	% GoG	% UNFPA & WAHO
ARVs	\$20,811,948	0%	67%	33%	0%
Rapid test kits	\$2,257,675	0%	100%	0%	0%
Lab reagents	\$7,761,0289	0%	100%	0%	0%
Condoms	\$1,744,614	62%	0%	0%	38%
Total	\$32,575,265	3%	73%	21%	2%

Notes

1. The reported data are in respect to calendar year 2014 (Jan-Dec 2014).
2. PEPFAR provided ARVs for Ghana using the Emergency Commodity Fund (\$1.9 million loan). This amount is included in the GoG funding for ARVs.
3. For lab reagents, quoted figures are from contracts awarded by MOH in 2014.
4. For condoms, the PEPFAR figure is for condoms donated through the PEPFAR/USAID commodity fund.

Table 1.2.3 Non-PEPFAR funded investments and integration by funding source, number of co-funded implementing mechanisms and objectives, 2017

Funding Source	Total USG Non PEPFAR Resources	Non PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contributions	Objectives
USAID MCH	8,000,000	800,000	2	2	Communication; Evaluation; Capacity building & Advocacy
USAID Malaria	28,000,000	1,050,000	3	3	Communication; Evaluation; Capacity building & Advocacy; Supply Chain
USAID FP	15,000,000	1,572,300	4	4	Communication; Evaluation; Capacity building & Advocacy; Supply Chain
CDC GHS	1,417,000	0	0	0	Develop and deploy novel diagnostics and strengthen laboratory systems; Improving Surveillance and the use of strategic Information.
USAID Water	8,500,000	900,000	2	2	Communication; Evaluation; Capacity building & Advocacy;
USAID Nutrition	7,000,000	962,000	3	3	Communication; Evaluation; Capacity building & Advocacy;
Total	67,917,000	5,284,300	-	-	-

Table 1.2.4 USG Non-PEPFAR Funded Investments and Integration						
Funding Source	Total Non-COP-PEPFAR Resources	Total Non-PEPFAR Resources	Total Non-COP funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contributions	Objectives
PEPFAR KP Challenge Fund (KPCF)	1,056,260	-	2	1	-	Evaluation
PEPFAR KPIS	1,550,000	-	2	1	-	Evaluation
PEPFAR Local Capacity Initiative (LCI)	710,000	-	1	1	3,000,000	Capacity Building and Advocacy
Total	3,316,260				3,000,000	

1.3 National Sustainability Profile

The process for completing the Sustainability Index Dashboard (SID) differed from 2015. The new process facilitated consensus building, and strong endorsement of the completed SID. PEPFAR Ghana facilitated three meetings to ensure completion of the SID 2.0. Meetings were convened in collaboration with key partners such as UNAIDS, Global Fund (Global Fund Secretariat, the Global Fund Country Coordinating Mechanism), and WHO. Opening remarks for the first meeting were given by the Minister of Health, Global Fund's Ghana Fund Portfolio Manager, and UNAIDS Country Director; and for the second and third meetings, remarks were given by the GAC; the meetings were chaired by the Global Fund Country Coordinating Mechanism (CCM), MoH, and GAC. The first meeting was held with senior decision-makers and policy makers, with objectives to introduce the SID 2.0 tool and objectives, and to highlight PEPFAR's goals towards epidemic control. The second meeting was held with the technical officers from the various stakeholder institutions, and the objective was to complete the dashboard. The final meeting included both senior and technical staff. The objective was to present the dashboard and to request clearance to publicize the SID. All comments were incorporated after the third meeting and the final version of the dashboard circulated to high level stakeholders for official country clearance by the Director General of GHS, with concurrence by the Director General of GAC.

The Stakeholders' involved in the entire process included GHS (NACP, National TB Control; and the Policy Planning, Monitoring and Evaluation program (PPME)); Ghana Armed Forces (GAF); multilateral partners (Global Fund, UNAIDS, GIZ, WHO); academia (ISSER¹², NMIMR); Civil Society Organizations (CCM, NAP+GH, GHANET, Socioserve Ghana); media groups; Ghana Employers Association; Korle Bu Teaching Hospital; USG agencies and their implementing partners. Participants appreciated that the SID provided a snapshot of Ghana's strengths as well as vulnerabilities. For policy makers in particular, the SID summarizes the key areas that must be addressed in order to improve access to quality HIV services and to increase technical and allocative efficiencies for a sustainable country response.

Sustainability Strengths

- **Planning and Coordination:** GAC convenes and coordinates the HIV response across all levels of government, key stakeholders, civil society and the private sector. GAC is leading the development of the 2016-2020 NSP. This strategy will serve as the primary reference document for Ghana's AIDS response.
- **Civil Society Engagement:** Local civil society organizations are active partners at all levels of the HIV/AIDS response. They are actively involved in the annual partnership forum convened by GAC. CSOs are consulted and actively participate in working groups to develop policies and guidelines. The current legislative framework allows for civil society to receive tax waivers upon application.

¹² ISSER: Institute for Social, Statistical, and Economic Research; NMIMR: Noguchi Memorial Institute for Medical Research

- Quality Management (QM): The MoH has institutionalized quality management systems to improve and maintain the quality of HIV/AIDS service delivery. HIV focal persons at various levels of health delivery have been trained in QM. QM is a major component of key guidelines, e.g., ART.

Sustainability Vulnerabilities: Donor funding has declined in recent years, which will force the GoG to prioritize HIV/AIDS services and increase domestic resources to support the HIV/AIDS response. PEPFAR Ghana is uniquely positioned to support:

- Commodity Security and Supply Chain: The Procurement Unit within the MoH is tasked with the responsibility of forecasting, procurement and warehousing, but there are continuous systemic issues that result in delays and occasional stock-outs of essential commodities. In addition, the GoG's commitments to purchase ARVs and test kits are usually not fulfilled on schedule. PEPFAR can use donor platforms and the CCM to elevate discussions around challenges associated with ARV purchase and distribution. In the event that the GoG receives one-time funds to purchase two years' worth of ARVs, PEPFAR Ghana will work with the GoG to develop a timeline for transition of financial responsibility from PEPFAR to the GoG. According to Ghana's National Health Insurance Act 852 (NHIA), the MoH receives annually 10% of the funding collected from Value Added Tax revenue for the National Health Insurance Scheme. Hitherto, that funding has been used for infrastructure development by the MoH. Given Ghana's current macroeconomic situation, the MoH has indicated that that funding will now be used for the purchase of drug commodities, in particular childhood vaccines and ART. In 2015, the NHIA received 968 million Ghana cedis (\$350 million) from VAT receipts of which 10% is to be transferred to the MoH. As the tax base continues to increase, additional funding will become available as a sustainable source of regular financing for commodity purchases.
- Laboratory: Ghana currently has regulations in place to monitor the quality of its laboratories and Point of Care Testing (POCT) sites, but such existing regulations are partially implemented. The country is currently developing specific guidelines and QA standards. PEPFAR is well positioned to provide technical assistance to GAC and NACP as they update national policies and guidelines relevant to the delivery of HIV services. This includes revised guidelines to implement Test and Start, laboratory policies, and the viral load scale-up plan.
- Service Delivery: Although there are improvements in service delivery, PEPFAR Ghana would need to gather the appropriate data to have an accurate description of linkages to care. PEPFAR Ghana in COP 15 was approved to implement the E-tracker system which will provide accurate information on number of persons linked to care and retained on treatment.

1.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR Ghana reviewed the expenditures by region and triangulated that with PLHIV and KP data. Figure 1.4.1 shows that there were opportunities to focus spending for maximum impact by moving out of regions that have smaller PLHIV numbers but high

expenditures, particularly the Upper West Region, Central Region, Northern Region and the Volta Region. The expenditure data versus percent PLHIV has been taken into consideration when identifying the geographic pivot to working in Greater Accra, Eastern Region, Western Region, Ashanti, and Brong Ahafo regions in the implementation of COP15. Based on PLHIV and KP data, these represent regions where the burden is highest and has the greatest potential for impact. In COP16, PEPFAR Ghana will continue to focus on those districts that provide the highest yield. A PEPFAR expenditure by FSW table (Table 1.4.2) has also been included to similarly highlight the expenditures by SNU for a segment of the key populations.

Figure 1.4.1

2015 Expenditure per PLHIV by SNU

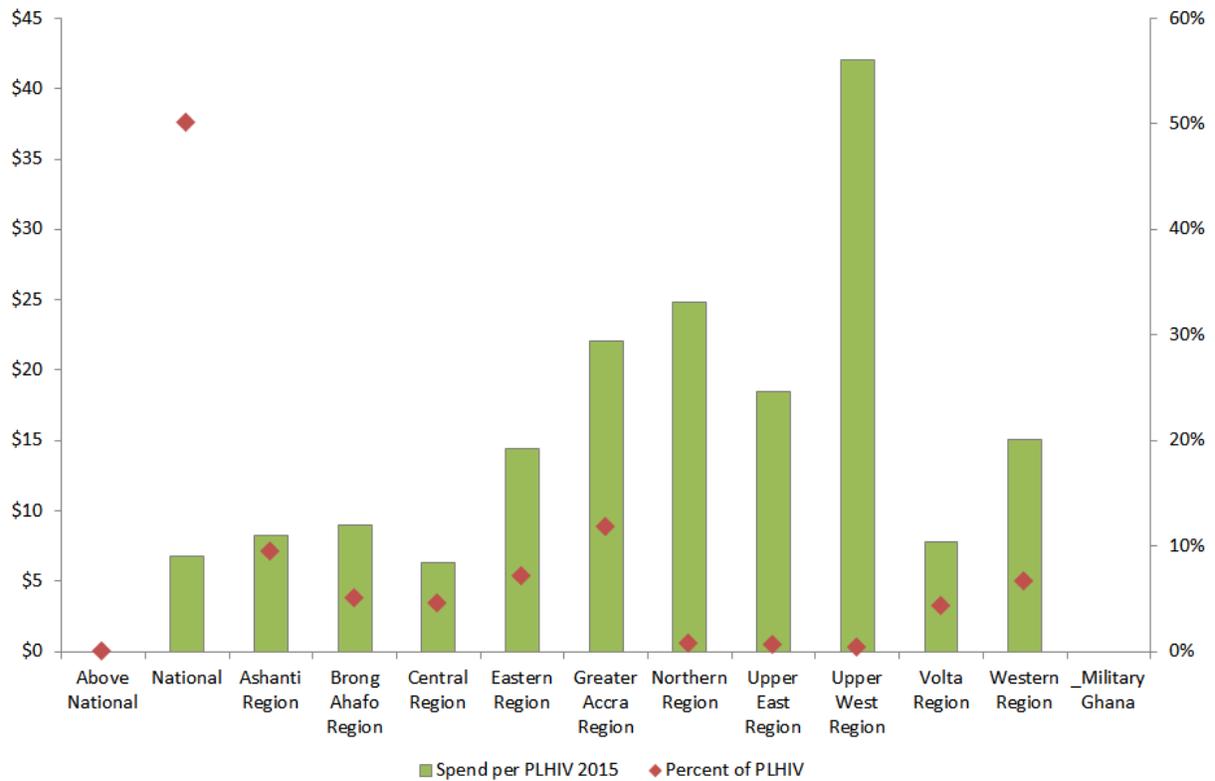


Figure 1.4.2

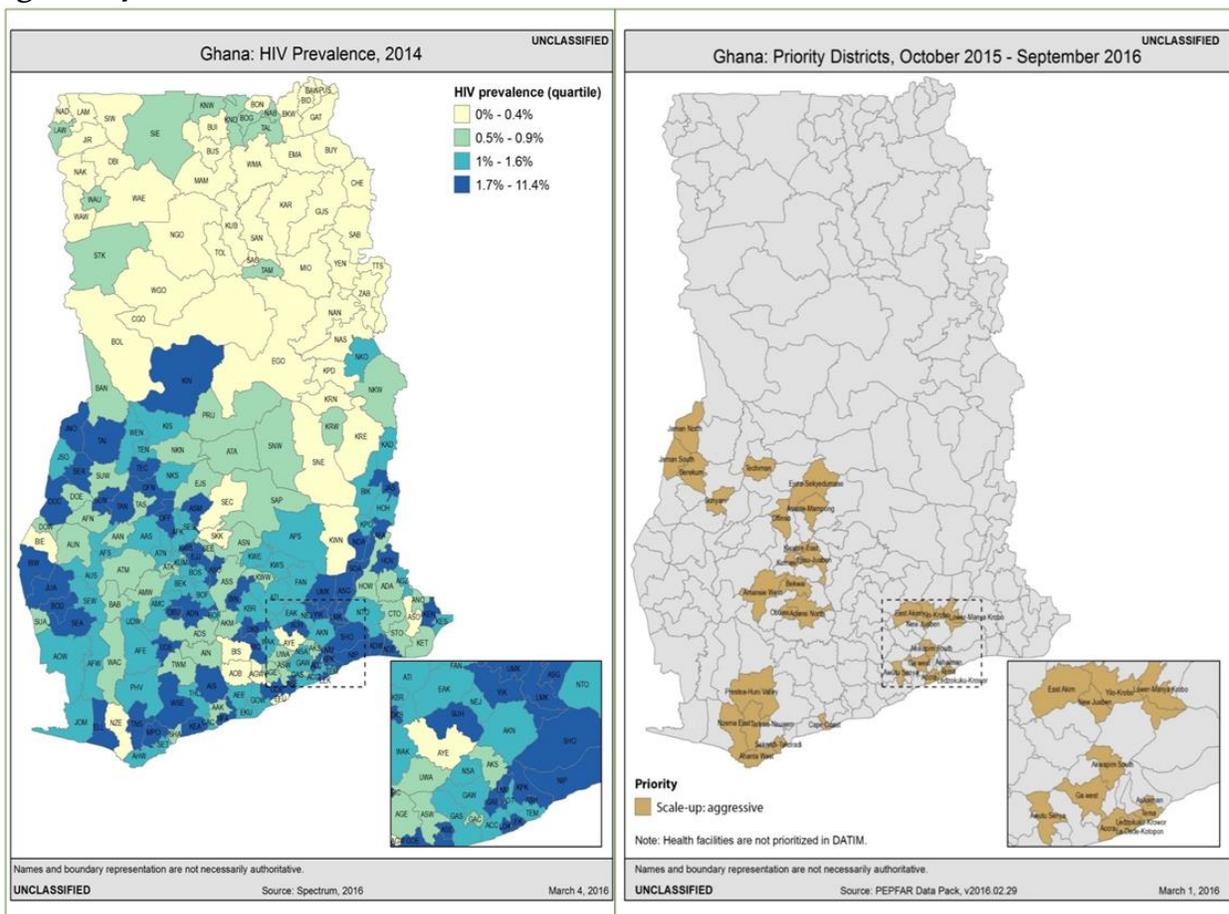


Table 1.4.2

Regions	Expenditure (USD\$) by Region	Total PLHIV by Region
Ashanti	390,127.28	47,114
Brong Ahafo	225,772.83	25,019
Central	140,243.82	22,228
Eastern	510,685.09	35,454
Greater Accra	1,302,569.04	59,010
Northern	84,564.54	3,406
Upper East	51,835.54	2,807
Upper West	53,882.57	1,282
Volta	164,000.73	21,088
Western	495,392.06	32,824
Military Ghana	291,898.53	-
National	3,710,972.03	250,232

1.5 Stakeholder Engagement

As a key partner in Ghana's HIV response, PEPFAR Ghana engages stakeholders on an ongoing basis to ensure synergies and to avoid duplication in programming funds for HIV/AIDS interventions. The team is represented on the CCM (USAID Health Director is a voting member); and on various steering and technical working groups (TWGs) of GAC, NACP, and GHS such as the Key Populations TWG; the Expanded TWG; the Research, Monitoring and Evaluation TWG; and the NACP TWGs for Care and Treatment and for HIVDR; and participation in the annual HIV Partnership Forum.

PEPFAR 3.0 was presented at the annual GAC Partnership Forum held in November 2015. Agreements from the Partnership Forum and its business meeting culminated in an Aide Memoire reflecting a shared commitment for HIV activities in 2016. In addition, PEPFAR briefed stakeholders on outcomes of the COP 16 Management Meeting. Following COP submission, the final SDS and supporting documents will be shared with partners. A series of meetings are tentatively scheduled between the submission date and the review date to give partners an opportunity to provide feedback on COP16.

CSO Engagement: Although 10 local CSOs are current PEPFAR implementing partners, and up to 20 will be engaged in COP16, active engagement of non-implementing partner CSOs is still in the beginning stages. Given the emphasis on community systems strengthening for KPLHIV, the PEPFAR Ghana team has engaged with and funded its 10 current CSO partners to support program planning and activity implementation at the community level. Last year, the team took steps to formalize its engagement with the broader network of CSOs and is now finalizing an engagement plan. The UNAIDS CSO forum has served as the entry point for this engagement.

In COP16, PEPFAR Ghana plans to increase the frequency and quality of engagement with its CSO partners, including information sharing, solicitation of feedback, quarterly planning meetings, and increased involvement in the COP planning process. In preparation for COP16, CSO leaders were briefed on PEPFAR funding opportunities, the COP process, and expectations of CSOs with regards to providing feedback on PEPFAR strategies and activity development. PEPFAR Ghana will regularly engage this CSO forum for on-going feedback on PEPFAR activities.

In COP16, PEPFAR Ghana will also increase the capacity of CSOs to effectively advocate on key issues in the HIV sector. In support of this objective, the team has repurposed funding through the Ambassador's Fund to support activities included in the CSO Engagement Plan. The US Embassy will work with CSOs to advocate on commodity issues such as "stock outs." The team will also assist CSOs in mobilizing and empowering communities to demand better and more equitable service delivery.

In tandem with the Ambassador's Fund, the Local Capacity Initiative (LCI) fund, which will be implemented in COP 16, will also strengthen CSO technical and leadership capacity to advocate and mobilize communities to address barriers to service uptake and

demand better health service delivery. The LCI will also strengthen CSO monitoring of health sector policies and processes. The activities of the two community engagement mechanisms will be tightly coordinated to avoid duplication of efforts.

2.0 Core, Near-Core and Non-Core Activities

In COP15, PEPFAR Ghana prioritized program activities as core, near-core, or non-core based on the review of available epidemiological data, the Ghana Investment Profile for the National HIV/AIDS Response, the results of the Sustainability Index and Dashboard assessment, and the USG comparative advantages. An additional review was conducted this year to ensure that activities would accelerate Ghana's progress toward reaching sustained epidemic control.

Core activities are those that will intensify KP case finding and linkage to care, increase availability of data and use of data to inform programming, and support development of lab policies needed to support Test and Start. Refer to Appendix A for a list of activities by program area.

3.0 Geographic and Population Prioritization

PEPFAR Ghana analyzed epidemiology and programmatic data to identify sub-populations and priority regions and districts to focus USG efforts to raise HIV coverage for epidemic impact. PEPFAR Ghana utilized national epidemiologic and programmatic data publicly available, including HIV sentinel survey, the NACP annual report; and further conducted series of enhanced data analysis and interpretation steps to ensure that the program is focused on the populations and locations where PEPFAR investments will have the greatest impact. Limitations in data for decision making, however, continue to hinder use of real time data for evidence based decision making and programming. For instance, size estimates and HIV prevalence for KP is outdated; there is lack of ART KP coverage data and other vulnerable populations; and there are no data for VL. In the last year, USG supported Ghana to conduct the Demographic and Health Survey (GDHS) but this does not include data on KP. There is, however, a Global Fund supported FSW IBBSS for which final results will be available by June 2016, while PEPFAR will implement an MSM IBBSS during the COP 16 period.

While HIV-infected FSW and MSM make up less than 0.5% of the total Ghanaian population, they may be associated with as much as 28% of new infections among adults aged 15-49 years of age (MOT 2014). Based on analysis of national prevalence and programmatic data, PEPFAR Ghana has already begun implementing the right things in the right places, and has transitioned out of non-core activities and working with lower risk populations. By the end of FY15, PEPFAR Ghana had transitioned all general

population prevention, OVC, PMTCT, and preparatory laboratory accreditation activities over to the Global Fund and the GoG. Also in FY15, PEPFAR Ghana completely transitioned out of four regions (Northern, Upper East, Upper West, and Volta). These four regions have a lower HIV burden, and they generally have higher costs to reach KP with prevention or HTS interventions (see figure 1.4.3). As seen in Tables 1.4.2 and 1.4.3, the highest estimated numbers of FSW and MSM in the five PEPFAR priority regions and nearly two thirds of all FSW are estimated as located in two of these regions, Greater Accra or Eastern Region (2011 FSW IBBSS).

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for priority locations and populations

As mentioned in 1.1, there are an estimated 44,289 FSWs and 20,921 MSM in the five priority regions supported by PEPFAR. To achieve the 90-90-90 targets, 4,424 FSWs and 3,295 MSM have to know their status; 3,982 FSW and 2,966 MSM linked to care; and 3,584 FSW and 2,669 MSM must attain viral suppression. In FY 17, PEPFAR Ghana will reach 12,500 MSM and 32,000 FSW with a comprehensive package of prevention services; and provide HIV testing services to 5,000 (MSM) and 21,000 (FSW) in Greater Accra, Ashanti, Western, Brong Ahafo, and Eastern regions. Table 4.1.1 shows the KP 90-90-90 estimated targets for the five priority regions.

Table 4.1.1 Key Population 90 90 90 Estimates for the Five Priority Regions, Ghana Projected to 2020¹³

Region	Pop estimates		HIV Positive		90% know their status		90% on Treatment		90% Viral Suppression	
	FSW	MSM	FSW-HIV+	MSM-HIV+	90%-FSW	90%-MSM	90%-FSW	90%-MSM	90%-FSW	90%-MSM
Ashanti Region	4,808	6,056	534	1,060	480	954	432	858	389	772
Greater Accra Region	19,840	5,813	2,202	1,017	1,982	916	1,784	824	1,606	742
Eastern Region	14,432	3,130	1,602	548	1,442	493	1,298	444	1,168	400
Western Region	1,918	3,084	213	540	192	486	172	437	155	393
Brong Ahafo Region	3,291	2,838	365	497	329	447	296	402	266	362
TOTAL	44,289	20,921	4,916	3,661	4,424	3,295	3,982	2,966	3,584	2,669

¹³ Based on Population Size Estimates from 2011 FSW and MSM IBBS surveys

Selection of Districts: Ghana currently does not have district level size and prevalence estimates for KPs. District selection and target setting is therefore based on the 90-90-90 targets set in COP 15 and program performance data (APR 15 and FY 16 Q1 data). COP 16 targets aim to progress toward increasing reach to test ratio to 40% for MSM and 66% for FSW compared to 40% each in COP 15.

PEPFAR Ghana's lowest level of program implementation is the district; therefore SNU 4 is district (SNU₂ = National, SNU₃ = Regional). The decision to not report data beyond district level is due to patterns of MSM and FSW access HIV services. Both groups tend to access services in more than one location within a district. In APR₁₅ (Q₂) PEPFAR Ghana attempted to collect site level data and the results showed gaps in data (numbers reached and test data could not be attributed to specific sites), and there was some data duplication between sites. LINKAGES was the prime implementing partner supporting KP related interventions. Due to KP data safety and security issues, LINKAGES/FHI₃₆₀ was not asked to report on site level data; only aggregated data was reported. Even though LINKAGES partners did collect site level data, this was never reported given the aforementioned safety/security issues. In addition, site level data collection was further complicated by the slow shift from paper based record keeping/tracking, to use of a UIC. Finally, with no formal data sharing agreement between the NACP and the USG, reporting on site level data is not possible. PEPFAR Ghana has been working with the government to have a formal data sharing agreement for USG programs. These data management issues have been raised with the new implementing partner, John Snow Inc., so they can already include preventive measures and plan to report site level data. For COP 17, PEPFAR Ghana should be able to analyze site performance data and identify high yield sites as well as key hotspots.

The geographic prioritization of districts was based on yield and other contextual factors: first, a cut off yield point of 6% based on the calculated median yield for all districts for FY 2016 Q₁, and second, a cutoff point of total positive of 5 based on the calculated median total positive for all districts from FY 2016 Q₁. Districts that met both criteria were selected. Districts that met at least one of the set criteria were then further analyzed based on country and program context. Districts that did not meet either of the two criteria and did not have a strong justification, were classified as *Centrally-supported*. One site, Cape Coast and one district, Awutu Senya were excluded from the analysis. Prior to COP development, PEPFAR Ghana had agreed with the GoG to transition the entire Central Region to the Global Fund, which currently has extensive program presence in the region. However, the transition plans have not been finalized, therefore Cape Coast and Awutu Senya will be included in the COP 16 cohort until final agreements are reached with Global Fund and the GoG. Out of the 33 districts plus one site, 21 districts will be categorized for *Scale-up* and 12 districts plus one site as *Centrally Supported*.

KP Target Setting for COP 16: A weighted proportion for each of the 21 selected districts was derived from the estimated number of PLHIV in each district by the total number of PLHIV in all 21 districts. (Number. of PLHIV in each district/84,956). The weighted

average formed the basis to target distribution among the districts. The overall target was derived by taking the total 'reached' in FY 2015 Q4 or FY 2016 Q1 (whichever was higher) for the 21 districts and multiplied by 4 (quarters) to get the estimated annual target. There are no targets for the *Centrally Supported* districts.

The MSM reach target was derived by adding up FY 2015 Q4 MSM reached performance data for the 21 districts (3,048), and multiplied by 4 (representing four quarters in the year) to get the estimated annual target for all 21 districts. The resulting figure (12,192) was rounded off, based on the potential for an improvement, and the anticipated performance from John Snow Inc. to get the final estimates of 12,500 for all the 21 districts. The 12,500 was then distributed among the districts based on the weighted proportions

FSW target derived from adding up FY 2015 Q4 FSW reached performance data for the 21 districts (8,257), and multiplied by 4 (representing four quarters in the year) to get the estimated annual target for all 21 districts. The resulting figure (33,028) was conservatively reduced to 32,000 by team as a compensatory measure. The 32,000 was then distributed among the districts based on the weighted proportions

The current SOP for implementing HIV programs among key populations¹⁴ recommends that at minimum 40% of FSW reached and 60% of MSM reached must be tested. However, with the transition to a new mechanism (John Snow Inc.), coupled with the anticipated improved performance, the testing target for both MSM and FSW was estimated at 80% representing 10,001 and 25,601 for MSM and FSW respectively. The number of estimated HIV positive was based on FY 2016 Q1 yield, adjusted by 15% for MSM and 11% for FSW.

In districts where there are no MSM programs and MSM CSOs, the reached target was zeroed and the associated target figure proportionally distributed to the remaining districts with MSM activated programs and CSOs.

¹⁴ GAC: Standard Operating Procedures for Implementing HIV Programs among Key Populations in Ghana, February 2014

Table 4.1.2 PEPFAR FY 17 Targets by District¹⁵

Region	District	PLHIV	KP_PREV			HTC_TST					
			MSM Reached Target	FSW Reached Target	Total Reach Target	MSM Tested Target	FSW Tested Target	Total Tested Target	MSM HIV +	FSW HIV +	Total HIV +
Greater Accra	Accra Metro	20,707	4,412	7,988	12,400	3,530	6,391	9,921	530	786	1316
	Ashiaman	3,235	-	1,218	1,218	-	974	974	-	97	97
	Ga West	2,741	-	1,032	1,032	-	826	826	-	125	125
	La Dadekotopon	3,782	148	100	248	118	80	198	24	40	64
	La Nkwantanang	2,831	-	1,066	1,066	-	853	853	-	85	85
	Tema Metro	3,372	616	2,086	2,702	493	1,669	2,162	74	167	241
Ashanti	Bekwai	973	630	108	738	504	86	590	76	15	91
	Ejura Sekyedumase	502	540	-	540	432	0	432	65	-	65
	Obuasi	2,872	-	1,082	1,082	-	866	866	-	104	104
	Kumasi Metro	18,522	2,511	2,988	5,499	2,009	2,390	4,399	323	239	562
Brong Ahafo	Berekum	3,472	-	1,308	1,308	-	1,046	1,046	-	105	105
	Jaman North	1,355	-	1,500	1,500	-	1,200	1,200	-	120	120
	Techiman	2,059	137	776	913	110	621	731	20	119	139
	Sunyani	2,646	509	997	1,506	407	798	1,205	62	80	142
Eastern	Lower Manya Krobo	4,051	-	704	704	-	563	563	-	56	56
	New Juabeng	2,264	520	3,289	3,809	416	2631	3,047	62	263	325
Western	Jomoro	1,345	480	507	987	384	406	790	58	61	119
	Prestea-Huni Valley	1,328	-	500	500	-	400	400	-	40	40
	Sekondi Takoradi Metro	4,789	1,416	3,466	4,882	1,133	2773	3,906	170	277	447
	Shama	455	581	171	752	465	137	602	70	71	141
	Tarkwa-Nsueam	1,656	-	1,114	1,114	-	891	891	-	89	89
	TOTAL	84,957	12,500	32,000	44,500	10,001	25,601	35,602	1,534	2,939	4,473

¹⁵PP_Prev Target not included but will be reported to OGAC by Department of Defense

Table 4.1.3 – PEPFAR FY 18 Targets by District^{16 17}

Region	District	PLHIV	KP_PREV			HTC_TST					
			MSM Reached Target	FSW Reached Target	Total Reach Target	MSM Tested Target	FSW Tested Target	Total Tested Target	MSM HIV +	FSW HIV +	Total HIV +
Greater Accra	Accra Metro	20,707	4,633	8,387	13,020	3,706	6,710	10,416	556	825	1381
	Ashiaman	3,235	0	1,279	1,279	-	1,023	1,023	-	102	102
	Ga West	2,741	-	1,084	1,084	-	867	867	-	131	131
	La Dadekotopon	3,782	155	105	260	118	84	202	24	42	66
	La Nkwantanang	2,831	-	1,119	1,119	-	895	895	-	90	90
	Tema Metro	3,372	647	2,190	2,837	493	1,752	2,245	74	175	249
Ashanti	Bekwai	973	662	113	775	504	91	595	76	15	91
	Ejura Sekyedumase	502	567	-	567	432	-	432	65	-	65
	Obuasi	2,872	-	1,136	1,136	-	909	909	-	109	109
	Kumasi Metro	18,522	2,637	3,137	5,774	2,009	2,510	4,519	323	251	574
Brong Ahafo	Berekum	3,472	-	1,373	1,373	-	1,099	1,099	-	110	110
	Jaman North	1,355	-	1,575	1,575	-	1,260	1,260	-	126	126
	Techiman	2,059	144	815	959	110	652	762	20	125	145
	Sunyani	2,646	534	1,047	1,581	407	837	1,244	62	84	146
Eastern	Lower Manya Krobo	4,051	-	739	739	-	591	591		59	59
	New Juabeng	2,264	546	3,453	3,999	416	2,763	3,179	62	276	338
Western	Jomoro	1,345	504	532	1,036	384	426	810	58	64	122
	Prestea-Huni Valley	1,328	-	525	525	-	420	420	-	42	42
	Sekondi Takoradi Metro	4,789	1,487	3,639	5,126	1,133	2,911	4,044	170	291	461
	Shama	455	610	180	790	465	144	609	70	74	144
	Tarkwa-Nsueam	1,656	-	1,170	1,170		936	936	-	94	94
	TOTAL	84,957	13,125	33,600	46,725	10,177	26,880	37,057	1,560	3,085	4,645

¹⁶PP_Prev Target not included but will be reported to OGAC by Department of Defense

¹⁷FY18 targets are set at an increase of 5% over FY17 targets

4.2 Priority population prevention

KP: Ghana's 2014 MOT study suggests that FSW and their clients and MSM are responsible for 28% of all new infections in the country. The GoG and its stakeholders have been implementing an extensive prevention program for over ten years to reach both MSM and FSW. However, major gaps exist including: the deficiency of robust systems to measure the quality and effectiveness of the interventions in a way that improves performance and quality; weak capacity and insufficient numbers of local CSOs to provide quality KP prevention; stigma and discrimination and gender barriers that inhibit KP from accessing services and adopting other healthy behaviors; lack of a cohesive policy and structure to incorporate Models of Hope and other KPLHIV community workers into the national program to enhance their authority and improve their performance; absence of a strong community/facility interface that constrains optimal facility-level use of community referrals and linkages; and lack of KPLHIV organizational capacity which limits their ability to effectively advocate for changes that address service barriers.

In COP 16, PEPFAR Ghana will address these issues both directly at the site-level and at the national policy and general programmatic levels with core and near-core activities that specifically address PEPAR technical considerations (Refer to Appendix A for a list of core and near core activities by program area.) Core prevention activities are: HIV testing services (HTS), condom and lubricant promotion and distribution, promotion of positive health, dignity and prevention, interventions to address stigma, discrimination, gender equity, and SGBV issues, CSO technical and organizational capacity building, and interventions to increase KP linkages to and retention in care and treatment.

Site-level core interventions in the communities and the facilities include 1) implementing the standardized, evidence-based prevention program for individual and/or small MSM and FSW groups detailed in the *KP Standard Operation Procedures*¹⁸ in targeted sites; 2) strengthening peer education and community-based KP outreach to better target services; 3) stimulating demand and use of quality HIV services and the uptake of protective behaviors to decrease infection risk; 4) increasing collaboration with GHS facility staff to better utilize successful community referrals and increase linkages to facility-based care and treatment services; 5) building the technical and organizational capacity of existing and new CSOs selected in a competitive process to improve high risk KP targeting and linkages to care and support; 6) increasing the advocacy skills of KPLHIV organizations to better address their own needs; and 7) increasing the number of KPLHIV lay counselors to attract more KP to services, and their adherence and retention in the services.

¹⁸ GAC; *Key Population Standard Operating Procedures*. February 2014. This document was developed with PEPFAR support and follows WHO prevention guidelines.

Interventions at the national policy and general programmatic levels include: 1) the development and use of quantitative and qualitative data to identify program gaps and barriers to uptake of prevention services and healthy behaviors, and to identify successful activities; 2) the use of these data to inform the creation or scale up of models that increase availability, accessibility, and quality of KP prevention services and linkages to HTS, care, and treatment; and 3) updating KP social and behavior change communication (SBCC) and training materials to incorporate the current emphasis on 90-90-90, stigma and discrimination, and gender. PEPFAR Ghana will also continue technical and institutional strengthening of CSOs supported by GAC (supported provided by GF); and will support updating geographic sub-district mapping of PEPFAR and Global Fund-supported community sites to avoid duplication and to identify new “hot spots” that will identify higher risk KP. PEPFAR Ghana will also engage Global Fund to: 1) support thematic work groups and high level discussions to improve the evidence base for prevention programming, with an emphasis on data collection, quality, sharing, and use; 2) integrate quality assurance/quality improvement (QA/QI) measures into the Continuum of Care framework and to strengthen linkages between prevention and the rest of the care and treatment continuum; and 3) support the GHS to link community and facility based data to facilitate the monitoring and case management of individual KPLHIV.

As mentioned in the goal statement, COP 16 builds off the OGAC-directed geographic prioritization that began under COP 15. COP 16 will again decrease the number of targeted districts from 33 districts and 1 site to 21. Working in fewer districts will enable PEPFAR Ghana to increase focus and use resources to create successful KP prevention service models that can then be used nationally and brought to scale.

There is a lack of data on KP sub-population sizes for decision-making and quality of programming as key challenges hindering effective KP targeting in project communities. To address these challenges, PEPFAR-Ghana is implementing FSW and MSM IBBSS in collaboration with the GoG, which will provide size estimates for both populations that will allow in depth analyses of data for program decision-making. Out of 27 initial SIMS assessments conducted in FY15 and quarter 1 of FY 16, seven (7) needed remediation action on the Key Populations and HTS CEES. PEPFAR has intensified CSO retraining in the use of the nationally developed KP SOPs to improve programming quality and uniform implementation. CSOs are encouraged to improve site level information to enable them address sites specific challenges and improve KP targeting, including improving referrals between community and facility level; documentation of HTC and STI referrals; management of STIs at DICs; and setting up of effective systems for CSOs to better track condom and lubricants stocks.

Prevention activities such as building the capacity of local CSOs and the recruitment of new CSOs, especially those with KP membership, will increase HTS uptake, referrals, and linkages to care and treatment services. In addition, Models of Hope, and especially KPLHIV trained to become certified lay counselors and motivated to use their networks,

will increase the identification of those at highest risk and the yield of KP testing positive. Newly certified peer lay counselors and patient navigators will also be used to personally escort newly diagnosed KPLHIV to care and treatment, and support their retention in these services. The introduction and evaluation of the activities will lead to the creation of new models and systems that can be adopted and scaled up nationally.

The recent gender analysis¹⁹ includes a number of important findings, including: more women than men access testing and ART services; and a persistent lack of KP knowledge exists, especially among MSM, on where to access services, including treatment. There is an increased difficulty in reaching MSM who do not identify as MSM and upper and middle class MSM who have greater anxiety about exposure. Additionally, MSM programming focuses on male to male relationships and ignores the female partners of MSM, and health care providers exhibit stigma and discrimination against them resulting in KP generally receiving a poor reception, and confidentiality being breached. These findings will be used to identify barriers and develop new approaches to these issues at both the facility and community levels. New interventions will include the development of gender diversity policies that will be incorporated throughout site-specific protocols, technical materials, and health personnel trainings. SBCC materials will be strengthened to address gaps in critical information about access and availability of prevention, care, and treatment services. New service delivery models will increase the reach to MSM who do not identify as MSM and those from the middle and upper classes. The inclusion and participation of MSM as peer KPLHIV care managers, more male-focused testing and counseling approaches, and outreach to female partners of MSM will also be included.

In COP16, PEPFAR-Ghana is undertaking a stigma and discrimination assessment in facility settings. Findings and recommendations will be used to support stigma-reduction activities both in healthcare settings and among the general population. Intensified stigma and discrimination training to HTS and other service providers in PEPFAR supported districts will ensure that they provide more KP-friendly services.

Military: A cohort of PEPFAR's priority populations is the Ghanaian military. Although HIV prevalence has historically been low among service men and women, this population is a priority population given their mobility. As a result of extended deployments, they are exposed to many challenges including limited access to HIV and AIDS services, and increasingly experience stigma and discrimination. Ultimately, this affects the uptake of services along the HIV cascade – HTS, enrollment in care, and ART initiation and retention.

The GAF HIV program focuses on demand creation for HTS services; risk reduction; increasing early detection of HIV positive individuals through provider initiated HIV testing and counseling (PITC); and supporting HIV positive clients to stay on treatment. The GAF program is conducting the HIV Sero-prevalence and Behavioral Epidemiology

¹⁹ A. Cannon et al; PEPFAR Ghana Gender Analysis Final Report; April 2016

Risk Survey (SABERS) to determine the HIV prevalence in Ghana's military that will inform future direction of the program. Results from this study will be used in COP 16 for strategic operational planning. PEPFAR will continue supporting the implementation of PHDP in the military and hold stigma and discrimination advocacy meetings to create a better environment.

4.3 Voluntary medical male circumcision (VMMC)

PEPFAR Ghana does not support VMMC because Ghana is estimated to have a relatively high circumcision rate (documented as 92% in the DHS 2014).

4.4 Preventing mother-to-child transmission (PMTCT)

PMTCT remains a national priority and is supported by the Global Fund, but not by PEPFAR.

4.5 HIV Testing Services (HTS)

In FY2014, PEPFAR Ghana reached 40,129 KPs and tested 15,549 (39%) with a positivity rate of 3.3% (APR14). In FY2015, however, with increased focus on higher risk KP, PEPFAR tested about 54% of the total KP reached, and attained an improved positivity rate of 7.6%. While program data shows that PEPFAR Ghana is beginning to do the right things in the right places, more needs to be done to reach higher risk KPs with testing.

A number of factors have been identified as barriers hindering KP access to and uptake of HTS, including general stigma and discrimination suffered by KPs in both community and facility settings; previous experience of discrimination by healthcare providers; shortages of test kits; gender bias that encourages more women than men to test, which particularly impacts testing uptake by middle and upper class MSM who have a heightened concerns about exposure; and a shortage of lay counselors both in facilities and community settings.

PEPFAR CSO partners are providing HTS for KP in PEPFAR focus districts. In addition to better targeting of higher risk KP, there is the need to establish routine quality control systems, create better linkage of those KP identified as PLHIV to care and treatment, and closely monitor and track results. In COP 16, PEPFAR Ghana will provide assistance to:

- Scale up successful HTS models for reaching higher risk KP through the increased use of KPHLIV, especially MSM, as lay counselors, and use innovative strategies such as social and sexual network testing and patient navigators to will increase HTS uptake and linkage to care and treatment
- Strengthen linkages from prevention activities to HTS referral and uptake
- Use operational research to develop other strategies to increase reach and numbers testing, and increase referrals of MSM to HTS
- Develop systems to monitor and track clients through the HIV cascade.

PEPFAR-Ghana's SIMS visits recorded poor QA systems to support comprehensive service delivery. Working with GHS, PEPFAR will support testing sites with comprehensive site

level training and institution of QA systems, including reinforcing training for staff who provide services at drop-in-centers on infection prevention and control. Although most testing sites provide services per current national guidelines, there is no proper documentation; therefore elements of the HTS CEE scored red, for example, HTC referrals to HIV Care and Treatment at the Organizational Assessment Point. The NFM Concept Note submitted to the Global Fund budgeted US \$5 million for rapid HIV test kits for 2015-2017. Nevertheless, there are still occasional shortages as a result of procurement and supply chain challenges, and prioritization of test kits for PMTCT. In FY2016, PEPFAR Ghana supported the purchase of rapid HIV test kits for the PEPFAR target populations in its five southern regions, and will continue in FY 2017. Technical assistance will continue to assure the quality of rapid HIV testing and to optimize the accuracy of HIV test results.

PEPFAR investments in FY 2015 and 2016 have supported the decentralization of the national quality assurance program for HIV rapid testing and HIV-related diagnostic testing with the objective of ensuring that the national external quality assurance (EQA) program is optimally functioning in PEPFAR targeted high burden districts in southern Ghana whilst ensuring the quality of testing results. A national assessment of laboratory systems with focus on testing capacity, logistics management and specimen referrals systems is being conducted in COP15. PEPFAR investments in COP16 will continue to support the EQA program to ensure the accuracy and reliability of HIV testing results prior to enrolling patients on treatment.

A review of PEPFAR program data shows slightly over 50% of all HTS yield in Quarter 1 came from GHS facilities, while mobile community sites and drop-in-centers (DIC), of which the majority are community-based, account for slightly less than 25% each. This means that GHS facilities are currently the dominant HTS provider despite claims of provider stigma and discrimination. However, the disparity in testing numbers in favor of GHS facilities may be an artifact of their greater numbers, as there are more than twice as many GHS HTS facilities than there are DIC. Furthermore, data from the recent gender analysis and an assessment of a hybrid DIC located in a GHS facility²⁰ suggest that DIC are particularly popular with MSM as they are viewed as free of discrimination and stigma. There is also a shortage of GHS certified lay counselors in community settings, which was cited above, and dependency on over-stretched GHS nurses for HTS in the community settings. Data from an upcoming assessment of the DIC will serve as the basis for recommendations regarding future DIC programming.

PEPFAR-Ghana will continue to analyze data to better understand the opportunities and challenges of each HTS delivery model, especially to better understand the opportunities and challenges of the community-based ones, and to develop new strategies that enhance community-based HTS, including increasing the numbers of lay counselors. Current

²⁰Robert Amofo, P. Appiah, et al. Assessment of the Ussher Polyclinic hybrid drop in center. LINKAGES; January 2016

governmental guidelines restrict HIV testing to counselors who have been NACP-certified. This applies to community-based health workers as well as health staff other than nurses in facilities. PEPFAR-Ghana will pursue efforts to widen the cadres of testers at the community level and, by extension, community-based HTS. PEPFAR-Ghana will also continue QI activities focused on improving facility-based HTS and linkage to HIV care. Finally, COP 16 will expand and strengthen HTS referrals to HTS via the use of mobile technology (such as SMS reminders), as well as increased use of 'peer-navigators' who will escort KP from community-based prevention services to HTS sites, especially those that are facility-based.

PEPFAR Ghana received a three year Key Population Implementation Science (KPIS) award for \$1.5 million from OGAC. These funds will assist to 1) characterize the status of linkage and retention in care and treatment for HIV-positive FSW and MSM; and 2) identify barriers and facilitators at each stage of the HIV continuum of care. We anticipate using the results to 1) design and implement interventions to improve linkages and retention in care and treatment; and 2) determine whether the interventions improve outcomes along the HIV continuum of care.

4.6 Facility and Community – Based Care and Support

PEPFAR Ghana does not directly implement clinical services but invests in capacity building and the development of models to improve reach to KP and PLHIV and their access to and retention in care and support services. Although the GoG identified FSW and MSM as priority populations in the 2010-2015 NSP and in the 2016-2022 NSP draft, quality care and support service delivery to these populations still has many gaps. Among the most critical are limited data on the size of these populations, and the unavailability of accurate facility and community based KP care and support services data. This means there are insufficient data to monitor the care cascade for KPLHIV, which in turn makes it a major challenge to determine the levels of support needed to ensure they have access to quality care. Other issues include: the lack of QA/QI measures that would ensure better service quality; the lack of interface between facility and community efforts that result in missed opportunities; incomplete knowledge of the areas and hot spots within the districts that would yield greater numbers of high risk KP; significantly more female PLHIV (72%) than males are on ART nationally, and many KP, especially MSM, do not know where or how to access care and treatment services and are especially difficult to reach; and poorly or untrained facility service providers who receive KP in a discriminatory manner and often breach confidentiality. All of this can result in delaying or, worst case scenario, rejecting entry into care and treatment.

In COP16, PEPFAR Ghana will implement a number of interrelated interventions to address these issues. Among the most critical will be PEPFAR Ghana's continued collaboration with the Global Fund and NACP to address critical issues around data collection, analysis, sharing, and use in decision making. In FY 2017, it is anticipated that national and program level data will be available and used to determine the present coverage of care and support services, identify such critical gaps as KP linked to and retained in treatment,

and then identify strategies to address those gaps. Through funding from the Global Fund, GAC is currently conducting a programmatic mapping and size estimation of KPs. This assessment is expected to provide valuable information to help address some of the mentioned gaps.

The new implementing mechanism, *Strengthening the KP Care Continuum*, will pilot innovative and/or new evidence-based continuum of care KP friendly service models in sites with high ART caseload. The goal is to increase KP service uptake and retention across the care cascade with interventions that fully integrate complementary facility and community based activities, and build local CSO capacity to assume selected services being implemented in the facilities wherever possible. For example, new interventions that train KPLHIV as Models of Hope, peer HTC and retention counselors, and peer navigators will both increase access into KP high risk networks and increase linkages and retention across services. Community based peer counselors will also increase availability and access to HTS, as present HTS services are dependent on the availability of GHS nurses. Building the capacity of local CSOs, especially those representing KP, will also increase access to KP networks and, by bringing services (e.g., HTS, ARV refills) closer to beneficiaries, will also increase linkage to and retention in services. The development of integrated community/facility service models will decrease the number of missed opportunities to link KP reached by PE to services and ensure a seamless cascade of care from identification of KPLHIV through viral load suppression. These new interventions will provide the GoG with successful models which will be effective in increasing the number of KPs who accept to test for HIV; enhance linkage of KPLHIV into care and treatment, thus improving adherence; strengthen the community-facility interface which has been the source of missed opportunities to provide KPLHIV with a comprehensive package of HIV services. The models will also include new training and motivational approaches for facility staff to improve their knowledge and their provision of KP friendly services.

PEPFAR Ghana will also support the application of QI/QA to facility and community based care and support interventions in target districts. New quantitative and qualitative data collection tools will be developed and used to better identify KP hotspots and especially harder to reach MSM, and to avoid duplication of efforts. The findings will also be used to better target both facility and community KP care and support efforts, increase KP service yields, and create new linkage models that improve KP access to and retention in care and treatment services. PEPFAR Ghana will expand its use of local CSOs, especially those that are KPLHIV dedicated. This approach is critical in establishing KP-friendly services at both community and facility levels and in building partnerships with GHS staff for the care continuum to reach KP. Through local CSOs, PEPFAR Ghana will also increase linkages to care and support services through the use of lay counselors, particularly members from these stigmatized communities. Stronger connections with STI and TB services as a near-core activity will also serve to identify KP and link them to additional care and support services.

PEPFAR Ghana will also initiate efforts to address the lack of care and support services in some targeted geographic areas. The new KP mechanism will explore opportunities for public private partnerships for care and support services, and efforts will also be made to leverage Ghana's strong focus on health financing and insurance schemes to ensure that HIV services are covered.

4.7 TB/HIV

Per the recommendations of OGAC, reconsideration would be given to TB/HIV activities in COP17.

4.8 Adult Treatment

Major gaps in achieving epidemic control among the general population and KP include limited external and domestic resources affecting the availability of ARVs and HIV test kits; weaknesses in managing program commodities and in the availability and use of logistics information for decision making; limited access to HIV care and treatment services in some parts of the country; unavailability of client centered data needed to provide quality services and to monitor the KPLHIV continuum of care; lack of a VL policy supportive of the third 90; and inadequate laboratory services for VL and for the identification of ART failure. Currently the Global Fund is the only reliable source of ARV funding— enough to maintain 62,000²¹ PLHIV on ART.

Although not directly involved in providing ART, in COP16 as in previous years, PEPFAR Ghana will provide technical assistance to address a number of treatment issues. In collaboration with the Global Fund, PEPFAR will provide support to the GOG to analyze data on care and support; and to use these data to improve the quality of services, identify weaknesses, and implement possible remedial actions to optimize the care continuum and effect cost savings. Related to this, PEPFAR Ghana will also continue collaboration with the Global Fund to promote policies and strategies supportive of Test and Start and a VL testing.

The new mechanism under JSI will be employed to develop a KP continuum of care framework that integrates strong QA/QI measure that will increase linkages to and retention of PLHIV in care and treatment. In COP 16, PEPFAR will build the capacity of community outreach staff and Models of Hope peers to provide adherence counseling and tracking of defaulters. PEPFAR will also support the development of an HIV E-tracker module within the DHIMS2 to facilitate the monitoring and case management of individual KPLHIV.

In addition, PEPFAR Ghana will improve the visibility of logistics information for HIV commodities throughout the public health supply chain through the use of the weekly SMS-based stock reporting system. Lack of HIV commodities, especially ARVs, is linked to treatment drop out among all PLHIV, and KP in particular. COP 16 will also

²¹Global Fund Concept Note, 2015-2017

strengthen quarterly supervision of M&E systems at regional and district levels to ensure availability of quality supply chain data for ARV and other HIV commodity decision-making at all levels, and the use of the Early Warning system, which will also ensure against stock outs.

4.9 Pediatric Treatment

Similar to PMTCT, pediatric treatment is a national priority and is supported by the Global Fund.

4.10 Orphans and Vulnerable Children (OVC)

Based on the current data and priorities in Ghana, OVC programming supported by PEPFAR ended in July 2015.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

Prior to October 2015, PEPFAR Ghana completed its transition of PMTCT and OVC related activities and its support for HTS among the general population in favor of increasing its investments in prevention among KPs. As described in 3.0, in COP 16, PEPFAR Ghana will intensify its efforts to reach and test KP, and will narrow its geographical footprint to target districts that contribute the most to the burden of disease.

Until transition plans for the centrally supported districts (and one site) are completed, PEPFAR Ghana will support activities that are needed to avoid disruption in service. The following interventions are currently implemented in these districts and in the Cape Coast urban area:

- Identification of KP and demand creation among these KP for prevention, care and support services;
- Distribution of condoms and lubricant;
- Provision of community based HTS at DIC and mobile sites and referral to facilities;
- Implementation of SBCC activities targeted specifically at KP, including the promotion of positive living and risk reduction;
- Linkage of KPLHIV to care, support, and treatment services; and
- Improvement of laboratory proficiency testing.

Out of the above, interventions that can be immediately curtailed are the identification and further efforts for service demand creation. However, other direct services will need sustaining including: the community based HTS, condom and lubricant distribution, referrals to care, support, and treatment; laboratory proficiency testing; and SBCC efforts, in particular those promoting healthy living and risk reduction.

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

The PEPFAR team, in agreement with the NACP, GAC, Global Fund, and other key stakeholders, including CSOs, will transition out of 12 districts and Cape Coast by March 2017. The 12 districts affected by the transition have 13 sites, plus the Cape Coast site, for a total of 14 sites. Transition plans will be developed to outline the transition and deliverables. USAID/Ghana will request for technical assistance from the USAID Office of HIV/AIDS (OHA), to help facilitate discussions, participate in site visits, document the transition process, and develop a report of the transition outcome. Below is a table with indicators to measure transition activities. There are no FY17 targets set for the 12 districts, therefore the team developed indicators to report on the transition; see Table 5.2.1.

Intervention	Indicator	End Date
Refresher training of providers on KP friendly services	Number of service providers trained in 13 facilities	September 30, 2016
Distribution of condoms and lubricants	Number of condoms and lubricants distributed	March 2017
Development of transition plans for current PEPFAR supported activities	12 districts plus Cape Coast transition plans completed	September 30, 2016

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

6.1.1 ARV Shortage: An adequate supply of ARV is a critical step to implement Test and Start and achieving the 90-90-90- goals. The Global Fund is currently the only certain source, and FY 2016 and FY 2017 targets cannot be met without procurement of ARVs. The current strained financial situation of the GoG and the MOH's operational budget for 2016 that is only US \$1 million, limits the government's ability to meet its procurement obligations stipulated in its Global Fund grants. The second major factor contributing to ARV shortage is weaknesses in the national commodity supply chain. Inadequate commodity consumption data from facilities results in incorrect quantification and distribution of ARVs which means that adequate quantities are not received in a timely way, however, stock availability of GF and USAID-supported commodities have improved with the establishment of a privatized sector supply chain. Table 6.1.1 details the systematic barriers to ARV shortage, outcomes expected after three years of investments,

proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element.

PEPFAR Ghana is collaborating with the Global Fund to assist the GoG to address this issue, and to provide a timely response for the ARV procurement proposal. The critical steps to replying successfully to this offer involve the acceptance of the most recent WHO guidelines for HIV Treatment, specifying the protocols that will guide implementation plans and policy, and stipulating the measures that will be taken to maintain ARV procurement in this amount after the two year time period. PEPFAR will also take advantage of Ghana's strong focus on health financing and insurance to explore opportunities to cover part of ARV procurement costs by alternative means.

PEPFAR Ghana is also collaborating with the Global Fund and other key stakeholders to address critical supply chain issues that result in ARV shortages nationally and thus, by extension, at the facility level. Since the tragic fire that completely destroyed the Central Medical Stores (CMS) in February 2015, in which \$8million of life saving medicines, equipment and commodities were destroyed, Ghana has continued to struggle to develop a functional pharmaceutical supply chain. With the indictment of at least 12 staff of the CMS and the acknowledgement of widespread mismanagement, the Ministry of Health is poised to undertake comprehensive reform. The recently awarded GHSC-Pharmaceutical Supply Chain Management award, implemented by Chemonics International will facilitate this transformative reform through the implementation of a revised Supply Chain Master Plan, build capacity to ensure "last mile delivery" to service delivery points of essential commodities, improve data visibility of pharmaceuticals through the deployment of a national Logistics Management Information System. The jointly developed system with Global Fund commenced under the previous project in April 2015 and Global Fund has agreed to continue this partnership with USAID through Chemonics International. Chemonics International will ensure implementation of an Early Warning System, provide TA and mentoring at the facility level on quality collection, analysis and use of programmatic data to inform ARV procurement decision making.

Table 6.1.1: Key Programmatic Gap: ARV Shortage						
Systematic barriers to ARV shortage, outcomes expected after 3 years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element						
Key Systems Barriers	Outcomes expected after 3 years of investment	Proposed COP16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element Score (if applicable)
Commodities Management <ul style="list-style-type: none"> • Quantification & Forecasting • Storage, Transportation & Distribution • E-Logistics management information system 	Consumption data available on monthly basis Donor funded commodities reintegrated into a GoG-managed entity (with private sector participation) e-logistics management system implemented and fully functional Timely reporting through Early Warning System for ARV commodities Scheduled delivery system to all service delivery points and	Provide TA and mentoring on quality collection, analysis and use of programmatic data to inform priority setting and associated decision-making for improved programming in support of 90-90-90 goals	OHSS	\$50,000	NEW - Global Health Supply Chain Program (Chemonics) 18415	Domain: Commodity Security and Supply Chain Score: 5.23 Elements: Stock: 1.48 Supply Chain Plan: 2.22
	Implement annual national quantification and supply chain reviews for health commodities	OHSS	\$20,000			

	ART centers implemented	Provide TA to the GoG in quantification, improvement in supply chain management, and development of guidelines and strategies that ensure commodity security for HIV programs.	OHSS	\$40,000	NEW - Global Health Supply Chain Program (Chemonics) 18415	Domain: Commodity Security and Supply Chain Score: 5.23 Elements: Stock: 1.48 Supply Chain Plan: 2.22
		Manage the USAID/Global Fund supported private sector supply chain system for commodity storage and distribution post-Central Medical Store fire	OHSS	\$110,000		

		Complete implementation of National Quantification Guidelines	OHSS	\$50,000		<p>Domain: Commodity Security and Supply Chain Score: 5.23</p> <p>Elements: Stock: 1.48</p> <p>Supply Chain Plan: 2.22</p>
Inadequate MOH operational health budget for 2016 (current budget is 3.8 million Ghana cedis (\$1 million))	<p>20 CSO trained and mentored in HIV advocacy issues</p> <p>Consultative meetings convened annually</p>	Provide TA and support to local CSOs to advocate for increased government spending in HIV	OHSS	\$10,000	<p>People for Health Project (Local Capacity Initiative, non-CoOP funds)</p>	<p>Domain: Commodity Security and Supply Chain Score: 5.23</p> <p>Elements: ARV Domestic Financing: 0.21</p> <p>Domestic Spending: 0.83</p>

		Support national HIV stakeholder consultative meetings to garner support for increased HIV spending by the GoG	OHSS	\$10,000	Strengthening the KP Care Continuum (JSI) 17318	Elements: ARV Domestic Financing: 0.21 Domestic Spending: 0.83
TOTAL				\$290,000		

6.1.2 Community Systems and Continuum of Care: Ghana’s KP program is grounded in civil society and outreach-focused with clinical services provided by GHS. However, there is limited formal community and facility interface. This includes a lack of functioning bi-directional referral system that links community-based prevention with facility-based care and treatment and back to community again for adherence and retention efforts. Additionally there is no policy framework that defines the continuum of care. High levels of stigma and discrimination of KP behavior and the prevalence of SGBV hinder activities all along the care continuum, and critical data gaps and leakages in the continuum of care severely limit data use for decision making. Table 6.2.2 lists systemic barriers to community systems and continuum of care, outcomes expected after three years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element.

PEPFAR Ghana will continue collaboration with the GoG, Global Fund, and other key stakeholders in FY 2017 to address many of these issues. COP16 will specifically focus on addressing a number of these problems, including providing technical assistance to the GoG to develop a continuum of care framework. It will also contribute to helping the GoG strengthen community systems and the continuum of care through the use of an intensive, holistic TA platform to pilot service delivery models. The TA platform will implement activities that address community/facility interface and bi-directionality; implement QI/QA methods across the care continuum; develop and integrate anti-stigma and discrimination and gender

equity policies, and SGBV prevention interventions; and provide mentoring on quality collection, analysis and use of programmatic data to inform priority setting and associated decision-making for improved programming.

Table 6.1.2 Key Programmatic Gap: Community Systems & Continuum of Care
Systematic barriers, outcomes expected after three years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element

Key Systems Barriers	Outcomes expected after 3 years of investment	Proposed COP16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element Score (if applicable)
Stigma, discrimination and SGBV	GAF Stigma and Discrimination policy developed	Provide advocacy training to the GAF command	HVOP	\$100,859	DoD TBD 18424	Domain: Policies and Governance Elements: Non-discrimination protections: 0.87
	GAF command trained to advocate for and implement stigma and discrimination policy	Provide TA for the development of a stigma and discrimination policy				
	Key GAF staff trained in gender integration issues	Build capacity of GAF to develop new materials and make strategic changes based on the gender analyses report	HVOP	\$27,225		
	Key GAF staff trained in gender material development	Provide TA to NACP to	HVOP	\$50,000		

		<p>implement a legal environment assessment and draft action plan based on results of assessment.</p> <p>Provide TA to GAC to develop national stigma and discrimination policy based on results of S&D study.</p> <p>Provide TA to GAC to develop national stigma and discrimination policy based on results of S&D study.</p>			<p>(Palladium) 18421</p>	
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Stigma, discrimination and SGBV		Development of a legal environment assessment and draft action plan	HVOP	\$150,000		Domain: Policies and Governance Elements: Non-discrimination protections: 0.87
		Develop new SBCC materials based on results of gender and S&D analyses and address barriers around 90-90-90 goal	HVOP	\$80,000	NEW - Communicate for Health 18410	
		Provide training and TA to facilities focused on KP issues including confidentiality, reduction in stigma and discrimination, SGBV, comprehensive KP care and treatment guidelines, psychosocial support, and	HVOP	\$50,000		

		case management				
Stigma, discrimination and SGBV		Provide training and TA based on site specific needs with a focus on KP issues including confidentiality, reduction in stigma and discrimination, comprehensive KP care and treatment guidelines, psychosocial support, and case management	HVOP	\$100,000	Strengthening the KP Care Continuum (JSI) 17318	Domain: Policies and Governance Elements: Non-discrimination protections: 0.87
Weak referral systems between community and clinical care	Regularized monitoring of KP care cascade across 90 90 90	Support GHS to harmonize and integrate the results of the Unique Identifier Code pilots into an HIV e-tracker module in	HVSI	\$100,000	GHS, #11951	Domain Strategic Information Elements: Epidemiological and Health data: 5.97

	Robust continuum of prevention, care and treatment cascade	DHIMS2				
		Strengthen and formalize linkages between clinical and community sites	HVOP	\$300,000	Strengthening the KP Care Continuum (JSI) 17318	Domain: National Service Delivery Elements: National Service Delivery

Lack of QA/QI systems to support implementation of KP interventions	Integrated QA/QI systems embedded in KP program approaches to ensure continuous quality improvement	Pilot models of service delivery in GHS high ART caseload health facilities at district level. Introduce innovative and evidence based QA/QI systems to improve KP services across the cascade.	OHSS	\$50,000	TBD QA/QI 18411	
		Support development and implementation of QA/QI measures to monitor linkage and retention in care	OHSS	\$130,000		
TOTAL				\$1,088,084		

6.1.3 HIV Testing Quality and Viral Load Test Planning: PEPFAR Ghana will continue to play a critical role in supporting quality laboratory services in the five priority regions in order to achieve sustained epidemic control and the UNAIDS 90-90-90 goals. The laboratory tiered structure reflects the health care delivery system of the Ghana Health Service (GHS) which is responsible for the national laboratory systems. PEPFAR has partnered with GHS to strengthen laboratory systems and

supported the continuous quality improvement process leading to the successful recognition of 16 laboratories under WHO's Strengthening Laboratory Information Systems through Accreditation (SLIPTA) program.

In COP14, 293 HIV rapid testing sites were supported in Greater Accra and Eastern regions, documenting an increase in testing proficiency from 27% in round one to 74% in round two in 2015. By the start of COP 15 PEPFAR will conduct PT testing in the Western region. Quality improvement, monitoring/supervision, and targeted corrective action are ongoing to ensure the quality cycle is completed. Challenges still remain with testing quality in the remaining two regions, that is, Ashanti and Brong Ahafo. Ghana currently has nine (Roche®) Viral Load (VL) machines placed in nine of the ten geographical regions; however coverage for VL testing of ART patients has been low (10-14%) and this can be attributed to the lack of policies and guidelines, weak specimen referral and result transmission system, reagent stock outs, insufficient training opportunities, and poor equipment maintenance schedules.

In 2015, national VL coverage was 12.5% of 89,113 clients and 13.5% in the five priority regions of the 71,509²² clients on treatment. Currently, there are no policies, guidelines and scale up plans for VL testing in Ghana. PEPFAR Ghana will support the development or revision of policies, guidelines and scale-up plans to guide the scale up of viral load testing and the optimization of country capacity. This would require a situational analysis of the current diagnostic capacity of laboratories in Ghana and identifying barriers for viral load scale up in the priority regions. The implementation of a quality improvement process will be key and will require training on policies, guidelines and SOPs, implementation of external quality assessment schemes and development of laboratory logistics management plans.

In COP16, PEPFAR Ghana's support to laboratory services will focus on the five priority regions and continue to support one district and one site in the central region with the goal of increasing access and uptake of services and to ensure accurate, reliable and timely results to support care and treatment programs. To achieve these goals, Table 6.1.3 lists key activities on which we will focus on:

²²Pending the results of the cohort analysis being conducted by NACP and funded by the Global Fund. The total number of clients on ART in the five priority regions is 71,509

1. Development and review of existing laboratory policies, guidelines and strategic plans to align with the UNAIDS 90-90-90 goals.
2. Development of training materials and training of all laboratory personnel on policies and guidelines.
3. Development of national SOPs to implement revised approved policies, guidelines and procedures at the national, regional, district and sub-district levels.
4. Support the development of a logistics management systems for the laboratory.
5. Provide continuous quality improvement support and technical assistance to ensure the accuracy of HIV and HIV-related diagnostic testing and monitoring tests that impacts the HIV clinical cascade.

Successful implementation of these activities would require maintaining the strong partnerships with GHS and working with other laboratory stakeholders and local implementing partners.

Table 6.1.3: HIV Testing Quality and Viral Load Test Planning Systematic barriers, outcomes expected after 3 years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID elements

Key Systems Barriers	Outcomes expected after 3 years of investment	Proposed COP16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate policies, guidelines and scale up plans	Policies, guidelines, and road map developed and launched for HIV testing and monitoring	Develop/review of existing laboratory policies, guidelines and strategic plans to align with the implementation of Test and Start	HLAB HTXS	\$100,000	CDC TBD IM 18428	Domain: Laboratory Score: 4.44
		Develop training materials and train laboratory personnel on the policy and guidelines.		\$100,000		
		Development of national SOPs to implement revised approved policies, guidelines and procedures from national, regional, district and sub-district level. Provide training on laboratory SOPs.		\$100,000		

Poor quality of HIV Rapid Testing Quality Assurance Program	95% of sites performing at 80% efficiency	<p>Expand program to: -Train lab technicians on panel preparation, characterization, packaging and transport</p> <p>Training on panel reconstitution and testing using national algorithm</p> <p>Data collection, entry and analysis</p> <p>Corrective action, supportive supervision and continuous quality improvement</p> <p>Usage of the standardized logbook</p>	HLAB HTXS HVSI	\$300,000	
Poor laboratory logistics management system	Strengthen the logistic management system	Support the development of a logistics management system and supply chain for the laboratory	HLAB	\$58,000	<p>Domain: Laboratory Score: 4.44</p> <p>Domain: Commodity Security and Supply Chain Score: 5.23</p>
TOTAL				\$658,000	

6.2 Critical Systems Investments for Achieving Priority Policies

In addition to the ARV shortage gap discussed above, major barriers to achieving Test and Start include the lack of critical policies and strategies supportive to its implementation; weaknesses in HIV commodity supply chain management, including quantification and forecasting for ARVs and rapid test kits; weakness in transportation and distribution of these commodities; lack of capacity to track patients once they have tested positive; and lack of the national laboratory policies needed to support the new WHO guidelines, particularly policies concerning the quality of testing. Barriers also exist to the successful implementation of the WHO guidelines and considerations, including acceptance of viral load testing as the gold standard; the lack of national models of patient-centered care that address health system challenges such as long waiting times to receive care and refills; and the patient's burden of direct and indirect costs of care. Table 6.2.1 lists systematic barriers to achieving Test and Start, outcomes expected after three years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element. Table 6.2.2 lists these for new and efficient models of services delivery

In collaboration with Global Fund, PEPFAR Ghana is advocating with and providing technical assistance to the GoG to achieve Test and Start implementation. The most critical new COP 16 HSS activities fall under the national strategy and policy development rubric, and focus on collaboration with all key stakeholders to negotiate the creation of policies and strategies supportive of Test and Start; technical assistance to the GoG for the development guidelines, costing estimates, and implementation plans related to Test and Start and 90-90-90 goals; and the development of a continuum of care framework with fully outlined standard procedures and QI measures to monitor linkage and retention in care within and between clinical and community settings. A final critical national policy activity will be support for a viral load testing policy.

As also discussed under ARV shortages, PEPFAR Ghana is collaborating with the Global Fund to assist the GoG to develop protocols that will guide Test and Start implementation and undertake measures that will ensure its sustainability. PEPFAR Ghana is also collaborating with key stakeholders to address relevant HIV commodity supply chain issues, including transportation and distribution, and the analysis and use of programmatic data to inform decisions. Data challenges to Test and Start implementation will be addressed nationally.

Table 6.2.1 Test and Start						
Systemic barriers, outcomes expected after 3 years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Test and Start is not yet implemented	Scale-up of HIV care and treatment services Increased number of persons on treatment	Collaborate with Global Fund and other stakeholders to develop guidelines and strategies supportive for Test and Start	OHSS	\$0	PEPFAR Ghana Team	Domain: Service Delivery Score: 7.18
Weak supply chain management system	Donor funded commodities reintegrated into a GoG-managed entity (with private sector participation)	Support private sector supply chain system for commodity storage and distribution	OHSS	\$50,000	NEW – Global Health Supply Chain Program (Chemonics) 18415	SID Domain: 8.6 Stock: 1.48

		Implement annual national quantification and supply chain reviews for HIV commodities.	OHSS	\$30,000		
Lack of a laboratory policy plan in support of test and start	Lab policy revised, adopted, and implemented	Develop/review of existing laboratory policies, guidelines and strategic plans to align with implementation of Test and Start	HLAB	\$0	CDC TBD IM 18428	Domain: Laboratory Score: 4.44
TOTAL	\$80,000					

Table 6.2.2 New and efficient service delivery models						
Systematic barriers, outcomes expected after 3 years of investments, proposed COP 16 activities, budget codes and amounts, implementing mechanisms, and the relevant SID element						
Key System Barriers	Outcomes expected after 3 years investment	Proposed COP16 activities	Budget codes	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Centralization of service delivery models for care and treatment Lack of formal integration of peer based models of service delivery in national guidelines, e.g. Models of Hope	Adoption and evaluation of standardized peer models of service delivery in five priority regions.	Support advocacy for the adoption of peer models of service delivery	OHSS; HBHC	\$40,000	People for Health (LCI; non-COP funds)	Domain 6.2: Responsiveness of community based HIV/AIDS services: 1.11
	Increase in number of nonmedical services transferred from the facility to community level	Increase transfer of nonmedical services from the facility to community	HBHC	\$40,000	Strengthening the KP Continuum of Care (JSI) #17318	
		Lessen frequency of nonessential services at the facility level	HBHC OHSS	\$20,000		

		Pilot evidence based and/or innovative service delivery models in sites with GHS high ART case loads	HBHC	\$100,000		
Military PLHIV and family members lack support for retention in treatment and adoption of healthy life styles	Positive Health and Dignity tool kit adopted and operational at the military hospital	Support GAF to build a robust counseling and support system to retain military clients and family members on treatment	HBHC	\$245,646	DoD TBD	Domain: Service Delivery Score: 7.18
TOTAL				\$445,646		

Outside of the COP 16 budget, PEPFAR is supporting one-time supplemental funding to support the GOG to bridge the ARV gap and accelerate achievement of 90-90-90 nationally. In 2018, the expectation is that the GOG will ensure funding for this PEPFAR-funded cohort of patients.

6.3 Proposed investments outside of planned COP16 activities: Supplemental funding for scale-up of treatment

Key Systems Barriers	Outcomes expected after 3 years of investment	Proposed activities	Budget Code(s)	Activity Budget Amount for 2 years (\$)	Associated Implementing Mechanism ID
Insufficient supply of ARVs and low VL update, to support aggressive scale-up of treatment	<p>Scale-up of HIV care and treatment services</p> <p>By 2020, 214,375 persons will receive treatment services</p> <p>Increased use and documentation of viral load testing</p>	<p>Collaborate with NACP and other stakeholders to develop roadmap for implementation of Test and Start</p> <p>Revise indicators to capture key data needed to monitor progress toward 90-90-90 targets</p> <p>Outline process for ARV procurement and delivery</p> <p>Implement VL scale-up plan</p>	HTXD HTXS	23,779,554	TBD

7.0 Staffing Plan

Collectively, all the USG agencies work to increase collaboration and joint activities that strengthen the capacity of the GoG, CSO and communities to manage the national HIV and AIDS response. CDC supports Ghana's efforts to improve disease surveillance and strengthen strategic information, as well as the quality of laboratory services. DOD supports the GAF in the implementation of comprehensive HIV activities and services. USAID focuses on KP prevention services health systems strengthening, building CSO capacity, policy, and supply chain management. The State Department's US Ambassador's Self-Help program changed its objectives from providing small grants to help meet the HIV-related needs of local communities through intensifying collaboration with CSOs.

Each PEPFAR implementing agency reviewed its staffing structure to ensure alignment with the program's focus to build a model KP program and provide quality technical assistance for laboratory and strategic information activities. Although there are 19 total technical/program positions (including vacant and planned), there are only 6 fully funded, full time PEPFAR technical/program staff. Two staff listed to be out of the office for 23% and 30% of the quarter on SIMS visits, respectively, also have large interagency commitments. This raises concerns around the team's ability to implement activities, actively engage in external technical working groups, conduct SIMS visits, monitor EA, and ensure the overall quality of the program.

In COP 15, PEPFAR Ghana prioritized the recruitment and hiring of three positions: a Deputy CDC Country Director, PEPFAR Country Coordinator, and a Senior SI Advisor. There are two positions proposed in COP 16: (1) Senior HIV/AIDS Care and Support Technical Advisor who will provide support for all facility based prevention services, community and facilities interface issues, integration of QA/QI measures, and will represent PEPFAR on GHS and NACP TWGs concerned with care and support; and (2) M&E Data Quality Specialist to provide support with data quality, SIMS, and to ensure an ongoing comprehensive and strategic data analysis of the HIV portfolio.

Per the COP 16 planning letter, OGAC proposed use of central funds to support a Global Fund Liaison. PEPFAR Ghana will begin steps towards recruitment for this position, prioritized as locally employed staff. The primary objectives of the position are to: 1) provide comprehensive, senior level public health advice and technical assistance on Global Fund issues to the USG; 2) provide technical assistance in the planning of future COPs and the Global Fund Concept Note; and 3) ensure that activities funded by PEPFAR and Global Fund complement each other and do not overlap. The Global Fund Liaison will sit in the PEPFAR Coordination Office.

The team recognizes that immediate support is needed for strategic information, specifically data management, and for revision of lab policies; therefore long-term TA will be requested to support these areas. Support will be requested in the fourth quarter FY16 to prepare IPs and the team for its third expenditure analysis exercise.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of implementation	Core Activities	Near Core Activities
District level	<ul style="list-style-type: none"> • Implement comprehensive package of services for MSM and FSW as outlined in national KP SOPs in targeted KP sites • Pilot innovative and/or new evidence-based continuum of care service models that fully integrate complementary facility and community based activities to increase KP service uptake and retention across the care cascade • Provide TA and mentoring on quality collection, analysis and use of programmatic data to inform priority setting and associated decision-making for improved programming • Support the implementation of integration of anti-stigma and Discrimination and Gender and Sexual Diversity policies throughout site- specific protocols, technical materials and trainings • Implement ongoing mapping of PEPFAR supported KP intervention sites to avoid duplication and to identify and prioritize KP hot spots. • Improve quality assurance of HIV Rapid testing (proficiency testing) 	

Level of implementation	Core Activities	Near Core Activities
National	<ul style="list-style-type: none"> • Collaborate with Global Fund and other stakeholders to support policies and strategies relevant to Test and Start • Provide TA for development of guidelines, costing estimates and implementation plans related to Test and Start • Develop continuum of care framework with fully outlined standard procedures and QI measures • Provide TA to the GoG to develop national stigma and discrimination policy based on results of S&D assessment • Develop lab policies, including VL scale-up plan • Support patient tracking system • Strengthening data generation, validation, analysis and quality assurance use systems • Strengthen monitoring and evaluation systems for the national response • Manage the USAID/Global Fund supported private sector supply chain system for HIV commodity storage and distribution • Implement the annual national quantification exercise • Implement the National Quantification Guidelines 	<ul style="list-style-type: none"> • Provide TA to the GoG in quantification, improvement in supply chain management, and development of guidelines and strategies that ensure commodity security for HIV programs. • Coordinate with the GoG and Global Fund to transition out of 13 districts • Support condom programming; procurement and distribution of lubricants

Table A.2 Program Area Specific Core, Near-core, and Non-Core Activities for COP 16

Level of implementation	Core Activities	Near Core Activities
<p>KP Prevention (including HTS)</p>	<ul style="list-style-type: none"> • Strengthen Peer Education and community-based KP outreach with GHS staff to better delivery of prevention services; stimulate demand and uptake of protective behaviors from HIV infection • Implement operations research to further refine and/or identify interventions that reach KPLHIV and successfully link them to care • Support condoms and lubricants distribution • Support HIV test kit provision for targeted sites and activities • Increase uptake of HTS to FSW and MSM reached in high prevalence regions • Increase the KPLHIV testing yield • Implement evidenced-based interventions that generate KP demand and use of HTS • Link community from outreach into testing 	<ul style="list-style-type: none"> • Strengthen STI prevention education and continue support for symptomatic screening of KP • Strengthen programmatic linkages and referrals for STI, FP, TB and cervical cancer screening and treatment • Update KP SBCC and training materials to incorporate current emphasis on gender, anti-stigma and discrimination, 90-90-90 goals, etc. • Provide TA to ensure non-discriminatory service delivery competencies and to develop institutional anti-discrimination policies at facility and community sites for personnel engaging KP and PLHIV • Implement HIV screening (and linkage) protocols at high volume STI clinics • Use of interactive communication and technology (ICT)-based strategies (including social media) to increase HTS demand in community sites and linkages to care and treatment

		<ul style="list-style-type: none"> • Conduct stigma reduction activities among community health workers and educators
Care and Treatment	<ul style="list-style-type: none"> • Addition of QA/QI measures into the continuum of care framework • Ensure linkage to care and treatment services • Conduct a KP lost to follow-up assessment and use the findings to inform future adherence support and training, particularly for community support • Implement findings from SIMS and other QI efforts to improve service delivery 	<ul style="list-style-type: none"> • Revise training materials for community outreach staff and Models of Hope to reinforce activities for adherence counseling and tracking of defaulters • Improve KP referral protocols to STI, FP, SGBV and SRH services • Develop interactive, accessible provider educational tools, e.g., e-learning modules, etc. emphasizing critical skills for HIV service delivery with new emphasis on Test and Start • Provide training and TA on confidentiality, stigma and discrimination reduction, comprehensive KP care and treatment • Develop/strengthen supervisory teams to champion KP enabling environment
Program/system support	<ul style="list-style-type: none"> • Revise lab policies to improve laboratory capacity • Strengthen supply chain management to support HIV commodities including the early warning system to ensure regional and facility level distribution • Support privatization of supply chain system for commodity storage and distribution 	<ul style="list-style-type: none"> • Support structural, human rights, and legal interventions (policy, guidelines) that address barriers to KP care, treatment, and retention • Develop training series and model program designs, tools, and

	<ul style="list-style-type: none"> • Provide TA and mentoring on quality collection, analysis and use of programmatic data • Provide TA to the GoG in quantification, improvement in supply chain management, and development of guidelines and strategies that ensure commodity security for HIV programs • Strengthen institutional and technical capacity of CSOs to improve HIV services uptake, planning, implementation, and monitoring • Provide TA to strengthen QI reviews through onsite multidisciplinary review teams established within selected high volume ART sites • Support consistent review and analysis of national cascade data to inform HIV program progress and priority decision making • Provide TA for development and standardization of one Unique Identifier Code (UIC) across health programs for integration into DHMIS-2 through E-tracker • Provide TA for implementation and integration of National Condom and Lubricant Strategy for HIV commodities • Support patient tracking system • Strengthening data generation, validation, analysis and quality assurance use systems • Strengthen monitoring and evaluation systems for the national response 	<p>indicators in support of gender integration (including SGBV interventions)</p> <ul style="list-style-type: none"> • Support development of an action plan from the findings and recommendations of the Legal Environment Assessment • Develop interactive, accessible provider educational tools, e.g., e-learning modules, etc. emphasizing critical skills for HIV service delivery with new emphasis on Test and Start • Provide TA to support revision of pre-service training curricula for supply chain management • Provide TA to improve forecasting and quantification of ARVs and commodities <p>Provide TA to revise plans to strengthen the supply chain management system</p>
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APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$US 3,948,109	\$US 8,464,798	\$US 12,448,907

Table B.1.2 Resource Allocation by PEPFAR Budget Code (New Funding only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	0
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	1,558,778
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	338,549
HBHC	Adult Care and Support	916,503
PDCS	Pediatric Care and Support	0
HKID	Orphans and Vulnerable Children	0
HTXS	Adult Treatment	750,000
HTXD	ARV Drugs	0
PDTX	Pediatric Treatment	0
HVTB	TB/HIV Care	0
HLAB	Lab	608,623
HVSI	Strategic Information	550,000
OHSS	Health Systems Strengthening	1,750,000
HVMS	Management and Operations	2,015,064
TOTAL		8,487,517

B.2 Resource Projections

The funding allotted for each implementing mechanism was estimated based on historical cost data for the mechanism and the activities included in Appendix A. The team completed the PEPFAR Budget Allocation Calculator however target-based budgeting was only possible for 2 out of 16 implementing mechanisms. The remaining mechanisms are not target driven.

This is PEPFAR Ghana's second year implementing the expenditure analysis. Although the experience was better than that in COP15, implementing partners did not appropriately report on expenditures per the requirements, and the primary implementing mechanism had the most outlier UEs in all program areas and in 3 of 5 priority regions. As a result a weighted average of HTS unit expenditures (UEs) was used to determine UEs for COP16 (see Table B.2.1). The factors which contribute the most to high programming costs are primarily travel for peer educators to reach implementation areas. Adjustments were made to account for the change in primary implementing partner, and close-out of all Peace Corps HIV programming.

Table B.2.1: Summary of COP16 Unit Expenditures

Program Area	UE COP15	UE COP16
HTC Tested	\$54.44	\$4.18
Prevention – FSW	\$42	\$53.47
Prevention – MSM	\$51	\$41.31

APPENDIX C

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools;	N/A

surveillance; other strategic information activities not classified above	
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included