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JOINT UNITED NATIONS PROGRAMME ON AIDS (UNAIDS)

GHANA
NATIONAL AIDS SPENDING ASSESSMENT 2005 AND 2006
LEVEL AND FLOW OF RESOURCES AND EXPENDITURES TO
CONFRONT HIV/AIDS

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LIST OF ACRONYMS

| | |
|---------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AGREDS | Assemblies of God Relief and Development Services |
| APOW | Annual Programme of Work |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BCC | Behavioral Change Communication |
| CBO | Community Based Organisations |
| CCE | Community Capacity Enhancement |
| CRIS | Country Response Information System |
| CRS | Catholic Relief Services |
| CSW | Commercial Sex Workers |
| DAC | District AIDS Committees |
| DACF | District Assembly Common Fund |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development. |
| DPs | Development Partners |
| DRMT | District Response Management Team |
| DSW | Department of Social Welfare |
| FBO | Faith Based Organisations |
| FHI | Family Health International |
| FP | Family Planning |
| GAC | Ghana AIDS Commission |
| GARFUND | Ghana AIDS Response Fund |
| GDHS | Ghana Demographic Health Survey |
| GFATM | Global Fund to fight AIDS, TB and Malaria |
| GHANET | Ghana HIV/AIDS Network |
| GHS | Ghana Health Services |
| GPRS | Growth and Poverty Reduction Strategy |

| | |
|--------|---|
| GSCP | Ghana Sustainable Change Project |
| GSMF | Ghana Social Marketing Foundation |
| GTZ | German Technical Cooperation |
| HAART | Highly Active Antiretroviral Therapy |
| HACI | Hope for African Children Initiative |
| HBC | Home Based Care |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education and Communication |
| ILO | International Labor Organization |
| IMAI | Integrated Management of Adolescent and Adult Illnesses |
| JAPR | Joint Annual Programme Review |
| JICA | Japan International Cooperation Agency |
| MARG | Most At Risk Group |
| MDA | Ministries, Departments and Agencies |
| MDBS | Multi Donor Budget Support |
| MICS | Multi-Indicator Cluster Survey |
| MLGRDE | Ministry of Local Government, Rural Development and Environment |
| MMDA | Metropolitan Municipal and District Assembly |
| MMR | MSHAP Monitoring Reports |
| MMYE | Ministry of Manpower, Youth and Employment |
| MOH | Ministry of Health |
| MOWAC | Ministry of Women and Children Affairs |
| MP | Member of Parliament |
| MSHAP | Multi Sectoral HIV and AIDS Programme |
| MSM | Men having Sex with Men |
| NACP | National AIDS Control Programme |
| NAP+ | National Association of People Living with HIV/AIDS |
| NDPC | National Development Planning Commission |
| NGO | Non Governmental Organisation |
| NHIS | National Health Insurance Scheme |

| | |
|---------|--|
| NSF | National Strategic Framework |
| OVC | Orphans and Vulnerable Children |
| PAF | Project Acceleration Fund |
| PEP | Post Exposure Prophylaxis |
| PLWH | People Living With HIV |
| PMTCT | Prevention of Mother-To-Child Transmission |
| POW | Programme of Work |
| PPP | Public-Private Partnership |
| PSM | Procurement and Supply Management |
| RAC | Regional AIDS Committees |
| RCC | Regional Coordinating Council |
| RNE | Royal Netherlands Embassy |
| RME | Research Monitoring and Evaluation |
| SHARP | Strengthening HIV/AIDS Response Partnership |
| STD/STI | Sexually Transmitted Diseases/Sexually Transmitted Infections |
| SWAA | Society for Women Against AIDS in Africa |
| TRIPS | Trade Related Intellectual Property Rights |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Project |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations Children Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Treatment |
| WAPCAS | West Africa Project to Combat AIDS and STIs |
| WHO | World Health Organization |

Section 1

Introduction

1.1 Background

Sub-Saharan Africa is the region with the largest burden of the AIDS epidemic. About 25 million people are living with HIV in sub-Saharan Africa. However, the epidemics in this region are highly diverse and especially severe in southern Africa but data also indicate that the HIV incidence rate has peaked in most countries. Even though considerable efforts have been made towards improving access to antiretroviral treatment in recent years, it is estimated that about 2.1 million Africans died of AIDS in 2006—almost three quarters (72 percent) of all AIDS deaths globally. West and Central Africa's smaller epidemics show divergent trends. There are signs of declining HIV prevalence in urban parts of Burkina Faso, Côte d'Ivoire and Ghana. In Ghana, adult HIV prevalence was estimated at 2.3 percent [1.9 percent–2.6 percent] in 2005 (UNAIDS, 2006) and there are signs that the country's epidemic could be in decline.

Ghana's comparatively low prevalence of HIV and AIDS has been due to a favourable policy environment facilitated by the formulation of supportive policies and guidelines and the establishment and use of decentralized institutionalized structures for the implementation of HIV and AIDS programs. In spite of these efforts, there are reported cases of new infections yearly. HIV and AIDS surveillance results (2005) point to the fact that there were approximately 32000 new infections in 2005 with about 5700 being children between age 0 and 14 years.

The financial burden on domestic economies in sub-Saharan Africa to combat the HIV and AIDS epidemic is enormous. In spite of that, domestic public expenditure from governments in low-income sub-Saharan African countries has also significantly increased with domestic resources reaching US\$ 2.5 billion in 2005 (UNAIDS, 2006). However, most of them heavily rely on external sources of funding. Currently, the Global

Fund to fight HIV and AIDS, Tuberculosis and Malaria (GFATM) and the World Bank's commitment to fight AIDS through the Multi-country HIV and AIDS Programs (MAP) and other AIDS operations are some of the notable efforts by multilateral agencies to commit resources to fight the epidemic. In addition to these two major initiatives, many other cooperation agencies are allocating resources in the region, most of it as bilateral assistance to development. In the past few years, the availability of resources has dramatically increased for some of these countries, at a pace unlikely to encompass the absorptive capacity of the institutional arrangements and health care systems¹.

The need to monitor resource flows for HIV and AIDS is critical given the scarcity of resources and the importance of effective allocation. Policymakers, programme planners, and international donors need this information to identify the financial gaps and the functional overlapping in order to increase funding in areas which have been neglected or otherwise. In addition, it is also important to keep track of the resources, to ensure the strengthening of local capacities and the best possible use of the additional funding. Effective resource monitoring helps identify gaps in the response, improves the strategic ability of countries and donors to target resources most effectively, and helps measure the degree to which words of commitment on HIV and AIDS are matched by financial resources.

In monitoring resource flows for HIV and AIDS, it has proven easier to collect information on donor governments, multilateral agencies, foundations and nongovernmental organizations (NGOs) than to obtain reliable budget information on domestic outlays for HIV and AIDS in affected countries. As a result, UNAIDS has focused significant efforts on strengthening the capacity of countries to monitor and track expenditures for HIV and AIDS.

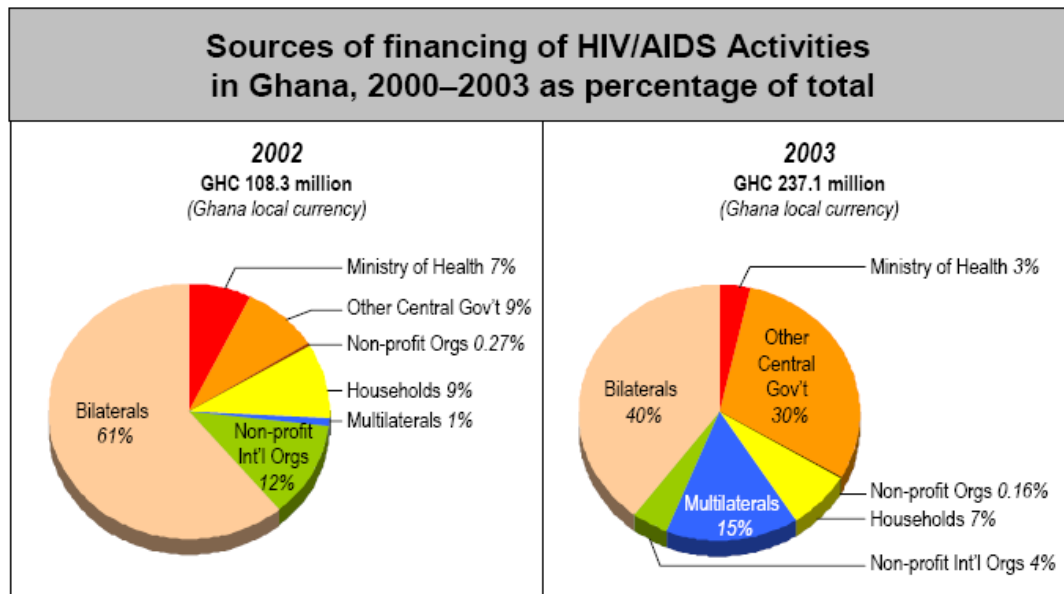
¹ UNAIDS, 2004. Ghana National HIV/AIDS Accounts, 2002-2003.

1.2 Tracking HIV and AIDS Expenditure in Ghana

To date there have been a number of approaches for tracking the level and flow of health expenditures on HIV and AIDS. There has been the National AIDS Accounts (NAA); the National Health Accounts (NHA) framework, State AIDS Budget Analysis among others. The uniqueness of the National AIDS Spending Assessment (NASA) is its complementarity to the other models and the fact that it provides greater details for National Strategic Programs for HIV and AIDS.

The NAA model was used to monitor expenditures on HIV and AIDS in several countries. In Ghana, the NAA was estimated in two rounds: 1999–2002 and in 2003. It gives some attention to the ratio of government to donor funding in HIV and AIDS activities and the results show that even though expenditures on HIV and AIDS are largely funded from external sources government spending has increased (see Figure 1.1).

Figure 1.1



Source: UNAIDS 2004

AIDS expenditures in Ghana primarily support Information, Education and Communication (IEC) interventions for young people and children. The increase of resources from external sources allowed for an enhanced response to HIV and AIDS outside the health sector (e.g., support to organisations and empowerment, including income-generating projects, of people living with HIV and AIDS). However, the current level of funding for health sector investments appears inadequate to create sufficient capacity to bring key services to scale.

1.3 National AIDS Spending Assessment

The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. It describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease. This is tracked by financing source whether it is public, private or foreign and among the different providers and beneficiaries (target groups). It provides a framework and tools for undertaking a comprehensive analysis of actual expenditures for HIV and AIDS which can either be a health or non-health activity such as social mitigation, education, labour, justice and other sectors related to HIV and AIDS.

1.4 Study Objectives

Specifically the aims of the study are to:

- (i) Refine and adjust the methodology for capturing the HIV and AIDS financial flows at national and regional/district level using HIV and AIDS sub accounts approach;
- (ii) Conduct NASA covering National and sub-national (district) levels;
- (iii) Through stakeholder consultations, build national level and regional/district capacity for systematic monitoring of HIV and AIDS financing flows.

The specific study objectives are to:

- Analyse the structure of HIV and AIDS-related services and organizations in Ghana in the public and private sector, including bi- and multilateral organizations active in Ghana;
- Agree on the methodology for tracking of HIV and /AIDS financial flows at national and district levels, modify instruments for data collection (mainly for non-health organizations) at the national and district levels (spread sheets);
- Develop a data collection plan for the national level and selection of districts (sample) – identify stakeholders/entities among financing sources, financing agents, and users/providers in the public and private sector;
- Develop a plan and conduct training for national level and regional NASA data;
- Validate, enter and analyse financial data for national and regional/district level data;
- Present and disseminate achieved results including full set of data to be included in the UNGASS report of Ghana 2007; and
- Document and share the NASA process for consideration of the Ghana AIDS Commission/Ministry of Finance.

1.5 Scope of Study

The study focused on the national and selected districts covering the period 2005 and 2006. Data collection covered all the domestic spending on HIV and AIDS, all the external aid for HIV and AIDS (including those funds channeled through the government) but did not cover the business sector comprehensively nor out-of-pocket expenditure. Seven sentinel sites in six (6) districts were selected for the study. Site selection was done in consultation with the key project partners using the following criteria:

- (i) high/low prevalence sites (districts); and
- (ii) urban or rural district.

The major sources of data/information include (see Table 3.1 for a more comprehensive list of sources):

- (i) Ghana AIDS Commission (GAC);
- (ii) Ministry of Health (MOH) and the National AIDS/STIs Control Programme (NACP);
- (iii) The Global Fund;
- (iv) Selected major donors; and
- (v) Key informants in the various ministries, GAC and MOH/NACP.

1.6 Structure of Report

The report has been organized in seven sections. Following section one is section two which gives a brief overview of the HIV and AIDS situation in Ghana and the National response (the National Strategic Framework for HIV and AIDS). The third section outlines the methods and techniques applied, as well as the study process and limitations faced. The fourth section contains the results and discussions of the NASA estimates. The findings of the qualitative research undertaken as part of the NASA study is presented in section five. The sixth section focuses on the findings of the site visits (case studies), to ascertain spending at the district level and uptake of programmes outlined in the National Strategic Framework (NSF). Recommendations are made in section seven.

Section 2

Country Background and HIV and AIDS Situation

2.1 National Policy on HIV and AIDS

The guiding principle of Ghana's national policy on HIV and AIDS and STIs is based on the following:

- (i) the 1992 Constitution of Ghana, Ghana Government's medium term strategy document, Ghana Poverty Reduction Strategy (GPRS), the revised Population Policy (1994) and the Millennium Development Goals (MDGs);
- (ii) Principles of social justice and equity; and
- (iii) Recognition that adequate health care is an inalienable right of every Ghanaian including those affected with HIV or other STIs.

In addition to the above, the policy also takes account of International Human Rights Conventions, particularly, the Convention on Economic, Social and Cultural Rights, the African Charter on Human and People's Rights all of which affirm the right to the highest attainable standard of health. Also Ghana is committed to goals agreed upon at various international fora, which outlined the profound concerns about the devastating impact of HIV and AIDS on socio-economic development and adopted strategic programmes of action and declarations for the fight against the epidemic. These include:

- (i) the United Nations Millennium Declaration, which enjoined member countries to halt and begin to reverse the spread of HIV and AIDS by 2015;
- (ii) the Abuja Declaration and Framework for Action for the Fight Against HIV and AIDS, Tuberculosis and other related diseases in Africa which considered AIDS as a state of emergency in Africa; and
- (iii) the United Nations General Assembly Special Session on HIV and AIDS of June 2001, at which Heads of State and Governments recommitted themselves in a Declaration on HIV and AIDS – "Global Crisis-Global Action" to ensure an urgent, coordinated and sustained response to HIV and AIDS.

HIV and AIDS surveillance results (2005) point to the existence of a stabilizing epidemic continuous favourable policy environment facilitated by the formulation of supportive policies and guidelines, strong advocacy and resource mobilization. Much of this has been achieved through strong political support; the establishment and use of and widespread civil society participation and support of the media and business sector.

Initially HIV and AIDS was managed as a disease and therefore the national response was narrowly focused on the Health sector and therefore directed by the Ministry of Health (MOH) through the National AIDS Control Programme (NACP). However in the subsequent years it was widely acknowledged that HIV and AIDS is an epidemic with major economic and developmental consequences in the countries battling this crisis. Hence the need for a well coordinated and decentralised national response which involved all the sectors. To this end, a comprehensive national strategic framework was designed in consultation with development partners and other stakeholders to chart the direction of the national response from 2002-2005. The main aim of this framework was to reduce the incidence of HIV and AIDS by 30 percent by 2005 and to improve the quality of life of people living with HIV (PLHIV) and the people affected by it.

The policy required that HIV and AIDS is planned for in sector, department and institution focusing on internal (workplace) and external (target population served) environment of each sector. The important role of the NGOs was acknowledged and therefore NGO activities were incorporated in the sector plans. The adoption of a multi-sectoral approach over the last five years has positively transformed the landscape of the national HIV and AIDS response, creating better conditions for stronger partnerships, effective coordination of stakeholder activities and steady harmonization of efforts and resources.

2.2 HIV and AIDS Situation in Ghana

HIV and AIDS has become the most deadly pandemic and a devastating developmental crisis ever witnessed in human history. The pandemic continues to spread rapidly in most countries in Sub-Saharan Africa including Ghana. In Ghana, the first AIDS cases were

reported in 1986. By the end of September 2003, a cumulative total of 72,541 AIDS cases had been reported. Estimates put the actual number of cases closer to 370,000. Cases have been reported in all the 10 regions as well as in all age groups.

The HIV prevalence rate estimated from the 2006 sentinel indicates an increase in the median HIV prevalence from 2.7 percent to 3.2 percent. Out of the total HIV samples, 93 percent were HIV type I only. HIV type II only formed 2.2 percent and dual infection of types I and II was 4.7 percent. HIV prevalence at the regional level ranged from 1.3 percent in the Northern Region to 4.9 percent in the Eastern Region. Western Region had the second highest prevalence rate of 4.3 percent. HIV site prevalence ranged from 0 percent in North Tongu (rural) to 8.4 percent in Agomanya. Koforidua which had the highest prevalence in 2005 declined from 6.4 percent to 4.4 percent in 2006. HIV prevalence in urban and rural areas showed differences with urban areas recording a slightly higher prevalence than rural areas. The median prevalence showed a higher urban prevalence of 3.4 percent as against 2.8 percent rural median prevalence.

The highest prevalence was recorded in the 25 to 29 year age group (4.2 percent). Age group prevalence showed two peaks, the first among the 25 to 29 year age group and the second in the 40 to 44 year age group (3.3 percent). The least level of infection (1.4 percent) was found in the 15 to 19 year age group. Prevalence among the younger age groups is higher in urban communities than in the rural communities while rural communities have higher prevalence in the older age groups.

2.2.1 Key Features of HIV and AIDS in Ghana

The HIV and AIDS situation in Ghana indicate the following features:

- ❖ Highest prevalence among pregnant women is identified in the age group 25-29 (3.6 percent);
- ❖ 63 percent of infected people are women and girls;
- ❖ Currently 2 towns have prevalence above 6 percent - these are Agomanya and Koforidua (2005);

- ❖ HIV prevalence among CSWs (seaters): 52 percent in Accra/Tema (2006) and 39 percent in Kumasi (2006);
- ❖ A study in 3 prisons showed 50 percent, 7 percent and 19 percent prevalence rate;
- ❖ Prevalence among all age groups has gone down;
- ❖ Prevalence among pregnant women aged 15-24 years has gone down three consecutive years.

2.2.2 Contributing Factors to HIV Infections in Ghana

- ❖ High prevalence of STIs (syphilis median prevalence 4.8 percent and 2.4 percent in rural and urban sites respectively);
- ❖ Poverty and malnutrition;
- ❖ Limited health education;
- ❖ Unequal power dynamics within relationships;
- ❖ Low self esteem among vulnerable groups;
- ❖ Youthful population – 41 percent under 15 years old;
- ❖ Urbanization, migration;
- ❖ Negative cultural practices e.g. widowhood rites, female genital mutilation; and
- ❖ Low condom use (28 percent).

The response to date has also seen significant progress in prevention, treatment, care and support and impact mitigation on all fronts. Prevention of new HIV infection has been vigorously pursued through promotion of safer sex practices, provision of safe blood and blood products, prevention of mother-to-child-transmission (PMTCT) and the provision of counseling and testing (CT) services in both public and private sector facilities. An average of 26 million condoms have been distributed annually over the last three years while various preventive services are being given to high-risk and vulnerable groups such as sex workers, prisoners, uniformed services and youth.

A Comprehensive Integrated Behaviour Change Communication and IEC Strategy has been developed and is being operationalised to stimulate coordinated and targeted behaviour change communication and IEC programmes.

Treatment, care and support programmes are being scaled up progressively. Highly Active Anti-retroviral Therapy (HAART) has been expanded from the initial two pilot sites to thirty-four sites. These sites include 2 Teaching Hospitals, 10 Regional Hospitals, 14 District Hospitals, 6 Private Self Financing and 2 Uniformed Services Facilities. This service has benefited more than 6,000 clients (male–2,109; female–3,251; pediatric–245) cumulatively.

In spite of these achievements, some activities need to be augmented and other innovative mechanisms found for social mobilisation and the creation of a more enabling environment. In particular, there is a need to address the widening gap in prevention activities in order to maximize the attainment of objectives in the next 4 years.

Addressing these gaps calls for accelerated prevention strategies through IEC and BCC, and PMTCT, proactive steps to mitigate the impact of the epidemic on infected and affected individuals and families and increased access to affordable prevention, treatment, care and support services within the general framework of continuum of care.

It is estimated that there are 200,000 Orphans and Vulnerable Children (OVC) in Ghana, many of whom have lost one or both parents to HIV and can, thus, be classified as AIDS orphans. With the increasing recognition of the implications of this situation for families and communities, support for OVC was intensified in 2006. MDAs and other implementing partners at the district and community levels have been supported to advocate for more support to OVCs and other marginalized groups. In February 2006, DSW with the support of UNICEF initiated a conditional cash transfer programme to cover the payment of NHIS premiums for caregivers of OVC and OVC themselves. Beneficiaries of the scheme need to ensure their ward (OVC) is enrolled and retained in a public school if he/she is of school going age, secure the birth registration of OVC less

than 5 years and concurrently ensure the immunization of the child. So far the Department of Social Welfare (DSW) has paid for a total of 1,235 caregivers covering 2,475 OVC. Furthermore in 2006, essential training for DSW was carried out at national, regional and district levels essentially for identification and monitoring of OVC as well as family and trauma counseling.

The National Social Protection Strategy (NSPS) has been developed. HIV and AIDS is one of the central foci of the NSPS which has further designed various strategies for mitigating AIDS impacts, including provision of cash grants for families or households made vulnerable by HIV and AIDS. The mainstreaming of the NSPS will be undertaken in 2007;

Development and implementation of the National Policy Guidelines on OVC which provides the basis for a national response to OVC through a multi-sectoral approach led to the development of an OVC workplan under the leadership of MOWAC;

There is dissemination of the National Workplace Policy. This policy gives impetus for scaling up of both public and private sector responses to HIV and AIDS; and

The National Network of People Living with HIV (NAP+) is also established. This is a network of associations of PLHIV with the vision to mobilize and empower PLHIV to increase their visibility in the national response to HIV and AIDS, provide care and support programmes for its members and fight stigma and discrimination.

2.3 The National Response – The National Strategic Framework, 2006-2010

In 2005, the Ghana AIDS Commission in collaboration with partners and representatives of key stakeholders agreed on a National Strategic Framework 2006-2010 (NSF II) and an accompanying Five-year Programme of Work both of which provide the framework for the national response from 2006 to 2010.

Five-year Programme of Work which provides the framework for the national response from 2006 to 2010. The 5 Year POW spells out the Strategic Objectives, Key

Interventions and Priority Activities for the HIV and AIDS agenda. The Annual Programme of Work for 2006 is derived from the 5 year POW.

This Annual Programme of Work 2006 describes the priority activities and expected outputs to be achieved for HIV and AIDS interventions for 2006 with key funding partners identified for priority activities. This annual programme of work for 2006, marks the beginning of the implementation of the 5 year POW for the national response and has an explicit focus on the vulnerable and aims to take forward governments agenda as defined also in the GPRS.

The goals of the NSF 2006 to 2010 are as follows:

- Reducing new infections among vulnerable groups and the general population;
- Mitigating the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; and
- Promoting healthy life-styles, especially in the area of sexual and reproductive health.

The objectives are to:

- Strengthen the decentralized, multi-sectoral national response to the HIV and AIDS epidemic;
- Reduce the proportion of men and women who engage in risky sexual behaviour;
- Empower women and other vulnerable groups to reduce their vulnerability;
- Reduce stigma and discrimination, especially towards PLWH and others affected by the epidemic;
- Mitigate the economic, socio-cultural, and legal impacts of the epidemic
- Provide appropriate treatment, care and support for PLWH, OVC, and other affected persons;

- Promote strong research, surveillance, monitoring and evaluation to inform programmes and activities;
- Mobilize adequate resources and provide funding arrangements to support the implementation of all required programmes

The Programme of Work for 2006 was based on the 7 agreed intervention areas identified in the National Strategic Framework 2006-2010. These are:

- Policy, Advocacy and Enabling Environment;
- Coordination and Management of the decentralised response;
- Mitigation of the Economic, Socio-cultural and Legal impacts;
- Prevention and Behavioural Change Communication;
- Treatment, Care and Support;
- Research, Surveillance, Monitoring and Evaluation; and
- Resource Mobilisation and Funding Arrangements;

2.3.1 Implementation Arrangements

The APOW will be implemented by a range of key stakeholders namely MDAs, RCCs, MMDAs, the Ghana Business Coalition and other private sector organisations, NGOs, CBOs, FBOs, PLHIV Associations and Networks, research and academic institutions as well as other civil society groups.

The financing of sub-projects to be implemented by these entities will be done either directly by development partners or through the GAC funding mechanisms; pooled and earmarked funding. Sub-projects to be funded under the pooled funding arrangement shall be in line with the year's APOW, and allocation of funds shall be made available through four (4) main windows, as defined in the operational manual for the national response as follows:

| | |
|-----------------|--|
| Window A | Will fund proposals from Ministries, Departments and Agencies (MDAs) and Regional Coordinating Councils (RCCs), and will finance activities for their staff and clients (both external and internal) based on the approved sectoral and regional HIV and AIDS strategic plans. |
| Window B | Will fund proposals of Metropolitan, Municipal and District Assemblies (MMDAs) to finance activities for their staff and clients as well as proposals of NGOs, FBOs, CBOs, and associations of PLHIV or groups of these entities (including networks) within the district for activities as described in the approved MMDA HIV and AIDS Strategic Plan. |
| Window C | Will fund proposals from the private sector, including trade and professional associations. |
| Window D | Will fund national programmes that can only be directed and controlled at the national level (e.g. national condom distribution, curriculum development), innovative projects to address the evolving trends of the epidemic and research proposals. Other sub-projects to be funded under Window D would include those to be undertaken by national umbrella organizations and international NGOs with the capacity and track record to carry out specific activities identified in the 2007 POW. |

Implementing agencies will access funds directly from GAC for the implementation of sub-projects under windows A, C and D. Under Window B, MMDAs will access funds directly from GAC while disbursements for sub-projects implemented by NGOs, CBOs, and FBOs will be done by MMDAs.

2.3.2 Financing the APOW

The Government of Ghana (GOG) and the development partners are channeling funds for the implementation of the APOW through three main funding mechanisms. The pooled, earmarked and direct funding mechanisms and their levels of funding are as follows:

- **Pooled funding;** where funds are pooled by development partners and are given directly to GAC for the implementation of the national HIV and AIDS programme.
- **Earmarked funding;** funds earmarked by development partners to be used for special programmes and channeled through the GAC.
- **Direct funding;** Funding given directly to the implementing agencies by development partners.

In 2006, of the total funds, the largest proportion was allocated to two intervention areas: Prevention and BCC (33 percent), and Treatment, Care and Support (53 percent). The high percentage allocation for treatment, care and support was mainly due to the high investments required at the early stage of rolling out ART programme and capacity building. Funding sources for treatment care and support was mainly from Global Fund, and the Treatment Acceleration Programme (World Bank). The breakdown of the 2006 budget according to the seven intervention areas are shown in Table 2.1 and Figure 2.1.

Pooled Fund

Some of the funds under direct funding are fixed and non changeable, such as Global Fund contribution for treatment, care and support activities. The earmarked funds are also allocated for special purposes, which are based on the NSF II prioritization, and allocated for this purpose by different development partners. While GAC has control over the pooled funds, the GAC secretariat and the task team for APOW 2007 worked on the allocations between the intervention areas, giving attention to the emerging priorities and the existing allocation from the different partners under earmarked and direct funds.

In accordance with national priorities, 31 percent of the pooled fund is allocated to prevention and behaviour change communication, 2 percent to treatment, care and support, 13 percent to impact mitigation, 4 percent to policy, advocacy and enabling environment, 38 percent to coordination and management, and 12 percent to research, surveillance, monitoring and evaluation. The percentage distribution of pooled fund

allocations is captured in Figure 2.2 and specific amounts allocated to the various thematic areas are also shown in Table 2.1.

Table 2.1 Breakdown of 2006 APOW Budget by Funding Source and Intervention Area

| Intervention Areas | Pooled funding | Earmarked funding | Direct funding | Total | Total % |
|--|-----------------------|--------------------------|-----------------------|-------------------|----------------|
| Policy, Advocacy and Enabling Environment | 265,556 | 152,057 | 780,750 | 1,198,363 | 2% |
| Coordination and Management of the Decentralized Response | 640,645 | 488,995 | 1,763,163 | 2,892,803 | 6% |
| Mitigating the Economic, Socio-cultural and Legal Impacts | 717,672 | 183,403 | 523,000 | 1,424,075 | 3% |
| Prevention and BCC | 1,581,900 | 4,148,607 | 11,477,160 | 17,207,667 | 33% |
| Treatment, Care & Support | | 2,959,540 | 24,687,473 | 27,647,013 | 53% |
| Research, Surveillance and M&E | 526,898 | 261,404 | 766,262 | 1,554,564 | 3% |
| Mobilization of Resources and Funding Arrangements | 31,875 | 0 | 0 | 31,875 | 0% |
| Total | 3,764,546 | 8,194,006 | 39,997,808 | 51,956,360 | 100% |

Figure 2.1 National Response Budget by Intervention Areas

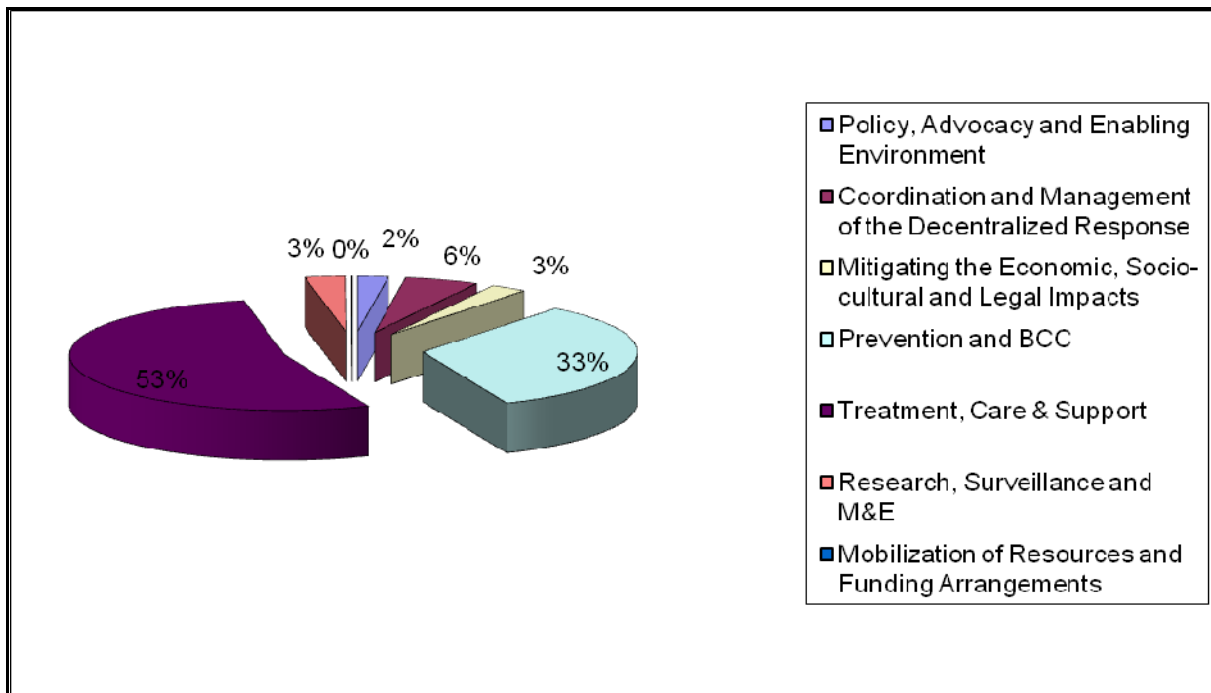
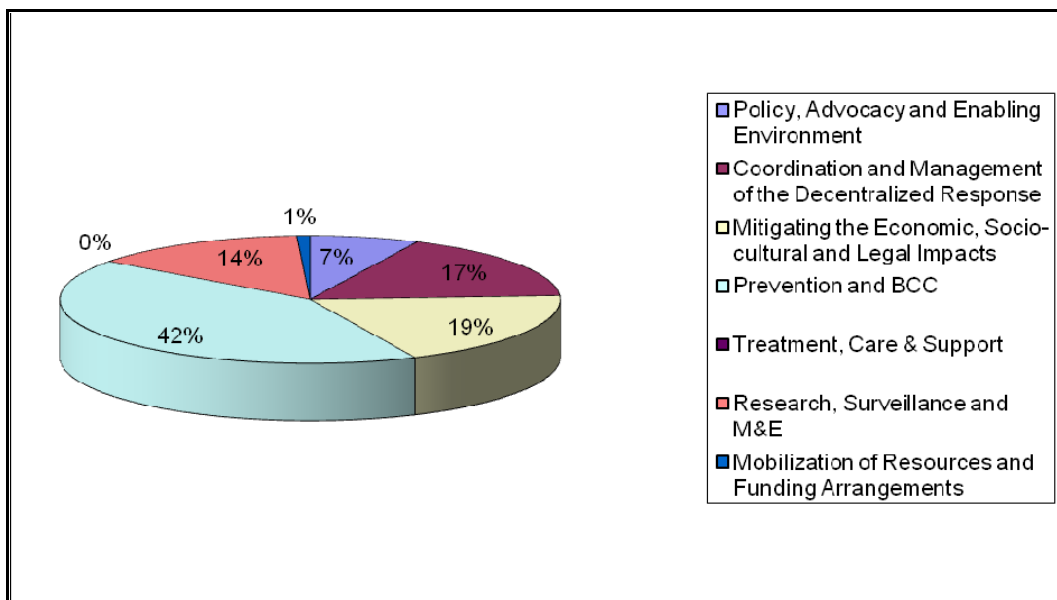


Figure 2.2 Allocation of Pooled Funds by Intervention Areas



Section 3

Methodology

3.1 Overall Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors are addressed to confront the HIV and AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, as a result of a continuing recording, integration and analyses, to produce, ideally, annual estimates; systematic, as the structure of the categories and records/reports must be consistent over time and comparable across countries².

Importantly, NASA captures all HIV and AIDS spending according to the priorities/categories found in national strategic framework, and thus allow countries to monitor their own progress towards their goals. In addition, it is not limited to health-related spending, but identifies and captures all the other spending related to HIV and /AIDS, such as social mitigation, legal services, educational and life-skills activities, psychological support, care for Orphans and Vulnerable Children (OVCs), and those efforts aimed at creating a conducive and enabling environment.

The financial flows refer to the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction compiles all of the elements of the financial flow, the transfer of resources from a financial source to a service provider, which spends the money in different budgetary items to produce functions (or interventions) in response to addressing HIV and AIDS addressing specific target groups or to address unspecific populations (or the general population). NASA

² UNAIDS. 2006. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level. (draft- work in progress).

uses both top-down and bottom-up techniques for obtaining and consolidating information.

This methodology employs double entry tables – matrices - to represent the origin and destination of resources, avoiding double-accounting the expenditures by reconstructing the resources flows at every transaction point, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities. In addition to establishing a continuous information system of the financing of HIV and AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS I & II) (UNAIDS, 2006).

3.2 Data Collection

Preparatory Mission

Training of the Ghana NASA team was conducted in the second week of May by a UNAIDS consultant. The training was for one week. The NASA Team was from the Institute of Statistical, Social and Economic Research (ISSER) of the University of Ghana.

Obtaining Permissions

Permission from the Directors of the selected Ministries involved was required in order to access the data. Permissions were also required for all the external and internal agencies working in HIV and AIDS related areas. The first batch of letters took two weeks to be received and this seriously hampered the data collection.

Database of all Stakeholders

A database of all the stakeholders involved in HIV and AIDS, sources, agents and providers, was developed using GAC's information and a database from UNAIDS as well as from a meeting with stakeholders prior to the commencement of the project.

Literature Review

In preparation for the NASA analysis and site selection, the team relied on background information and literature regarding the HIV and AIDS epidemiological profile of Ghana, the surveillance findings, and the national response from the GAC. Ghana has a well-developed HIV and AIDS and STI surveillance systems which serves as a vital source of information for action within the National Strategic Framework II. In addition, the public service providers report quarterly to MOH and GAC on the numbers of clients, and thus each service had records of their beneficiary populations.

Development and Administering of Questionnaires

The UNAIDS NASA format for the questionnaires was adjusted to suit the Ghana, particularly the addition of qualitative questions regarding funding processes and challenges. The adjusted questionnaires (see Appendix 1) were sent to the key respondents and appointments then made during which the data was requested and the forms completed. Generally the questionnaires were too complicated to be self-administered. The administering of the questionnaires/data collection tool took about six weeks instead of the planned four weeks by the Ghana NASA Team.

3.2.1 Sources of Data

Most of the key sources of data (detailed expenditure records) were obtained from the majority of primary sources, for 2005 and 2006. For the purposes of this study a financial year was from 1st January to 31st December. Only a few were not available and were either obtained from secondary sources (e.g. expenditure of small NGOs were captured

from GAC's and other donor reports), or were estimated using the best available data and most suitable assumptions. Table 3.1 shows the list of institutions visited for the HIV and AIDS expenditures and the status of the data collected. The institutions were grouped into the following categories; Public, External, NGOs and Businesses. The businesses visited were those supported directly or indirectly by GAC and some of the major donors. Information from businesses on how much of their own resources/contribution that they put into workplace HIV and AIDS activities were not covered in this study. Details of the status of the data collected with comments are presented in Appendix Table 1.

Table 3.1 List of Institutions and Status of Data Collected on HIV/AIDS Spending

| INSTITUTION | 2005 | 2006 |
|------------------------------|------|------|
| <u>PUBLIC</u> | | |
| Ghana AIDS Commission | ✓ | ✓ |
| NACP - hospital exp. | ✓ | ✓ |
| NACP - PMTCT exp. & nos | ✓ | ✓ |
| NACP - ARVs exp & nos. | ✓ | ✓ |
| NACP – STIs & TB exp & nos | x | x |
| TB Control Program | x | x |
| MoH - CMS & procurements | ✓ | x |
| MoH – Health Fund | x | x |
| MoH - Nat. Reference Lab | x | x |
| MoH – Salaries | x | x |
| GHS | | ✓ |
| MLGRDE (district resources) | ✓ | ✓ |
| MoESS | ✓ | ✓ |
| MOWAC | ✓ | ✓ |
| Dept.S.Welfare (MOMPYE) | ✓ | ✓ |
| Trade Union Congress | | ✓ |
| Other Ministries (Workplace) | ✓ | ✓ |
| Research Agencies | ✓ | ✓ |
| Regional & District Service | | ✓ |
| | | |

| | | |
|--|---|---|
| <u>EXTERNAL</u> | | |
| USAID (Int & Ghana) | ✓ | ✓ |
| GLOBAL FUND | ✓ | ✓ |
| DANIDA | ✓ | ✓ |
| UNICEF | ✓ | ✓ |
| UNFPA | ✓ | ✓ |
| UNAIDS | ✓ | ✓ |
| World Bank | ✓ | ✓ |
| WHO | ✓ | ✓ |
| UNHCR | ✓ | ✓ |
| UNESCO | ✓ | ✓ |
| WFP | x | ✓ |
| ILO | ✓ | ✓ |
| JICA | ✓ | ✓ |
| GTZ | ✓ | ✓ |
| SHARP | x | x |
| DFID | ✓ | ✓ |
| Royal Netherlands Embassy | ✓ | ✓ |
| WAPCAS | ✓ | ✓ |
| OICI (Int. & Ghana) | ✓ | ✓ |
| PLAN International | | |
| Futures Group | ✓ | ✓ |
| Family Health Int. (& Ghana) | ✓ | ✓ |
| Other donors to GAC (MSHAP) | ✓ | ✓ |
| | | |
| <u>NGOs</u> | | |
| CARE | ✓ | ✓ |
| CRS | ✓ | ✓ |
| NAP + | ✓ | ✓ |
| GHANET | ✓ | ✓ |
| ARHR | ✓ | ✓ |
| AWARE | ✓ | ✓ |
| GSCP | ✓ | ✓ |
| GSMF | ✓ | ✓ |
| ActionAid Int. & Ghana | | |
| QHP | | |
| Right to Play | | |
| All MSHAP transfers to NGOs/CBOs (via GAC) | ✓ | ✓ |
| | | |

| <u>BUSINESS</u> | | |
|--------------------------|---|---|
| Ghana Business Coalition | ✓ | ✓ |
| Ghana Employers Assoc. | ✓ | ✓ |
| Chamber of Commerce | ✗ | ✗ |
| ANGLO GOLD | | |
| Lister Hospital | ✗ | ✗ |
| Nyaho Clinic | ✗ | ✗ |

data was unavailable

- ✗ data was available but not captured in RTS to avoid double-counting
- ✓ data was captured in NASA RTS

On the whole, all the players in HIV and AIDS activities; Government, NGOs, and donors were very keen to share their records with the research team. They also shared their problems and their thoughts on the solution to the problems.

Site Visits

The sites visited determined the districts for the case studies. The site (case study) visits were to provide more detailed expenditure information from the service providers at district level, as well as providing an insight into the funding mechanisms and implementation challenges.

The criteria for the selection of the seven sites were based on the 2006 sentinel survey report. The highest, average and lowest prevalence rates for the urban and rural sentinel sites were selected (see Table 3.2). Koforidua in the New Juaben Municipality of the Eastern Region was added as the seventh site because of the drastic fall in the prevalence rate from 6.4 in 2005 to 4.4 in 2006.

At each site, the District Assembly, NACP Accredited Health Facility and some NGOs, were visited.

Table 3.2 Selected Sites (Districts) Used as Case Studies.

| Regions | Site | District | HIV high | HIV low | Av. HIV | Urban | Rural |
|----------------|-------------|-----------------|-----------------|----------------|----------------|--------------|--------------|
| Northern | Nalerigu | East Mamprusi | | 1.0 | | x | |
| Volta | North Tongu | North Tongu | | 0.0 | | | x |
| Upper Eaast | Bulisa | Bulisa | | | 2.8 | | x |
| Ashanti | Obuasi | Obuasi | | | 3.6 | x | |
| Western | Eikwe | Nzema East | 5.6 | | | | x |
| Eastern | Agomanya | Manya Krobo | 8.4 | | | x | |
| Eastern | Koforidua | New Juaben | 4.4 (from 6.4) | | | x | |

Effort was made to interview the following positions in each site (where available):

- District Chief Executive (DCE) where available;
- District HIV/AIDS focal person at the District Assembly;
- Health personnel(s) at the District hospital; and
- A minimum of 3 NGOs.

These site visits and interviews provided invaluable information, from the perspective of district programme implementers; regarding the financial flow mechanisms, reporting mechanism, actual expenditure and outputs, and the challenges and bottlenecks in spending being experienced.

Data Processing

The data collected was first captured in Excel® sheets, and checked and balanced. All the information obtained/collected was verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers and also avoid double counting. The data was then transferred to the NASA Resource Tracking Software (RTS), which has been developed to facilitate the NASA data processing. It provides a step-by-

step guidance along the estimation process and makes it easier to monitor the crosschecking among the different classification axes. The RTS outputs (double-entry matrices) were exported to Excel® to produce summary tables and graphics for analysis.

3.3 Assumptions and Estimations

A few development partners had different financial year periods from that used by the government. Effort was made to capture the actual expenditure within each fiscal year, according to the government's fiscal year, that is from January to December.

Where funds are pooled, then the specific contribution of donor to the activities was assumed to be equal in equal proportions as the contribution to the total income. The same rationale was also applied to any under spending. Also where detailed expenditure records of providers were not available, then we assumed equal split of funds between the key activities, unless instructed otherwise.

GAC funds to NGOs, CBOs and private organisations. The actual recipient's data was available but a breakdown of activities and beneficiaries were not readily available. Also the GAC's MSHAP pooled funds indicated sources, but could not be linked specifically to activities.

Public sector spending in this study includes pooled funds to GAC from the IDA of the World Bank. This is because the IDA funds was a credit to Ghana at an interest rate of zero percent.

The annual exchange rate of the US dollar to the cedi was used in this study. For 2005, the rate was 9,130.80 cedis to US\$ 1 and 9,235.30 to US\$1 in 2006 (SGER, 2007)³.

3.4 Limitations of the Assessment

As mentioned, the project could not include private expenditure; such as private insurance, businesses, traditional healers, and out-of-pocket payment expenditures, in the short project timeframe. It is hoped that GAC will collaborate with the Ghana Business Coalition Association to identify all businesses in Ghana who are involved with HIV and AIDS activities (including work place HIV/AIDS programmes). This will help to estimate the major stakeholders and also help in the data collection for the next NASA for Ghana.

Data on salaries of health and non-health personnel working in HIV and AIDS related activities from MoH and GHS were not easily available and thus was not included in the NASA given the short period for the study. In order to capture the data on salaries, it would take time to disaggregate what percentage of salaries goes into HIV and AIDS related activities and projects. Also one needs to know the proportion of staff time spent on HIV and AIDS related activities so as to be able to factor it in the salary.

Overheads of most UN agencies were not available and thus not included in the NASA.

The data on beneficiaries were not disaggregated and detailed enough due to the nature of data received from providers as such the bulk of it was assumed to be targeted to the general population. However for prevention programs such as mass media and HIV-Related Information and education with no specific target group we assumed the general population as the key beneficiaries.

³ SGER (2007). The State of the Ghanaian Economy in 2006. Published by the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana, Legon.

The data collected on HIV/AIDS related research was limited to the information provided by donors and NGOs. The universities and other research bodies were not interviewed in this regard. Therefore the research expenditure presented here may therefore be an underestimation.

We were unable to carry out a detailed comparison of the key priority areas of the NSF with that produced by the NASA RTS software. However we do not view it as a limitation of the NASA software rather stakeholders need to agree on a way by which we could harmonise the two priority areas.

The timeframe for the study was further shortened by the delayed receipt of data from the relevant government bodies and some development partners. This was due to the late release of the GAC letters of introduction requesting permission and administrative/bureaucratic procedures in some institutions.

Generally, data collected were not in the suitable format even though 2006 data was much better than 2005. The quality of statistical data especially of the number of persons benefiting from HIV and IADS related activities was poor.

The study also excluded the following expenditure which were difficult to collect due to the timeframe of the study or in assigning to HIV and AIDS related activities:

1. Sexual reproductive health spending share that might be related to HIV and AIDS;
2. DFID spending of US\$5.7 million in 2005 on condom because we could not estimate what share was related to HIV and AIDS; and
3. The proportion of TB treatment that was related to HIV and AIDS.

Section 4

Findings – NASA Estimation

4.1 Total Expenditure on HIV and AIDS and Sources of Funding in Ghana

The total expenditure on HIV/AIDS activities in Ghana increased from \$28,414,708 in 2005 to \$32,067,635 in 2006, representing an 11.4 percent increase. Figure 4.1 shows that in both years the largest proportion of the funds was from international organisations. This can also be seen clearly from Figures 4.2a and 4.2b. In 2005, funds from International organizations formed 71 percent of total spending on HIV and AIDS and reduced slightly to 68 percent in 2006. Public funds formed 28 percent of the total expenditure in 2005 and increasing to 31 percent in 2006. This increase can be attributed mainly to an increase in public sector funds towards treatment and care. Private funds

Figure 4.1

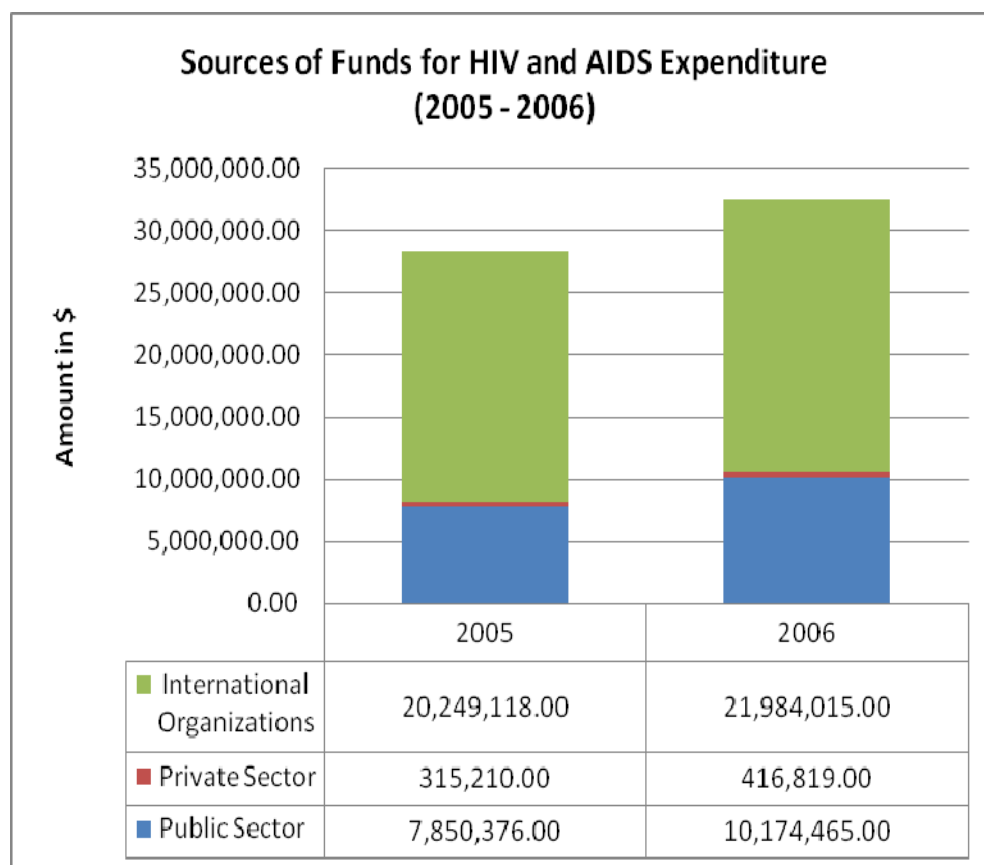


Figure 4.2a

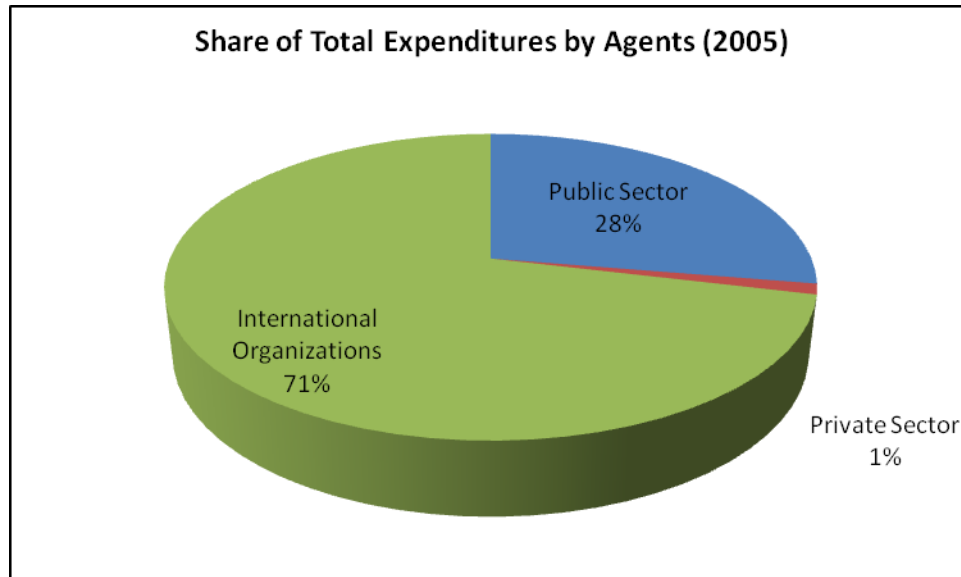


Figure 4.2b



accounted for 1 percent of the total in both 2005 and 2006. However, since the study did not systematically collect all private (business and out-of-pocket) spending on HIV and AIDS, this does not represent their contribution to the total spending on HIV and AIDS.

Comparing the total expenditure on HIV and AIDS in 2006 and what was budgeted in the National Response for 2006 of US\$52,075,837 total expenditure formed only 61.6 percent of what was budgeted.

The private spending did not include other private funds, namely those contributed by the business sector, private insurances and individuals and households besides those from Ghana Business Coalition against AIDS and Ghana Employers Association. Thus the private share shown above does not reflect their total contribution to HIV and AIDS.

The public sector spending includes pooled funds to GAC from the IDA of the World Bank. Since this is a credit to the Ghana Government with a zero interest rate it was considered as part of government's spending. The public sector spending excludes salaries of health and non-health personnel involved in HIV and AIDS activities. International organisations are mainly the UN agencies and the development partners with presence in Ghana.

4.2 Composition of HIV and AIDS Spending

Table 4.1 shows the total spending on the key priority areas in 2005 and 2006. In 2005, most of the funds were spent on Prevention Programmes (39 percent); Programme development and strengthen health care systems for HIV and AIDS activities (32 percent); Treatment and Care (16 percent) and HIV and AIDS - Related Research (excluding operations research) forming 10 percent. In 2006, most of the funds (40 percent) were spent on Programme development and strengthening of health care systems for HIV and AIDS activities, while 23 percent went to Prevention Programmes and 22 percent for Treatment and care activities.

Table 4.1 Total Spending on Key Priorities, 2005 and 2006

| Key areas of Expenditure | 2005 (US\$) | Percent (%) | 2006 (US\$) | Percent (%) |
|--|--------------------|--------------------|--------------------|--------------------|
| Prevention Programmes | 11,157,054 | 39.27 | 7,352,150 | 22.93 |
| Treatment and care components | 4,682,149 | 16.48 | 7,050,088 | 21.99 |
| Orphans and Vulnerable Children (OVC) | 354,865 | 1.25 | 344,997 | 1.08 |
| Programme development and strengthen health care systems for HIV and AIDS activities | 9,133,721 | 32.14 | 12,820,701 | 39.98 |
| Human Resources for HIV and AIDS activities | 130,246 | 0.46 | 130,620 | 0.41 |
| Social mitigation | 46,669 | 0.16 | 164,425 | 0.51 |
| Community Development and Enhanced Environment to Reduce Vulnerability | 214,902 | 0.76 | 995,591 | 3.10 |
| HIV- and AIDS-Related Research (excluding operations research) | 2,695,102 | 9.48 | 3,209,063 | 10.01 |
| Grand Total | 28,414,708 | 100.00 | 32,067,6350 | 100 |

From Figures 4.3a and 4.3b, the results show that total expenditure on prevention programmes decreased from \$11,157,054.00 in 2005 to \$7,352,150.00 in 2006 representing a 34 percent decrease. The share of total expenditure for Programme development and strengthening of health care systems for HIV and AIDS activities

remained relatively the same in both years, increasing by 4 percentage points in nominal terms from 2005 to 2006. Treatment and care component saw an increase from about 17 percent of total expenditure in 2005 to 22 percent of total expenditure in 2006. In nominal terms total expenditure for Treatment and Care increased from \$4,682,149 in 2005 to \$7,050,088 in 2006 representing a 50 percent increase whilst expenditure on prevention programmes dropped by 34 percent from \$11,157,054 in 2005 to \$7,352,150 in 2006. The decrease in funds allocated for prevention intervention and the increase in funds allocated for treatment and care components between 2005 and 2006 could be due to the Three by Five Initiative which focused primarily on treatment and also to the Global Fund to Fight AIDS, TB and Malaria (GFATM) proposal which focused on treatment.

Figure 4.3a Total Expenditure Breakdown by Intervention Areas, 2005

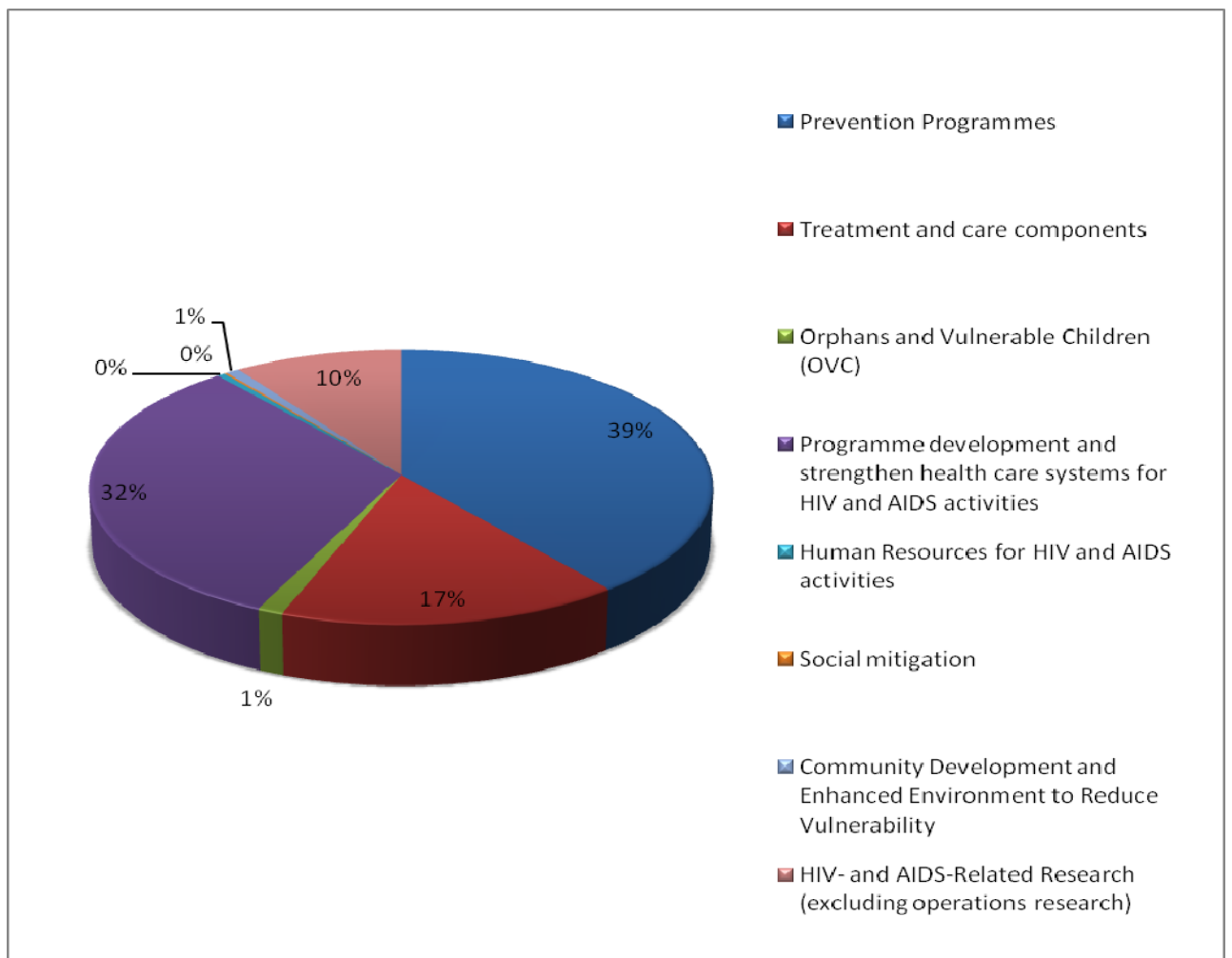
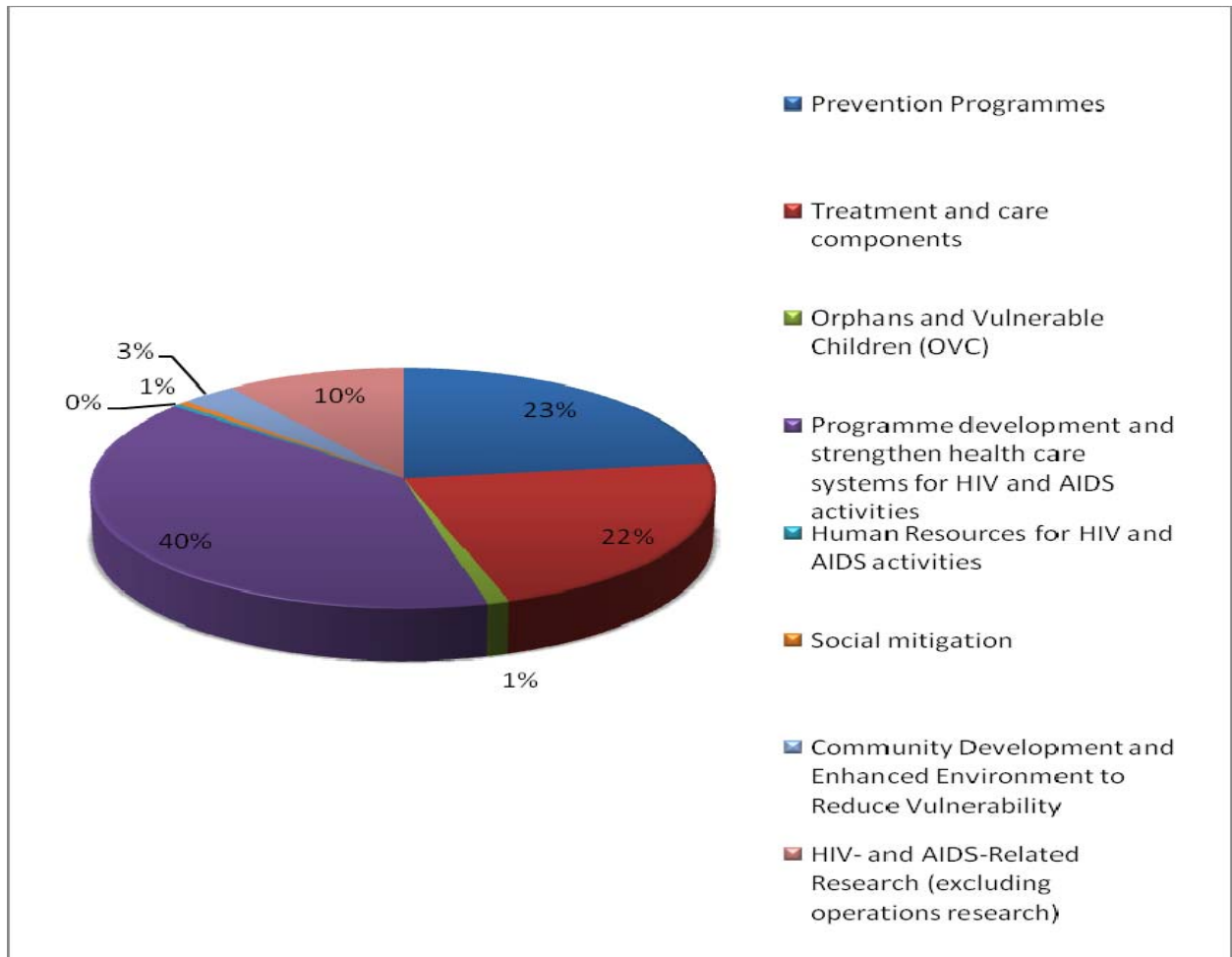


Figure 4.3b Total Expenditure Breakdown by Intervention Areas, 2006



The percentage share of total expenditure on HIV and AIDS – related research remained at 10 percent in both 2005 and 2006. Total expenditure on community development and enhanced environment to reduce vulnerability increased from a 1 percent share in 2005 to 3 percent share in 2006. Social mitigation is another priority area that has also received some amount of attention in 2006. In 2006, total expenditure on social mitigation amounted to about \$164,425 from \$46,669 in 2005.

According to the APOW 2006, the largest proportion of the National Response budget which includes pooled, earmarked and direct funding was to be allocated to two intervention areas; Prevention and BCC and then Treatment, Care and Support (53 percent and 33 percent respectively). Comparing this with the actual percentage share of total expenditure of these two components from the NASA estimates (see Figure 4.3b), Prevention programmes accounted for 23 percent whilst the Treatment and care component accounted for 22 percent of total funds spent on HIV and AIDS.

4.2.1 Key Spending Priorities by Agent

This section attempts to highlight the key priority areas by the various agents captured in the NASA RTS. In 2005, Programme development and strengthen health care systems for HIV and AIDS activities took the majority of the funds from external sources (32 percent), followed by prevention programmes (26 percent), treatment and care (23 percent) and then HIV-related research (13 percent). These four areas accounted for about 95 percent of total spending on HIV and AIDS activities from external sources. The Public sector funding went in two main priority areas; prevention programmes which comprised of about 65 percent of the total from the public sector, followed by programme development and strengthen health care systems for HIV and AIDS activities which accounted for about 32 percent of the total. These two areas accounted for almost 97 percent of total funds from the public sector, which shows that the other key areas benefitted far less (see Table 4.2a). The total amount of funds from the private sector went into Prevention programmes.

In 2006, the results show that overall, Public sector funds for HIV and AIDS activities increased substantially by about \$3 million whilst funding from external sources increased slightly by about \$100,000.00 from 2005. The breakdown by priority areas show that in the case of external sources of funding the distribution amongst the key areas of funding remained almost the same as in 2005. Programme development and strengthen health care systems for HIV and AIDS activities still accounted for the largest portion of external funds but reduced slightly to 34 percent from 36 percent of the total in

Table 4.2a Spending Priorities by Agents, 2005 (US\$)

| Key Priority Areas | Public sector | Private sector | International Organizations | Grand Total |
|--|---------------|----------------|-----------------------------|----------------------|
| Prevention Programmes | 5,496,186.00 | 315,210.00 | 5,345,658.00 | 11,157,054.00 |
| Treatment and care components | 2,742.00 | | 4,679,407.00 | 4,682,149.00 |
| Orphans and Vulnerable Children (OVC) | 9,120.00 | | 345,745.00 | 354,865.00 |
| Programme development and strengthen health care systems for HIV and AIDS activities I | 2,711,104.00 | | 6,422,617.00 | 9,133,721.00 |
| Human Resources for HIV and AIDS activities | 128,087.00 | | 2,159.00 | 130,246.00 |
| Social mitigation | 11,135.00 | | 35,534.00 | 46,669.00 |
| Community Development and Enhanced Environment to Reduce Vulnerability | 126,842.00 | | 88,060.00 | 214,902.00 |
| HIV- and AIDS-Related Research (excluding operations research) | 21,130.00 | | 2,673,972.00 | 2,695,102.00 |
| Grand Total | 8,506,346.00 | 315,210.00 | 20,249,118.00 | 28,414,708.00 |

2005. The percentage share of treatment and care reduced from 23 percent in 2005 to 18 percent of total spending in 2006 with the share of the HIV-related research component increasing to 15 percent in 2006 from 13 percent in 2005. These four areas accounted for 97 percent of total spending from external sources. The Public sector funding saw quite a dramatic change in 2006. The share of prevention programs which comprised of about 65 percent of the total from the public sector in 2005, decreased to about 15 percent of the total spending in 2006. The largest portion of public sector funding (48 percent) went into programme development and strengthen health care systems for HIV and AIDS activities in 2006. The treatment and care component which previously benefited very little saw a sharp increase in funding from 0.03 percent of the total in 2005 to 28 percent of the total in 2006. These three areas accounted for almost 80 percent of total funds from the public sector, which shows that the other key areas benefited more in 2006 compared to 2005. More public sector funds were committed to other key areas such Community Development and Enhanced Environment to Reduce Vulnerability, social mitigation and Human Resources for HIV and AIDS activities in 2006 than in 2005 (see Table 4.2b).

4.3 Prevention Programmes Spending Activities

Figures 4.4a and 4.4b show the key areas of expenditures in 2005 and 2006. The share of Prevention programmes in the total expenditure decreased from \$11,157,054 in 2005 to \$7,352,150 in 2006 and this is mainly attributed to a decrease in total expenditure on prevention programs for non-targeted populations. However, total expenditure on HIV-Related information and education increased by about 20 percentage points from 2005 to 2006. Voluntary Counselling and Testing (VCT) showed a mark increased from 2005 to 2006 with condom social marketing also increasing from 2005 to 2006 (see Figure 4.4b). In 2006 the results show that there was no expenditure specifically targeting PMTCT even though about 5 percent of total expenditure on prevention programmes was targeted to this group in 2005. A point worth noting is that looking at the key spending priority areas proportionally, the share of prevention programmes for the non-targeted groups reduces dramatically from a 56 percent share in 2005 to 27 percent share in 2006. The main reason for this is that the level of disaggregation for 2006 data was much better compared to 2005.

Table 4.2b Spending Priorities by Agents, 2006 (US\$)

| | Public sector | Private sector | International Organizations | Grand Total |
|--|----------------------|-----------------------|------------------------------------|----------------------|
| Prevention Programmes | 1,714,811.00 | 138,190.00 | 5,499,149.00 | 7,352,150.00 |
| Treatment and care components | 3,246,740.00 | | 3,803,348.00 | 7,050,088.00 |
| Orphans and Vulnerable Children (OVC) | 541.00 | | 344,456.00 | 344,997.00 |
| Programme development and strengthen health care systems for HIV and AIDS activities | 5,405,484.00 | 254,911.00 | 7,160,306.00 | 12,820,701.00 |
| Human Resources for HIV and AIDS activities | 128,087.00 | | 2,533.00 | 130,620.00 |
| Social mitigation | 100,054.00 | | 64,371.00 | 164,425.00 |
| Community Development and Enhanced Environment to Reduce Vulnerability | 714,063.00 | 23,719.00 | 257,809.00 | 995,591.00 |
| HIV- and AIDS-Related Research (excluding operations research) | 16,602.00 | | 3,192,461.00 | 3,209,063.00 |
| Grand Total | 11,326,382.00 | 416,820.00 | 20,324,433.00 | 32,067,635.00 |

However, another reason could be that in 2006 more of the prevention programmes were targeted to PLWH. The results show that the share of prevention programmes for PLWH in the total expenditure for prevention programmes increased from 30 percent in 2005 to about 52 percent in 2006.

Figure 4.4a Prevention Spending Activities, 2005 and 2006 (US\$)

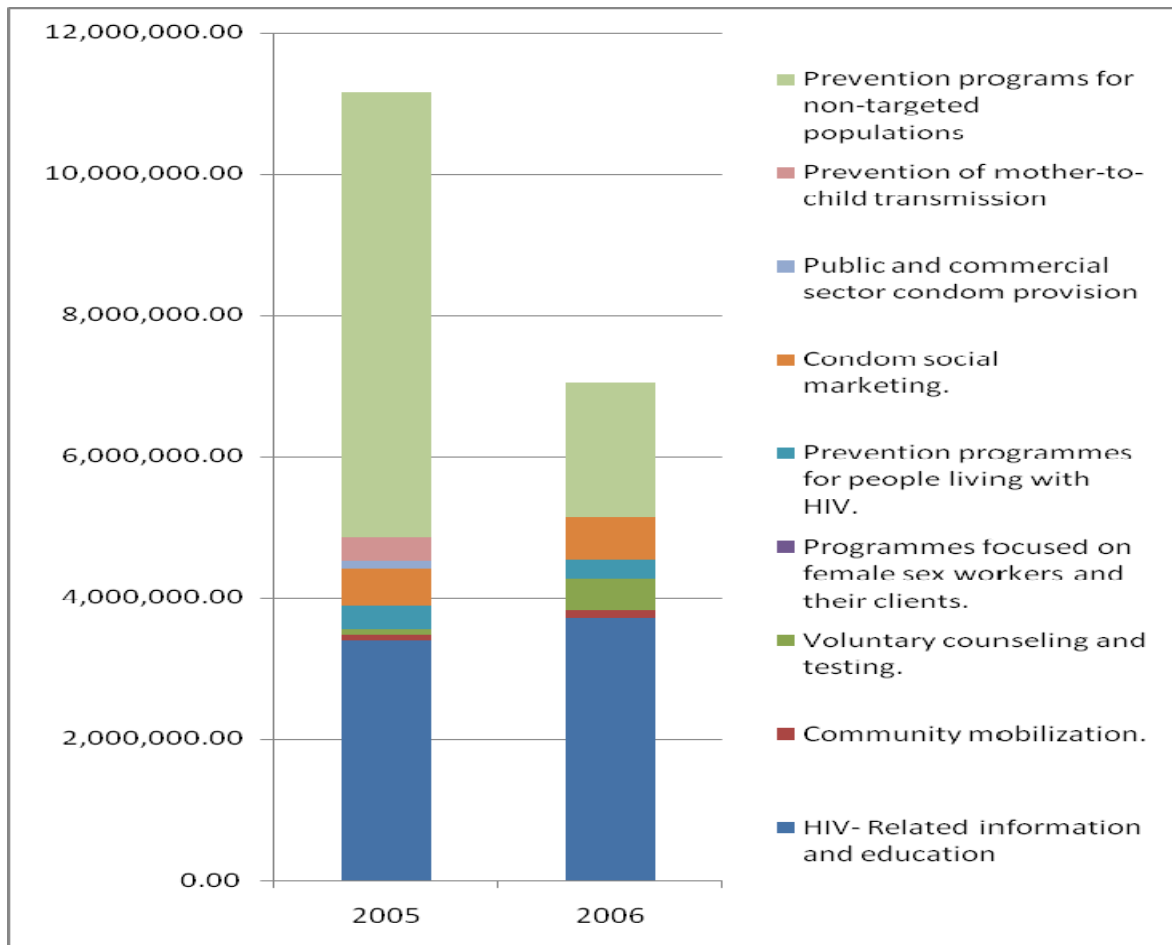
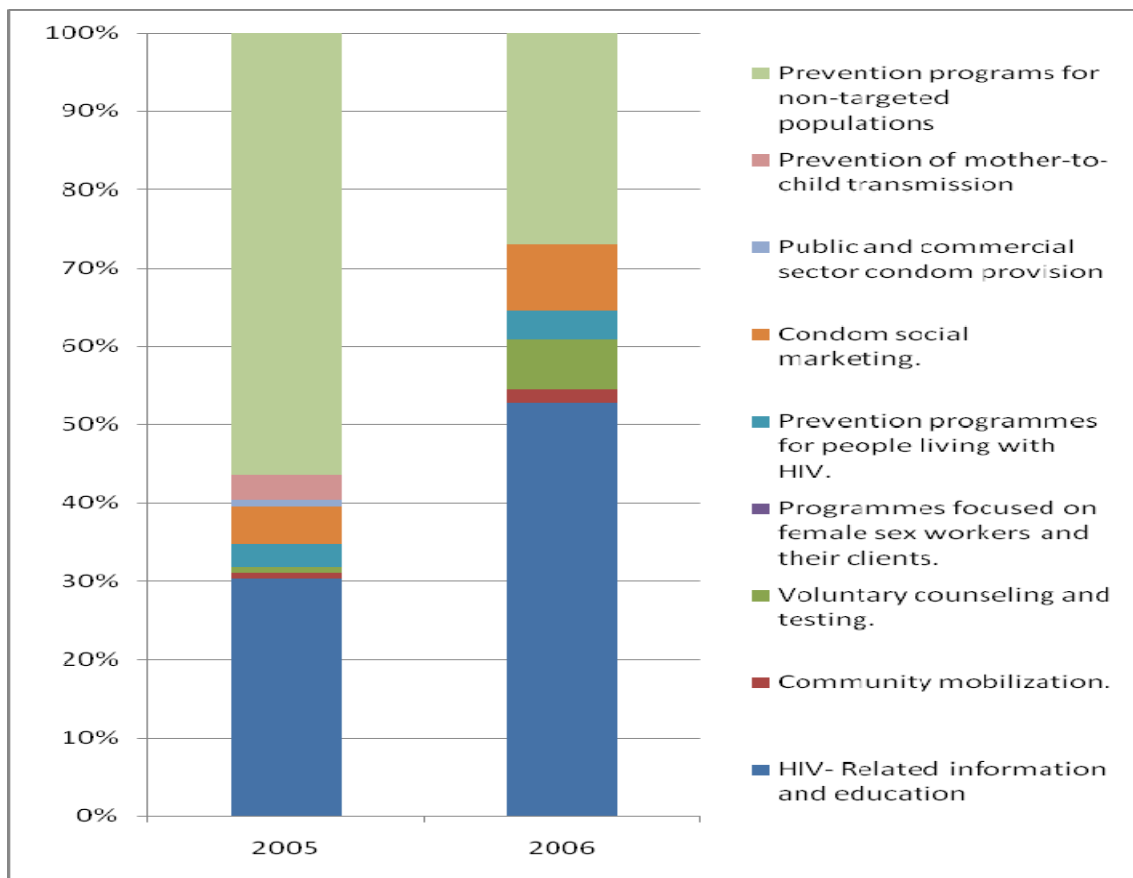


Figure 4.4b Proportional Prevention Spending Activities, 2005 and 2006 (US\$)



4.3.1 Prevention Spending Activities by Agent

Considering the broad categories of programmes in response to HIV and AIDS activities, the different priorities between the public and external sectors (agents) are shown in the Figures 4.5a, 4.5b, 4.5c and 4.5d. In 2005 the Public sector spent slightly more than International Organisations on prevention programs (see Figure 4.5a). However, in 2006 International Organisations spent about 3 times what the Public sector spent on Prevention programs (see Figure 4.5b and Appendix Tables 2 and 3). Proportionally in 2005, 80 percent of Public sector funding was on Prevention programs for non-targeted populations and 20 percent on HIV-Related information and education (see Figure 4.5c), whilst in 2006, 99 percent of public sector funding was on HIV-Related information and education (see Figure 4.5d). In 2005, about 80 percent of funding from International Organisations was evenly divided between HIV-Related information and education and

Prevention programs for non-targeted populations with the rest on condom social marketing, prevention programs for people living with HIV and AIDS and VCT. The same trend was carried through to 2006 but funding for VCT increased to \$446,805.00 from \$87,183.00 in 2005.

Figure 4.5a Prevention Spending Activities by Agent, 2005 (US\$)

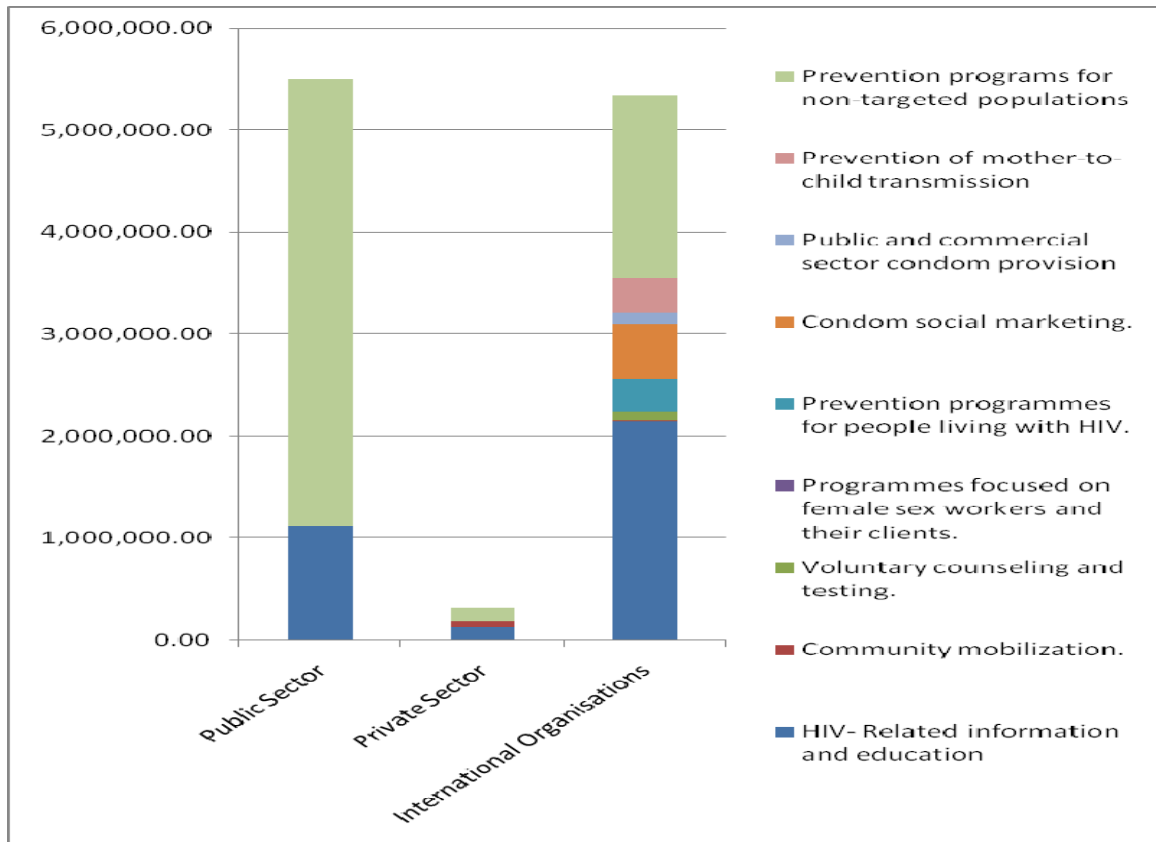


Figure 4.5b Prevention Spending Activities by Agent, 2006 (US\$)

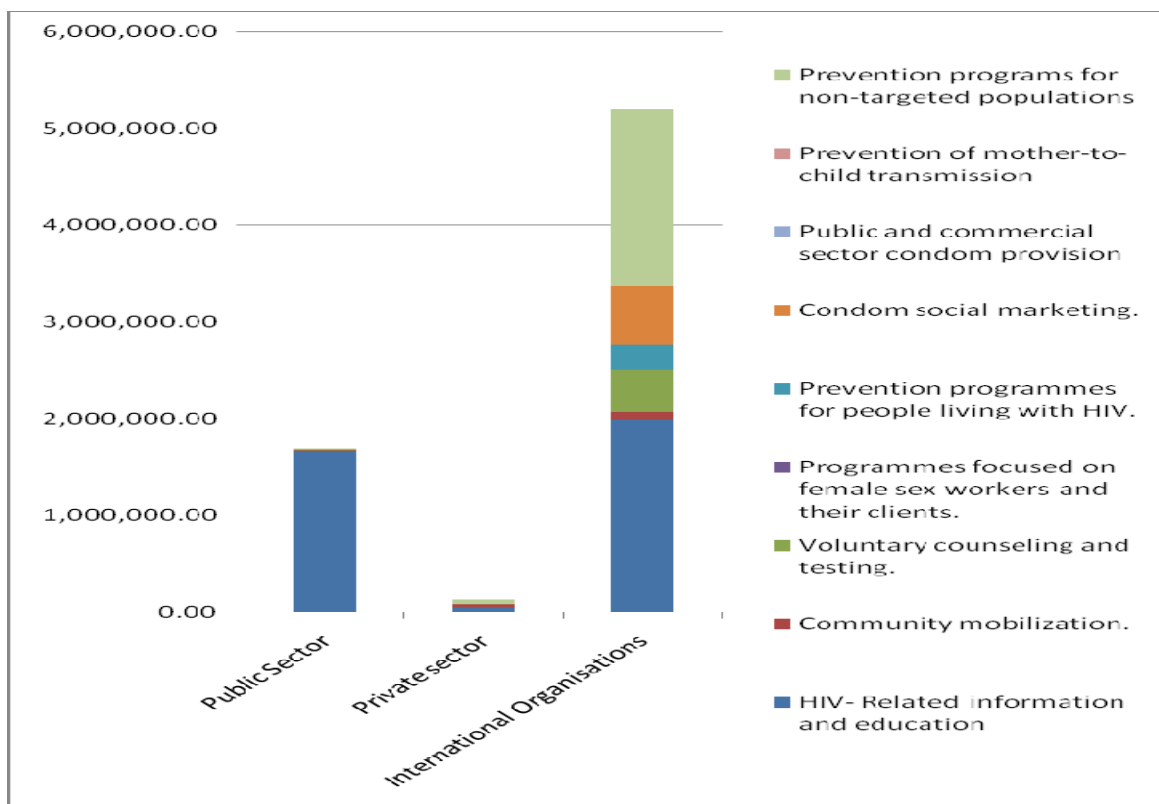


Figure 4.5c Proportional Prevention Spending Activities by Agent, 2005

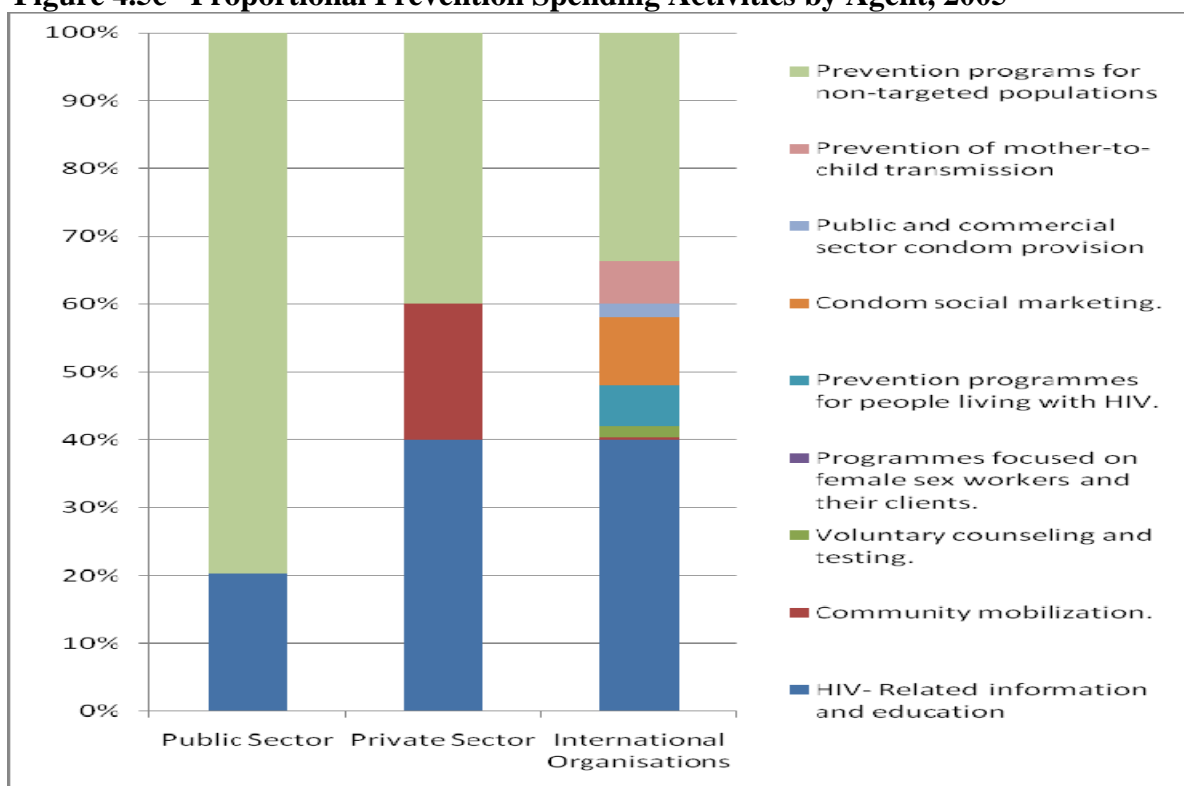
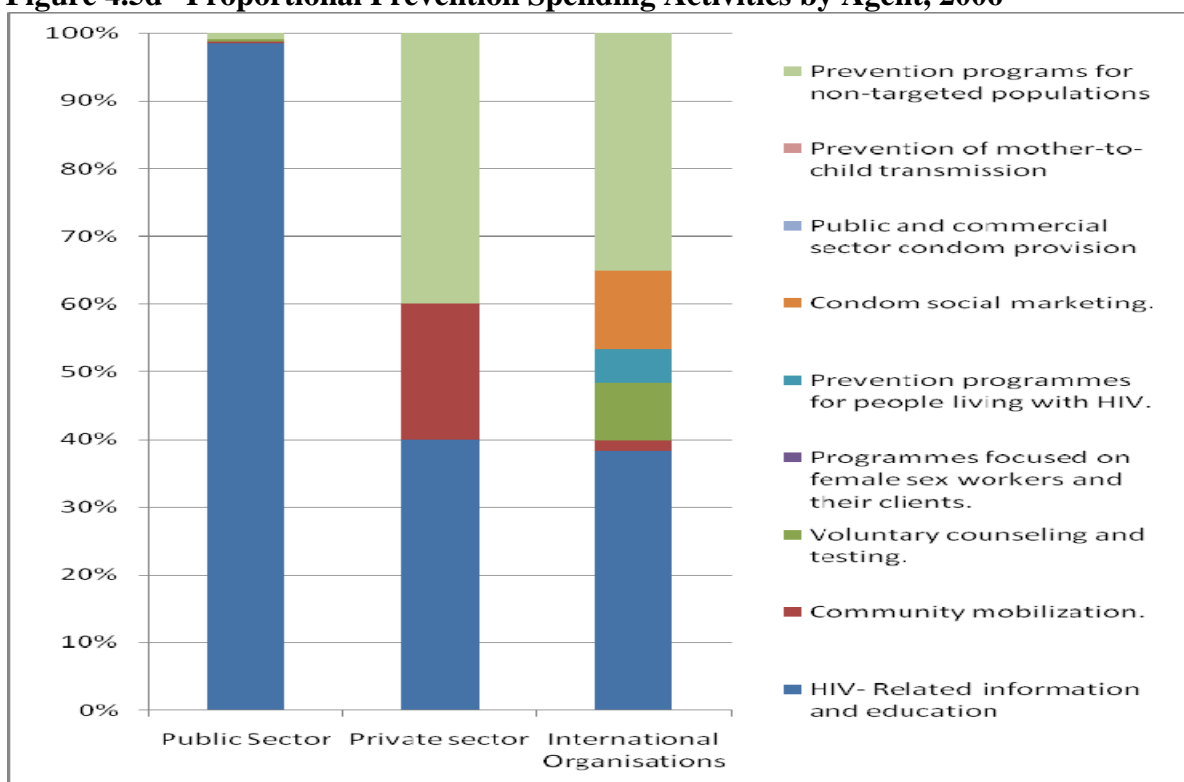


Figure 4.5d Proportional Prevention Spending Activities by Agent, 2006



4.4 Treatment and Care Spending Activities

Tables 4.3a and 4.3b show the key areas of expenditures in 2005 and 2006 on Treatment and Care categories. The share of Treatment and Care in the total expenditure for HIV and AIDS increased from \$4,682,149 in 2005 to \$7,050,088 in 2006. In 2005 there was very little public sector funds for expenditure on treatment and care. Almost all the funding for this component came from International organizations with the bulk of it going into Antiretroviral therapy (ARV). In 2006, the results show that expenditure on the Treatment and care component was quite evenly spread between the Public Sector and International Organisations although the International organizations funded more.. Again most of the spending went into Antiretroviral therapy..

Table 4.3a Treatment and Care Spending Activities by Agents, 2005 (US\$)

| Treatment and care | Public sector | International Organisations | Grand Total |
|---|----------------------|------------------------------------|--------------------|
| Provider initiated testing | - | 375,000 | 375,000 |
| Antiretroviral therapy. | - | 3,053,989 | 3,053,989 |
| Nutritional support associated to antiretroviral (ARV) therapy. | 2,742 | 425,600 | 428,342 |
| Prophylaxis for Opportunistic Infections. | - | 3,074 | 3,074 |
| Hospital treatment and care. | - | 15,000 | 15,000 |
| Laboratory monitoring. | - | 646,935 | 646,935 |
| Palliative care. | - | - | - |
| Alternative and informal providers | - | 84,809 | 84,809 |
| Treatment and care not classified elsewhere | - | 75,000 | 75,000 |
| Grand Total | 2742.00 | 4,679,407 | 4,682,149 |

Table 4.3b Treatment and Care Spending Activities by Agents, 2006 (US\$)

| Treatment and care | Public sector | International Organisations | Total |
|---|----------------------|------------------------------------|------------------|
| Provider initiated testing | - | - | - |
| Antiretroviral therapy. | 1,795,089 | 2,501,549 | 4,296,638 |
| Nutritional support associated to antiretroviral (ARV) therapy. | 992,433 | 235,890 | 1,228,323 |
| Prophylaxis for Opportunistic Infections. | - | 1,740 | 1,740 |
| Treatment of Opportunistic Infection | 294,126 | 197,681 | 491,807 |
| Hospital treatment and care. | 122,129 | 403,815 | 525,944 |
| Laboratory monitoring. | - | - | - |
| Palliative care. | - | - | - |
| Alternative and informal providers | 9,826 | - | 9,826 |
| Treatment and care not classified elsewhere | 33,137 | 462,673 | 495,810 |
| Grand Total | 2,952,614 | 3,605,667 | 7,050,088 |

4.5 The Beneficiaries of Spending on HIV and AIDS

The five main NASA Beneficiary categories are shown in Table 4.4.

Table 4.4 NASA Beneficiary Categories

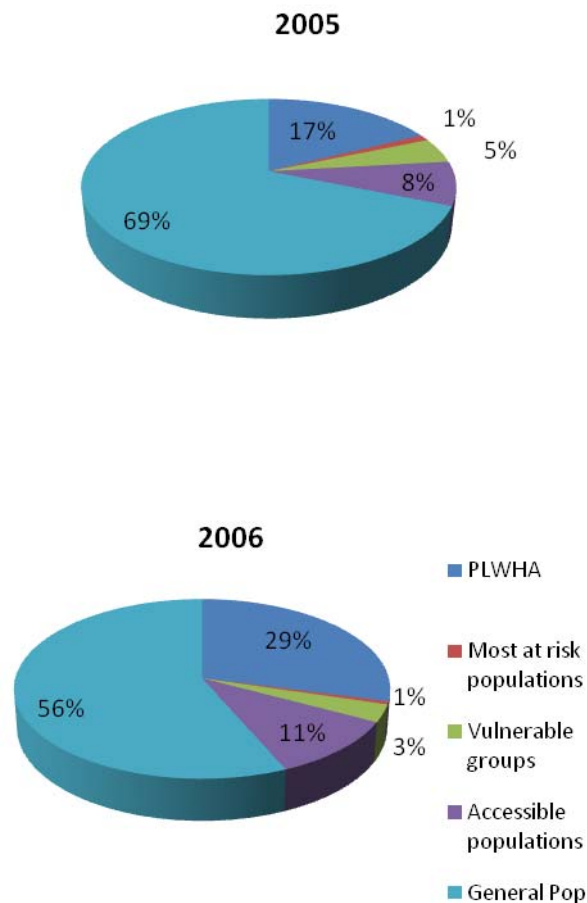
| | Main category | Disaggregated |
|----------|--------------------------------------|---|
| 1 | People living with HIV (PLWH) | Age Sex |
| 2 | Most at Risk | IDU Sex workers MSMs |
| 3 | Accessible Populations | STI Clinic patients Children and youth at school People at work Health workers Migrant workers Long distance truck drivers Military, police |
| 4 | Vulnerable Groups | OVCs Children born from mothers with HIV Migrants, refugees Prisoners Women & children: trafficking and violence Youth at social risk, out of school, in streets Partners of people living with HIV |
| 5 | General Population | Non-targeted |

The analysis by beneficiary group shows that the General Population group formed the largest beneficiary group in both 2005 and 2006. The General Population group received 69 percent and 56 percent of the total spending in 2005 and 2006 respectively (Figure 4.6). The share of funding to People Living with HIV (PLWH) increased from 17 percent in 2005 to almost 30 percent in 2006. Total expenditures on vulnerable groups decreased from 5 percent in 2005 to 3 percent in 2006. Other groups benefitting from HIV and AIDS spending included accessible and most at risk groups. However, there was no reported spending on some of the most at risk populations, such as male commercial sex workers, men who have sex with men (MSM), and intravenous drug users (IUDs) in both years. Accessible population spending was primarily through school educational programmes and some targeting the police and defense forces. Programmes targeting women specifically were also limited. The pattern of spending on HIV and AIDS beneficiaries shows that Ghana is experiencing a generalized epidemic with interventions focused more on the general population. Appendix Table 4 shows the details of beneficiaries and the amount spent by Agents for 2005 and 2006.

4.5.1 Functions by Beneficiaries

Figures 4.7a and 4.7b shows the various population groups and their share of the main intervention areas captured in NASA. Overall, in 2005, the general population benefitted most from the total expenditure on prevention programmes, accounting for 72 percent; 21 percent went to accessible groups and 4 percent to PLWHs. For the treatment and care component, 94 percent of total spending went to PLWH; 2 percent to the general population and 5 percent to vulnerable groups. For the programme development component, 95 percent of the total went to the general population and 4 percent to vulnerable groups in 2005.

Figure 4.6 Spending by Beneficiary Group, 2005 and 2006



In 2006, even though general population sub group benefitted most from prevention programmes, their share of total expenditure fell from 72 percent in 2005 to 50 percent in 2006. We see more groups being targeted for prevention programmes in 2006; 40 percent went to accessible groups, 6 percent to vulnerable groups but the share of total spending to PLWHs remained the same at 4 percent. For treatment and care, 96 percent of total expenditure went to PLWH showing a 2 percent increase from 2005; 1 percent to general population and 2 percent to vulnerable groups. For the programme development component, 87 percent of the total went to the general population showing a decrease from 2005 by 8 percentage points.

The following section shows a breakdown of the various groups and their proportional share of expenditure on the key priority areas. This can be seen from Figures 4.7c and 4.7d.

PLWH

Overall, total spending on PLWH increased from \$5 million in 2005 to \$9.5 million in 2006, a 92 percent increase. Proportionately, in 2005, PLWH benefitted most from Treatment and care which took about 89 percent of the total expenditure on PLWH. However, in 2006 treatment and care share dropped to 71 percent. About 15 percent of total spending on PLWH went into programme development from 1 percent in 2005.

Most at risk

Overall, total spending on the most at risk decreased from \$305,904 in 2005 to \$175,244 in 2006, a 43 percent decrease. Proportionately, in 2005, the total expenditure on the most at risk group was shared evenly between prevention programmes and HIV and AIDS related research. However, in 2006 there was a marked fall in the share of prevention programmes in the total spent for this group; dropping to 9 percent from 50 percent in 2005. However, expenditure on treatment and care takes up 30 percent of total spending and the research component increases to 61 percent from 50 percent in 2005. Total spending under this group went to female commercial workers in both 2005 and 2006.

Accessible Populations

Total spending on the accessible groups increased from \$2,275,609.00 in 2005 to \$3,498,750.00 in 2006, a 54 percent increase. In 2005 the total spending on this group went into prevention programmes, whilst in 2006, 93 percent went into prevention programmes and 7 percent into programme development. About 80 percent on this expenditure was targeted to youth at school and the specific prevention programme was HIV-Related Information and Education.

Vulnerable groups

Overall, total spending on vulnerable groups decreased from \$1,286,641 in 2005 to \$1,031,746 in 2006, a 20 percent decrease. The breakdown of total spending on this group in 2005 is as follows: 15 percent on prevention programmes; 17 percent on treatment and care; 28 percent on OVCs and 10 percent on human resources with the rest shared amongst the other key areas. In 2006, the breakdown shows an increase on the total expenditure on prevention programmes from 15 percent in 2005 to 44 percent in 2006; share of treatment and care remained the same (17 percent); OVCs share increased to 33 percent and 5 percent on programme development. Detail of OVC spending expenditure is shown in Appendix Table 5.

An amount of \$70,000 was spent on PMTCT in 2005 and this increased to \$133,765 in 2006. These benefited children to be born whose mothers live with HIV. Migrants, refugees and IDPs also benefited from HIV related information and education programmes as well as social mitigation. However, majority of the funding for refugees and migrants programmes were sourced from UNHCR; 95 percent in 2005 and 100 percent in 2006. Some youth groups also benefited. The main ones targeted were youth at social risk, living in the street, youth out of school and youth in school. The key intervention for these groups was HIV related information and education programmes.

General population

In 2005, total expenditure on the general population was \$19,385,868 but decreased to \$18,461,476 in 2006, a 5 percent decrease. In 2005, 41 percent of the total for this group was spent on prevention programmes, 45 percent on programme development and 13 percent on HIV-related research. In 2006, the total share of prevention programmes of the total spending on this group reduced to 21 percent; share of programme development increased to 61 percent and expenditure on HIV-related research increased to 17 percent.

Figure 4.7a Spending Categories to Beneficiary Groups, 2005

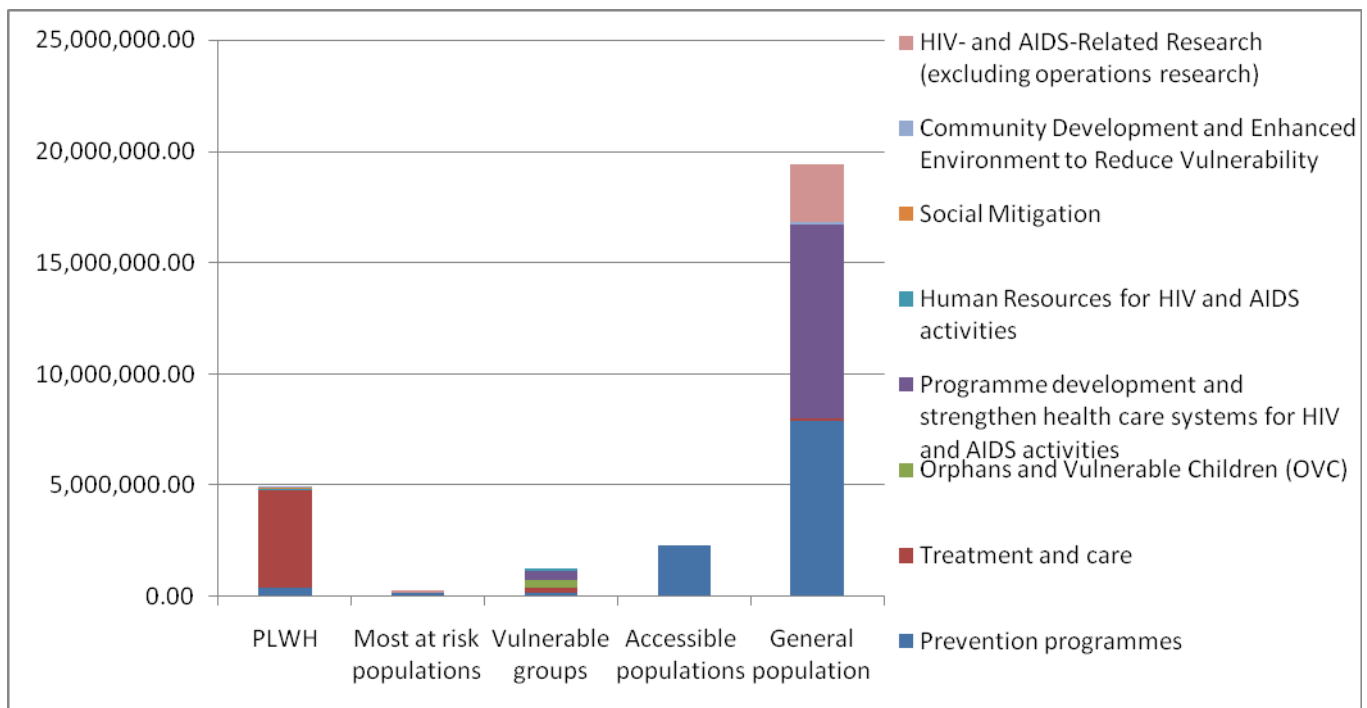


Figure 4.7b Spending Categories to Beneficiary Groups, 2006

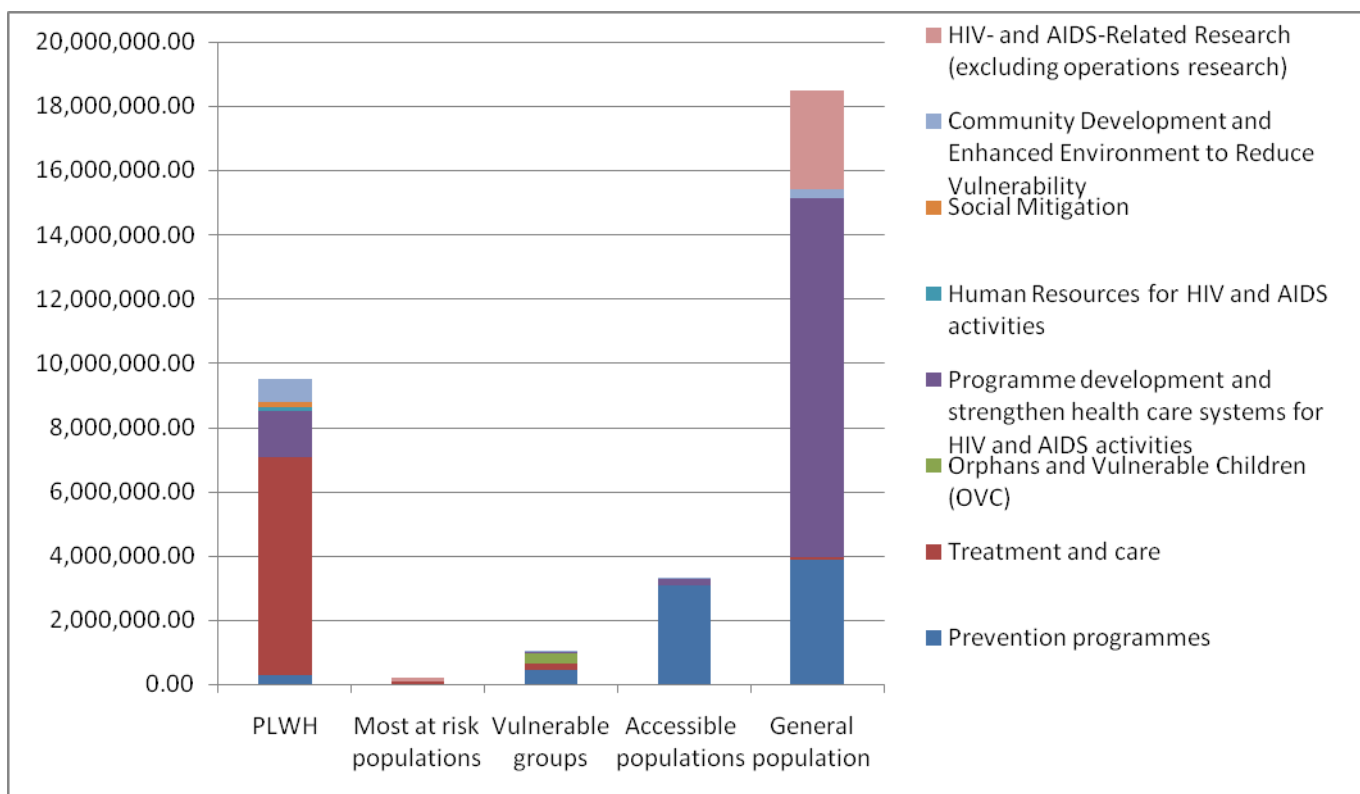


Figure 4.7c Proportional Spending Categories to Beneficiary Groups, 2005

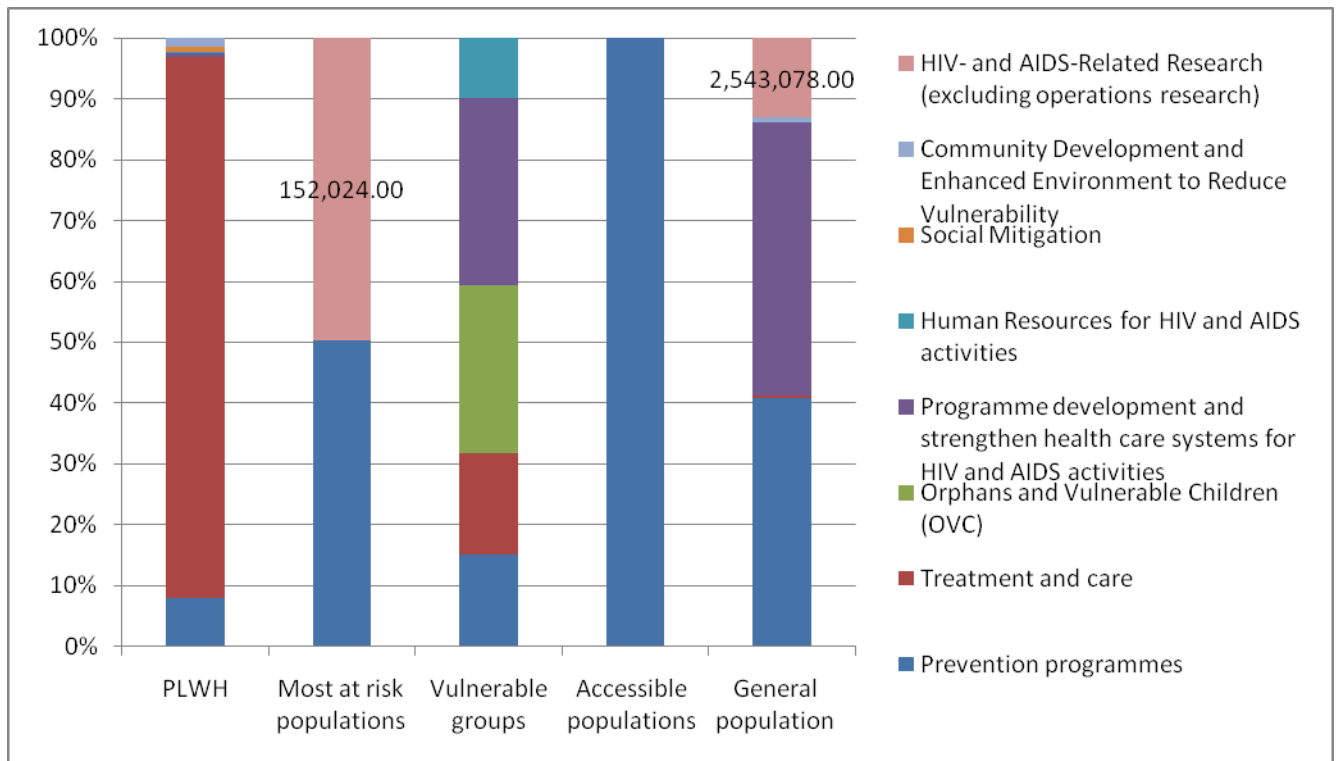
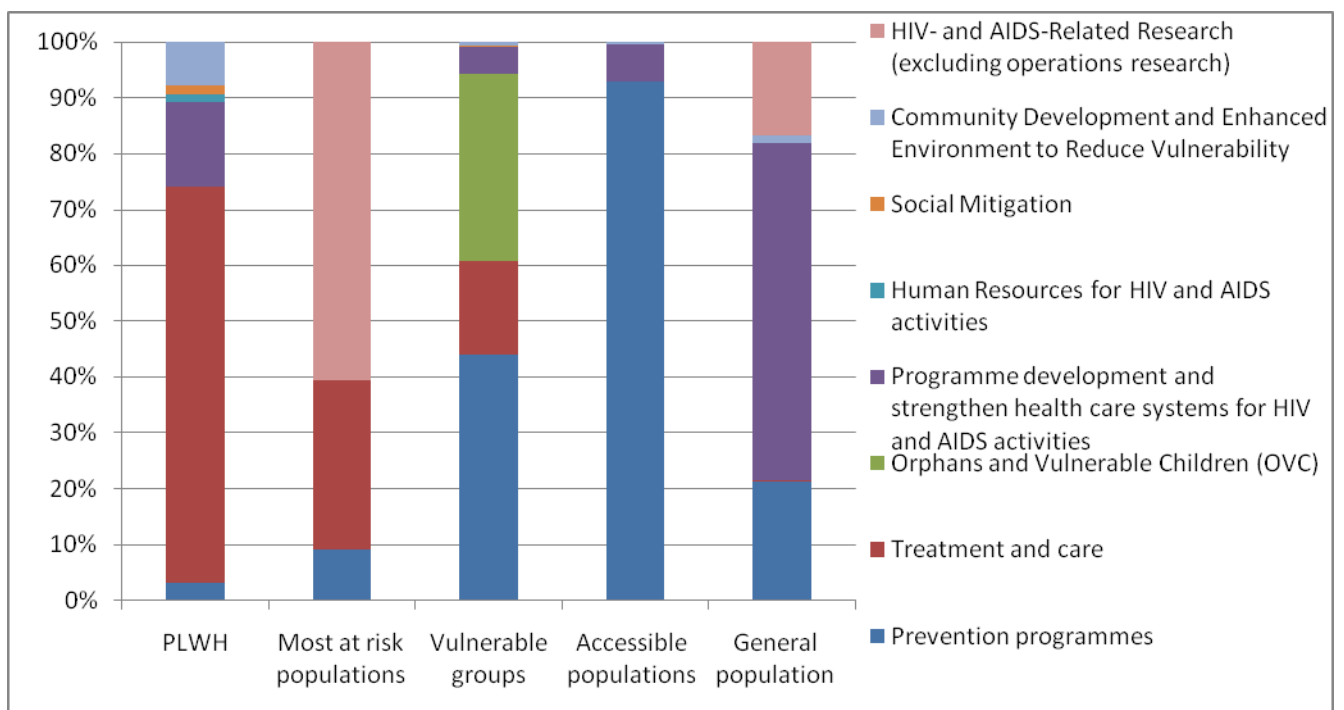


Figure 4.7d Proportional Spending Categories to Beneficiary Groups, 2006



Section 5

Findings - Qualitative Section of NASA Questionnaire

In addition to the collection of information on spending on HIV and AIDS programmes and activities in Ghana, the NASA questionnaire also contained a qualitative section which aimed to assess the funding processes and reporting requirements of the various stakeholders and the challenges and bottlenecks they face in accessing funds or disbursing funds for these programmes. The major stakeholders are the Development Partners, NGOs, UN Agencies, the private and public sectors. Since most of the DPs and NGOs used the same financial years as the government's the analysis of the NASA data was not greatly impeded. A few financial accounts needed to be adjusted but on the whole most financial reporting was from 1st January to 31st December.

5.1 Development Partners in Ghana

The key Development Partners (DPs) in Ghana are DANIDA, USAID, DFID and the Global Fund. The UN Agencies also make differing contributions, some primarily in technical support resources. Other donors include GTZ, RNE, FHI, JICA among others. Since the inception of the National HIV/AIDS Strategic Framework in 2000 funding for HIV and AIDS activities from DPs have been mainly channelled through the GAC as a pooled fund (described in detail in Section 3). This fund supports the activities of MDAs, NGOs CBOs, FBOs, academic institutions, traditional institutions and religious bodies. Funds from the GAC are disbursed through a decentralised process to ensure that all districts and sub-districts are allocated resources to implement HIV/AIDS programmes. However, some development partners prefer to channel their funds directly to implementers.

Challenges and Recommendations

The major challenge faced by the GAC is to do with the complex report requirements from the donor community as they often have to submit several different sets of financial reports concurrently. These reporting requirements delay requests for funding, which may hinder project implementation. Also there is inadequate capacity of district level staff to facilitate accurate and timely financial reporting. It has been suggested by many NGOs that DPs should help them build their administrative capacity by funding salaries of personnel if need be to ensure effective implementation of programmes.

Some of the records from the DPs did not harmonise well with that of the implementers or NGOs who they had transferred monies to. In many of these cases the implementers indicated that the monies were sent too late for any of the programs scheduled for the year to be implemented resulting in an *overestimation* of the actual spending on HIV and AIDS programmes and activities. It is recommended that DPs should compare the annual actual expenditure by implementers with their annual transfers or commitments in order to solve the problem of under-spending. Also DPs should avoid “dumping” of funds towards the end of financial years, and decrease the delays in transfers. This is to allow the recipients adequate implementation time.

5.2 Non-Governmental Organisations (NGOs)

The NGOs operating in Ghana are not-for-profit organisations receiving funding from a wide spectrum of donors like USAID, DANIDA, DFID, the Global Fund and the Government of Ghana, among other donors. International NGOs operating in Ghana, act as both programme implementers/service providers and as agents for the donor organisations. In Ghana, NGOs go through the process of tendering for international donor funds once program announcements are made by donor organisations. Donors transfer funds to the NGOs either quarterly or monthly based on the cash flow projections.

Challenges and Recommendations

As with GAC, many of the NGOs and CBOs found the reporting requirements from donor organisations to be too cumbersome. They also face a number of challenges in securing funding. Among them are:

- Delay in receiving the funds;
- Long bidding process;
- Slow response by the GAC in the disbursement of their funds
- Bureaucratic nature of the funding process further delaying service delivery.

It was noted that many NGOs have poor administrative capacity. Many struggle to fund their administrative functions as donors are only interested in funding those functions that directly impact their programmes. Since many of the DPs do not allow their funds to be used to pay salaries, NGOs are forced to employ persons of limited skills. Many NGOs agreed that their staff were not adequately equipped to run their secretariats due to the fact that funds were not adequate to hire people with the requisite skills. Efforts to build capacity in financial systems are undermined by the high rate of staff turn-over. It is recommended that DPs and the government through the GAC begin to find ways of helping NGOs financially to build their capacity to ensure effective implementation of programmes.

5.3 UN Agencies Funding Processes

The UN agencies operate in Ghana through their implementing partners. In Ghana their partners are primarily government ministries and departments, and a number of NGOs. UNAIDS, UNICEF, UNDP, UNFPA and WHO explained that they work closely with the government in determining their strategic plans and areas of prioritisation, so as to fit with the countries priorities. The reporting requirements of UN Agencies do not differ much from other DPs in the country. Institutions making requisitions for funds are required to submit quarterly expenditure reports directly to the UN agency before

additional tranches will be processed. Efforts are made to ensure sustainability of projects through quarterly and annual review meetings.

Challenges and Recommendations

The process of disbursement from UN agencies can take some time. For example the Programme Acceleration Funds (PAFs) from UNAIDS are often delayed because of delays in transferring money from UNAIDS/RST (Regional Support Team) to UNDP Headquarters before they are sent UNDP, Accra to be disbursed to implementing agencies. In addition, the late submission of reports also delays subsequent disbursements of funds.

Overall the 2006 data was more detailed and disaggregated compared to the 2005 financial reports. The inception of the UN Implementation Support Plan of 2006 ensured that all UN agencies engaged in HIV and AIDS related activities submitted detailed activities to be carried out in the year, the budget and expenditure by the close of the year as well as a progress update from the agencies. The 2006 data was reliable because there was no clear overlap in expenditures by the Agencies. The only set back was the fact that with the exception of UNAIDS most of the other UN Agencies were unable to provide us with accounts of their overheads and salaries which made it difficult to estimate which proportion could be attributed to HIV and AIDS related activities.

Also, for UN Agencies where there had been changes in staff between 2005 and 2006, some of them were unaware of the records before they were employed. It appears also that a large proportion of funds are spent, usually by head quarters, on technical experts for Ghana. These amounts, including their consultancy fees, travel and per diem could not be ascertained, as these records are maintained at the headquarters. We recommend that access should be granted to these information to enable them to be included as part of total expenditure of HIV and AIDS in Ghana.

5.4 Public Sector

Public sector funding for HIV/AIDS in Ghana is mostly from the Government of Ghana (GoG). GoG funds are released to the MOH/GHS through the Ministry of Finance and Economic Planning. IDA (of the World Bank) credit to Ghana is disbursed by GAC as public sector funds. Finally metropolitans/ municipals/districts are required to use 1% of their District Assembly Common Fund for HIV/AIDS activities in their districts. The report on the case studies conducted in the seven districts highlights the various funding processes and challenges faced by the district hospitals and NGOs who rely on public sector funds to implement their programmes (see Section 6).

5.5 The Private Sector

The private sector accounts for the majority of employed people in the country and as such the activities of the private sector in the management of HIV and AIDS is critical. The establishment of the Ghana Business Coalition against AIDS as an umbrella organisation through which individual companies will participate will ensure private participation in the fight against HIV and AIDS.

Due to the short timeframe for this analysis, the private sector expenditure on workplace activities was not captured. It is believed that this would form a significant proportion of the total spending on HIV/AIDS and thus should be captured in the next phase of the NASA.

Section 6

Case Studies - Site Visits

As part of the National Aids Spending Assessment (NASA) project, seven sites were selected for special case studies on the basis of their peculiar HIV prevalence rates as well as rural and urban biases. This has been explained in much detail in the methodology. This chapter gives a brief summary of these sites with regard to spending on HIV/AIDS in the district among the key players and tries to ascertain any linkages between the level of expenditures on HIV and AIDS and the HIV prevalence rate in the districts.

6.1 Volta Region - North Tongu (North Tongu District)

Prevalence of HIV/AIDS

The report on the HIV Sentinel Survey for 2006 indicates that the North Tongu District has a 0% prevalence rate of the disease. However, discussions with the District M&E Focal Person for HIV and AIDS, Mrs Edith Edinam Dorfenyoh revealed that the current prevalence rate of the disease in the district is estimated to be about 2.3 percent.

Indeed, most stakeholders in the district including NGOs, CBOs and the District Aids Committee (DAC) have disputed and questioned the outcome of the 2006 Sentinel Report that pegged the prevalence rate of the disease at 0% on the following grounds:

- i. The GAC random measurement focused only on 3 health centers namely Avedo CHPS zone, Volo and Torgorme health center;
- ii. The choice and undue dependence on the sentinel sites that excluded the five red flag zones in the district namely: Mepe, Battor, Adidome, Aveyime and Juapong, which between them account for about 34 percent of the total population of the district;
- iii. The choice of women attending pre-natal and post natal clinics as the sampling base compounds the problem in the North Tongu District resulting in the

- exclusion of the most sexually active in the five key settlements in the sampling net; and
- iv. The sharp increase in the membership of the PLWH association based in Battor from 132 as at the end of 2005 to 219 by the end of 2006.

In another development, a survey conducted on HIV and AIDS among 190 respondents across the district in September 2006 revealed that HIV and AIDS awareness is very high in the district as 100 percent of the people interviewed has heard of the disease and could mention common causes, signs and symptoms. However, the report indicated that behavioural change practices were very low as only 44.3 percent of the respondents had ever used condoms.

Again the only VCT centre at the Battor Catholic Hospital has recorded 180 cases as at December 2006 with 115 being females and 65 males. Table 6.1.1 also shows the district record on HIV and AIDS cases from 2004 to 2006.

**Table 6.1.1 Number of HIV Cases and Deaths at Battor Catholic Hospital
(2004-2006)**

| Year | 2004 | 2005 | 2006 |
|-------------|-------------|-------------|-------------|
| Cases | 334 | 328 | 400 |
| Deaths | 32 | 42 | 41 |

Finances for HIV and AIDS Activities

Financing of HIV and AIDS activities remains a major problem for the North Tongu District. Indeed funding was largely limited to the then GARFUND which was received only in 2004. For the period 2005 and 2006 however, no funds were received by the district for HIV and AIDS programs. The implication of this development was that the activities of various NGOs, CBOs and FBOs towards the prevention and spread of the disease in the district was stalled as they could not access funds from GAC through the

DA making them inactive for the period 2005 and 2006. The only funding or expenditure information made available to the Survey Investigator by the District Focal Person for 2006 indicated that about **¢58,488,000 (US\$6,357)** was spent on various programmes such as:

- Burial of PLWH rejected by their families;
- Training & workshops;
- Advocacy and communication;
- Programme management and coordination;
- Meetings, and
- Personnel Allowances.

The funds was said to have come from the DA support and the MSHAP Account with no breakdown given.

Human Resources

The North Tongu district has constituted a District Aids Committee (DAC) comprising 15 members including the District Chief Executive (DCE) as the chairman, the M&E Focal Person and 13 other members from the traditional authorities, PLWH among others.

Peculiar Causes of the Spread of HIV and AIDS in the North Tongu District

The following are some of the major factors driving the spread of HIV and AIDS in the North Tongu District.

- Cross border trading with neighbouring Togo and sister district Manya Krobo. It is noteworthy that Agormenya market is heavily patronised by traders from North Tongu District of which Agormenya has the highest prevalence of the disease in Ghana;
- Customary practices such as the “trokosi”, oracle treatment for example offer potential to fuel the spread of HIV and AIDS;
- The traditional health delivery system, home-based circumcision, incision offers potential dangerous windows for new infections;

- High level of poverty (unemployment and underemployment);
- Lack of good parental care and increasing single parenthood;
- The free-for-all “sexual harvest” offered by various festivals and other annual celebrations bringing together commercial sex workers;
- High level of superstition and denial about the existence of the disease;
- Peer group influence;
- High rate of illiteracy;
- Increased wake keeping and entertainment; and
- The practice of unprotected sex and low rate of condom use.

Challenges

The key challenges noted from the North Tongu district during the site visit are mentioned below.

- No pragmatic measures were in place to identify and cater for PLWHs, OVCs and their immediate families;
- Limited promotion of VCT;
- No programme to promote PMTCT;
- Limited promotion and use of condoms among high risk groups;
- Limited focus on behavioural change programmes e.g. formation of abstinence groups;
- STI management in the district was limited to only Adidome and Battor hospitals;
- Limited institutional capacity to support HIV and AIDS programmes;
- Limited stakeholder’s participation in HIV and AIDS activities and programmes;
- Inadequate funding and logistics to support HIV and AIDS programmes as funding was limited to the then GARFUND;
- Lack of an ARV and treatment centre;
- Ineffective functioning of hospitals with respect to HIV and AIDS related problems; and

High level of stigmatisation against PLWH.

Profile of some Selected NGOs in the North Tongu District

A list of over 20 NGOs and CBOs operating in the district was made available to the Survey Investigator. Out of this 10 NGOs and CBOs were either contacted or visited and their names are listed below:

1. Akavo Evangelistic Mission
2. Xornam Development Association
3. Africa Women Initiative for Development & Empowerment
4. Battor Schools CBO
5. Social Welfare – North Tongu
6. Agbelengor Foundation
7. Service To Humanity
8. Friends of Ghana Lay Association
9. Missions International
10. Millennium Youth Foundation

As mentioned earlier on, lack of funding was the major problem hindering all these NGOs and CBOs mentioned in the table above. It is important to state that none of the above organisation has access any form of funding for the period 2005 and 2006 with exception of Xornam Development Association (the only NGO currently active in supporting PLWH in the district). Though most of them have prepared elaborate programs of action towards HIV and AIDS activities in the district, proposals meant to be forwarded to GAC through the DA for financial support were delayed resulting in their proposals not given the needed attention. In view of these developments the organisations remained largely dormant over the period.

To buttressed the issue of lack of fund, the M&E Focal Person indicated that it is only this year 2007 that funds will be accessed from the MSHAP of which 2 NGOs in the district have already been selected to benefit from the funds to be accessed.

1. Xornam Development Association

Currently, Xornam Development Association is the only identified active NGO operating in the North Tongu district with respect to HIV and AIDS. The association is attached to the Battor Catholic Hospital and thus receives much support from the Hospital in terms of funding of its activities. It has being in existence since 2003 providing support for PLWHA. Its membership as at the end of 2006 stands at 219 PLWHs.

The major activities of the association include the following:

- Providing a platform for socialisation for PLWH;
- Community mobilisation on HIV and AIDS through film shows;
- Distribution of HIV and AIDS awareness materials;
- Advocacy and communication on HIV and AIDS and home visits;
- Awareness creation on behavioural change toward unprotected sex and dangers associated with teenage pregnancy;
- Facilitate access to ARV drugs for its members i.e. PLWH;
- Support for OVCs education;
- Nutritional supplements for PLWH;
- Payment of out patient bills.

Source of Funding:

The activities of the association are funded by Battor Catholic Hospital for 2005 according to Madam Comfort Bobobi, the Project Officer. In 2005 the expenditure of the association amounted to ₦193,127,000 (US\$10,123). However, records made available to the Survey Investigator shows that for 2006 funds for the association's activities came from 3 main sources as shown in the Table 6.1.2.

Table 6.1.2 Source of Funds for Xornam Development Association, 2006

| | <u>Amount</u> | |
|----------------------------|--------------------|---------------|
| | ¢ | \$ |
| GAC/MSHAP | 135,000,000 | 14,674 |
| Catholic Hospital - Battor | 37,151,000 | 4,038 |
| Keta/Akatsi Diocese | 34,740,000 | 3,776 |
| Total Funds | 206,891,000 | 22,488 |

Some Challenges:

Xornam Development Association is confronted with myriad of challenges, some of which are outlined below.

- Inadequate funding to support programmes for the PLWH and cater for the increasing membership of the association;
- Lack of ARV Therapy center to cater of PLWH in the district;
- Lack of staff motivation since they are not paid;
- Lack of logistics e.g. means of transport;
- Inadequate number of adherence counsellors due to lack of fund to provide necessary training.

6.2. Eastern Region – Koforidua (New Juaben Municipal)

HIV Prevalence

The Eastern Region which has a relatively high HIV prevalence rate recorded 4.7 percent prevalence in 2005 as against 6.5 percent in 2004. New Juaben District recorded 6.4 percent in 2005 as against 5.4 percent in 2004 which indicates that the rate increased in 2005. The region has five HIV sentinel sites as shown in the table below:

Table 6.2.1 HIV Prevalence Rate for Sentinel Sites in Eastern Region, 2003 - 2006

| SENTINEL SITE | 2003 | 2004 | 2005 | 2006 |
|----------------------|-------------|-------------|-------------|-------------|
| Agomenya | 9.2% | 7.4% | 6.0% | 8.4% |
| Koforidua | 2.6% | 5.4% | 6.4% | 4.4% |
| Fanteakwa | 6.6% | 6.8% | 4.8% | 5.1% |
| Birim South | - | - | 3.4% | 3.6% |
| Afram plains | - | - | 3.0% | 2.8% |

Koforidua central hospital which is also the regional hospital and also a sentinel site recorded 338 new cases in 2006 as against 120 in 2005. About 66 percent was recorded for females in 2006 and 60 percent in 2005.

Finances

The region received an amount of ₵1,757,500,000.00 from GAC under MSHAP for HIV and AIDS activities. A total amount of ₵487,422,100.00 was paid into the HIV and AIDS accounts as 1 percent contribution toward HIV and AIDS activities from the District Assembly Common Fund. Table 6.2.2 shows a breakdown of the funds among the various districts.

**Table 6.2.2 Breakdown of the 1% District Assembly Fund for HIV and AIDS
Activities, Eastern Region (2006)**

| NO | NAME OF DISTRICT | 1% OF THE COMMON FUND (1ST -3RD QUARTER) | M-SHAP TO DISTRICT ASSEMBLY | M-SHAP FUND TO NGOs AND CBOs | TOTAL OF (M-SHAP) |
|--------------|-------------------------|---|------------------------------------|-------------------------------------|--------------------------|
| 1 | Kwahu South | 29,000,000.00 | - | 80,000,000 | 80,000,000 |
| 2 | Akuapem North | 11,957,000.00 | - | - | - |
| 3 | Birim South | 35,592,573.00 | 31,500,000.00 | 167,000,000 | 198,500,000 |
| 4 | Birim North | 73,256,875.00 | 31,500,000.00 | 80,000,000 | 111,500,000 |
| 5 | Atiwa | 50,000,000.00 | 60,000,000.00 | - | 60,000,000 |
| 6 | Suhum/Krabo Coalter | 5,500,000.00 | - | - | - |
| 7 | East Akim | 42,000,000.00 | 31,500,000.00 | 60,000,000 | 91,500,000 |
| 8 | Akuapem south | 57,800,000.00 | 63,000,000.00 | 80,000,000 | 143,000,000 |
| 9 | New Juaben | 52,000,000.00 | 63,000,000.00 | 65,000,000 | 138,000,000 |
| 10 | Fanteakwa | 17,934,558.00 | 31,500,000.00 | 80,000,000 | 111,500,000 |
| 11 | West Akim | 35,070,000.00 | 67,000,000.00 | 163,000,000 | 230,000,000 |
| 12 | Asuogyaman | 25,881,635.00 | 31,500,000.00 | 80,000,000 | 115,500,000 |
| 13 | Kwahu East | 20,000,000.00 | 60,000,000.00 | 80,000,000 | 140,000,000 |
| 14 | Manya Krobo | - | 31,500,000.00 | 79,500,000 | 111,000,000 |
| 15 | Yilo Krobo | - | 31,500,000.00 | 80,000,000 | 111,500,000 |
| 16 | Kwaebirirem | 72,000,000.00 | 31,500,000.00 | 80,000,000 | 111,500,000 |
| 17 | Afram Plains | - | 31,500,000.00 | 80,000,000 | 115,500,000 |
| Total | | 487,422,641.00 | | | 1,757,500,000 |

Aside the GAC funding for HIV activities in the District some NGOs such as PPAG (Planned Parenthood Association of Ghana) and 4-H Ghana receives money direct from donor organizations such as JICA and SHARP. 2005 was a transition period so there was

no funding on HIV and AIDS through the municipality. The municipal assembly in 2006 received an amount of ₵138,000,000 from GAC and ₵80,000,000 of this amount was used to support 3 NGOs and 6 CBOs. Table 6.2.3 below gives a breakdown of that amount amongst the various NGOs/CBOs. The rest of the amount was used by the municipality to carry out HIV and AIDS activities such as advocacy workshops for 70 religious leaders, community sensitization, training for health committees and film shows.

Funding for HIV and AIDS programs in the region are on contract bases and what was received in 2006 was not enough for the activities presented in the budget for 2006. Only half the amount was released which means not all the activities were carried out yet new cases of HIV and AIDS are being reported all the time.

Table 6.2.3 Breakdown of MSHAP Fund Among NGOs/CBOs for HIV/AIDS Activities, 2006

| NGO | AMOUNT (₵) |
|--|--------------------|
| Dynamic Alliance foundation | ₵17,500,000 |
| Faith and Hope support Group | ₵17,500,000 |
| Royal Palm Foundation | ₵15,000,000 |
| CBOs | |
| Non formal education Unit | ₵5,000,000 |
| Progressive youth | ₵5,000,000 |
| Ghana National Dressmakers Association | ₵5,000,000 |
| New Juaben Queen mothers Association | ₵5,000,000 |
| Adeg youth network | ₵5,000,000 |
| Future leaders club | ₵5,000,000 |
| Grand Total | ₵80,000,000 |

Human Resources

Majority of organizations that carry out HIV and AIDS programs employ their staff when they get a contract. Their staff is normally made up of the project coordinator, accountant and a secretary who does typing and printing work. Staffing for AIDS activities is inadequate as a result of the inadequacy in funding. They release their staff when the contract ends and call them back when funds are released for another project. The Planned Parenthood Association of Ghana under the HAPE Project in New Juaben District in 2006 sponsored by JICA had a staffing capacity of four made up of the project coordinator, the driver and two national service persons who were not paid under the project.

Peculiar causes of the spread of AIDS

HIV and AIDS education in the New Juaben District does not reach every community in the district. This is as a result of insufficiency in financing HIV and AIDS education. Commercial sex activities are on the increase in the district as a result of the poor living standards of the people. The youth between the ages of 10 – 24years leave school and travel to other towns within the region and outside the region with the intention of going to work to better their living conditions but they come back home with the disease. Homosexuality in the district is also a major cause of the spread of the disease. The use of condoms is minimal and this also a major cause of the spread of the disease.

Livelihood

New Juaben District does not have a major economic activity. It has a mixture of various economic activities such as farming, trading, professional and all kinds of businesses. The income levels of people in the district are very low and this makes it difficult for people to have a major source of livelihood. People earn their livelihood through trading in foodstuffs and all sorts of farm products. Those living in the Zongo communities are cattle rearers and petty traders.

Challenges

The district encountered some major challenges during the period under review.

- Inadequate funds to support local programs on HIV and AIDS.
- Inadequate quality of home-based care of PLWH.
- The high level of stigma and discrimination against PLWH and OVC.
- There is also the unfriendly attitude and unsupportive environment from family members and communities towards PLWH.

Profile of some selected NGOs in the New Juaben District

1. 4-H Ghana

In September 2005 to August 2006 the organization was granted an amount of approximately \$10,019 USD for a program on HIV and /AIDS for roamer sex workers in the Zongo communities in the district by SHARP. The project was divided into five milestones. 4 – H Ghana was able to identify some hot spots to track roamers and their clients and also provided condoms. They were also able to identify 6 roamers who went through intensive 3-day training as peer educators.

2. Faith and Hope Support Group

Faith and Hope support group was also granted an amount of ₵17,500,000 from Ghana AIDS Commission in August 2006 to support their project on treatment, care and support for 313 PLWHs.

3. Dynamic Alliance Foundation

Dynamic Alliance foundation in 2005 was granted an amount of ₵160,000,000 from GARFUND and ₵17,500,000 from Ghana AIDS Commission (GAC), to embark on its HIV and AIDS activities in care and support for OVCs. Some of the activities of the project include formal education for OVCs and their upkeep, payment of school fees purchasing of textbooks, uniforms etc. and seed capital. 40 of the OVCs were in school and 10 were out of school.

6.3 Eastern Region – Agomanya (Manya Krobo District)

Manya Krobo District is located in the Eastern Region of Ghana. It was chosen as one of the site visits as it has the highest rate of infection in the country, currently at 8.4 percent. The age bracket most affected is between the ages of 18-35. In terms of gender the females outnumber the males.

HIV Prevalence

HIV prevalence rate in this district has been consistently high over the past decade. The lowest prevalence rate of 6.0 for the district was recorded in 2005 however this was followed by sharp rise to 8.4 in 2006. Even though Manya Krobo accounts for the highest rate of infection in the country, it is interesting to note that the district hospitals do not only serve people from the area. The five surrounding districts, namely Asuogyaman, Dangbe West, Akuapim North, North Tongu and Yilo Krobo have no hospitals equipped to take care of AIDS cases. Therefore people from the afore-mentioned districts travel to Manya Krobo which has two hospitals dealing with HIV and AIDS cases for medical assistance. Also, people travel from as far as Bawku located in the Northern Region and Takoradi from the Western Region to the district to avoid stigmatization from their towns. This may explain the high prevalence rate.

There is also a problem of double registration going on. People infected think that by registering at different hospitals they might be able to get different treatment. This also contributes to the high rates recorded in the district.

Finances

The district received funds directly from the District Assembly Common Fund; a total amount of 45,000,000 cedis in 2005 and in 2006 it received funds from GAC a total amount of 31,500,000 cedis. The financial resources for the district are woefully inadequate and do not meet the needs of the activities the district supports. For example in 2006, a percentage of the District Common Fund which is earmarked for the AIDS programme was not released by the District making work very difficult. The process of accessing funds is long and very bureaucratic. For instance, as at 13th of July 2007 no

resources have been received for 2007 from GAC for HIV related activities. The district assembly concentrates on three main areas; care and support for PLWHs, OVCs, monitoring of NGOS dealing with AIDS cases and training activities.

Human Resource

The department of Social Welfare has now been given the task of monitoring the AIDS programmes for the District in addition to their workload. It will be good to have a department dealing with just HIV and AIDS issues.

Peculiar Causes of the Spread of HIV and AIDS in Manya Krobo

There are some cultural practices peculiar to the people from Manya Krobo District, the Krobos which has contributed to the spread of the disease. “Dipo” is a puberty rite performed for girls who attain the age of eighteen to prepare them for marriage. At this ceremony all the girls must have their hair shaved. Unfortunately, a sharp object like knives are used for the exercise and the same object is used for all the girls. Still within this tradition, if a girl in the community got pregnant without undergoing the “Dipo” rite she was banished from the town. In recent times, the “Dipo” rite is performed before the attainment of age 18, sometimes at birth. Therefore the girls without fear of being banished engage in early sex exposing themselves to STDs.

There is also another cultural practice called “Lapomi”. “Lapomi” is a system where any child born out of wedlock becomes the responsibility of the woman and not the man. The woman therefore assumes the role of a father and a mother. This usually leads to waywardness on the part of the children and little or no parental control.

Livelihood

Most of the local inhabitants are farmers. In the past, young women travelled to Cote d’Ivoire and other francophone countries to practise prostitution. When they became infected with HIV, they returned back home to be treated. However, in recent times the rate of migration has reduced dramatically. There is also a high rate of unemployment in

the district. This is also a major contributing factor to the high rate of infection among the youth.

Superstitions

There are still pockets of the community who believe that the infection of the disease is by “juju” and sicknesses that is passed on by ghosts as punishment to people who have misunderstandings with their living children. Only about 2% of the population still have these beliefs.

However, through awareness programmes about 80% of the population are aware that it is a sexually transmitted disease. Most of them are yet to come to terms with the fact that the disease can be transmitted through the use of sharp objects which have been used by an infected person. They therefore fail to take precautionary measures against this notion. For instance when going to the barbers they don’t take their own blades or fail to insist on the use of a new blade by the barber.

Challenges

The major challenge facing the district is that the financial resources available to the district are woefully inadequate. Accessibility of roads is another challenge especially in rainy season when it becomes very difficult to reach certain areas of the district. There is also the difficulty in getting the communities together during the farming season.

Profile of Some Selected NGOs/CBOs

There are about 22 NGOS’ and 8 CBOS’ working on AIDS programmes in the district.

1. Youth and Women Empowerment (YOWE)

Youth and Women Empowerment was established in 2000 and mainly target the youth and women in the community. Their main activities involve the following:

- Educating the youth and women about HIV and AIDS
- Training some members of the community as peer educators.
- Provides counselling services for the PLWH

- Supports 10 people on ART treatment by paying for the drug which is 50,000 cedis in addition to their transportation cost to and from the hospital.
- Supports the education of some OVCs by providing them with uniforms, sandals, bags and exercise books.
- Provides credit facilities for some HIV and AIDS patients and the youth so as to make them self sufficient.

The main support for YOWE comes from VILLAGE AID UK. The funds they received from their donors for the year 2005 and 2006 was 86,000,000 cedis about 9000 US dollars which was inadequate for their activities. They also face logistic problem which sometimes results in their inability to visit certain inaccessible areas due to a breakdown of their motor bikes.

2. Queenmothers Association

The queenmothers in Manya Krobo district have formed an association to help bring up the orphans and vulnerable children in the community. There are 371 queenmothers living at home with about 1035 OVCS. They live with them in their homes providing them with shelter, food, clothing, healthcare and parental guidance.

The GAC together with FHI were supporting 450 of the OVC up until November 2005. From November 2005 –December 2006 Rescue Mission also came in to support only 40 of the orphans. Under the new MSHAP project, about 125 of the orphans will be supported but handpicking 125 out of the total OVC population has been difficult so funds are yet to be released. Presently, the Catholic Relief Services have being giving 450 OVCs nutritional support. OICI also gives nutritional support for the remaining 585 OVCs. Last year GAC gave the association an amount of 5,000,000 cedis as support for the vacation programme for the OVCs. In 2005 and 2006, 85 OVCS' were supported by PPAG. They were provided with school materials.

One of the main activities of the organisation is to train the queenmothers who in turn go back to educate members of their communities. The training is mainly on counselling

services, behaviour change, difference between HIV and AIDS. Since the queenmothers are respected and looked up to in the community, using them as educators is very effective. However, inadequate funds have often hampered the provision of such services.

3. Kloddrivers Alliance

This organisation was started in year 2000 mainly from contributions from GPRTU branches in the district. The target audience for this group is drivers, migrant traders and lorry station workers. They concentrate on prevention, behavioural change and care and support.

FHI supported the group from September 2004 to November 2005. During this period they gave the group 110 million cedis. Since 2005, the group has relied on benevolent contributions from organisations such as the Upper Manya Rural Bank which gave them 2million and 1million from a British intern working in the community. These monies were paid into an account at the hospital for payment of medication on behalf of the PLS being supported by the organisation.

Christian Council also trained some members of the organisation on “stepping stone” in HIV methodology. Those trained in turn trained some facilitators who were sent into the communities to educate the public. The Christian Council gave the organisation 5million cash, logistics, T shirts and some pamphlets.

The group supports 25 OVCs (paying for their school fees and school books) and 32 PLS. The group pays for the medication of the PLS, their ARVs and sometimes blood tonic etc.

6.4 Ashanti Region – Obuasi (Obuasi Municipal)

Ashanti Region has over sixty active NGO’s working in the region. Most of the NGO’s work with some UN Agencies such as the World Health Organisation (WHO). They also work with SHARP and the District Response Initiatives. Prevalence of HIV and AIDS in

the region was previously high and even became the highest in the country. Subsequently, a lot of work was put in by opinion leaders, chiefs and queen mothers and the prevalence rate declined in 2004 and 2005. However, in 2006 there was increase in the prevalence rate to 3.6 from 2.8 in 2005.

In Obuasi, there were five NGOs working in the district excluding AngloGold which had its own HIV/AIDS management and funding arrangements. The NGO's involved are listed below:

- (1) Social Support Foundation
- (2) PRO-LINK
- (3) YOCAF
- (4) PACA
- (5) Jesus Is Lord

HIV Prevalence Rate

Obuasi Municipality has been associated with high rate of HIV/AIDS prevalence since 2001. The total number of known HIV cases in Obuasi reveals a fluctuating pattern. In the year 2000, 358 cases were recorded by AngloGold, and Obuasi Government Hospitals, 356 cases were recorded in 2001 while year 2002 had 313 cases. This figure rose to 389 in the year 2003 and 2004 had 324 cases reported.

Finances

In 2005, there were no funds sent to the District Assemblies and so no funding was sought by the NGOs. In general funding is only received from MSHAP (GAC) and in some cases the 1 percent from the District Assembly Common Fund.

Human Resources

The NGO's have a few permanent staff of about between 4 and 10. Provision of resource persons in capacity building, specifically for staff and for outreach programmes is

provided by the Office of Regional Focal persons of GAC. Recommendations of NGO's are also made to other sponsors for good work done.

Peculiar Causes of the Spread

Obuasi produces most of Ghana's major Gold. The existence of AngloGold Ashanti and its subsidiaries and other service providers means high employment opportunities for not only the inhabitants but also emigrants who have been employed and stay there permanently, and those who troop there daily in search of job or to perform a job. The itinerant and extravagant life styles associated with most of the miners such as extensive entertainment and multiple sex partners with high risk behaviours explain the trend of the diseases (Obuasi Municipal Assembly 5 Years HIV and AIDS Strategic Plan, 2000-2010).

The underlying causes of the spread include poverty; low education; inaccessibility to information; inaccessibility to medico-social services and unemployment. This hampers efforts to prevent of new infections. Moreover, HIV-related information and education programs offered by most of the CBOs are also ineffective in changing people behaviours. In spite of this, the care and support services which are being provided by the 5 NGOs has led to a destigmatization of the disease to a minimal extent.

Livelihood

Most of the young men and women due to low education and unemployment, and poverty roam the streets in search of work and easily fall prey to the itinerant and extravagant life styles of these miners. They finally end up having unprotected sex. The vulnerable groups are also exposed to the acquisition of the HIV and AIDS through this same means.

Superstition

Not much is known on this but a few still believe HIV and AIDS is not real.

Challenges

The main challenges expressed by the District Assemblies, the NGOs and Focal Persons dwell on funding. That funding from GAC (MSHAP) delays a lot. It was found out that most of the funds earmarked for HIV and AIDS related projects often reach implementers in the last quarter of the year making them unable to undertake the bulk of the programs scheduled for the year. There was also inadequate support for bed ridden PLWH's and supply of Food Rations/Supplement from Catholic Relief Services (CRS) was not readily accessible to new PLWH groups. The next major challenge is how to get most of the youth to know their HIV and AIDS status.

Profile of NGOs/CBOs active in Obuasi

1. Social Support Foundation

Social Support Foundation has been getting assistance from GAC, SHARP and CRS and also from its own meagre resources to provide the following services:

- (1) Help PLWHs to form groups to help themselves
- (2) Has been helping PLWH Associations to source for funding to help themselves.
- (3) They have permanent staff who provide services to help PLWHs in other districts.
- (4) They also provide social support and help build capacity for staff of the group.
- (5) Distribute food items from CRS to PLWHs associations.

2. Youth Care Africa (YOCAF)

YOCAF provides services to youth groups in Obuasi. YOCAF is not as big as Social Support Foundation, they mainly promote the use of condoms to youth care centres and communities. They offer the following services:

- (1) Build Capacity of Peer educators
- (2) Provide support and counselling for PLWHs

- (3) Provide Social Reproductive Health Education constantly in communities, in churches and schools and on radio stations.
- (4) Provide training and builds capacities for workers and staff.
- (5) Distribution of Information, Education and Communication materials to the general population.
- (6) Counselling for the youth on HIV and AIDS and the distribution of condoms.

3. Pro-Link

Pro-Link works mainly with the general population on HIV and AIDS related programs. They had 50 million cedis from GAC for the year 2005 but nothing for 2006. Their budget for the year 2005 was ¢217 million cedis and ¢195 million for year 2006. These amounts were spent on the following:

- (1) Advocacy and preventive education for the general population.
- (2) Support for OVCs.
- (3) Support for PLWHs to purchase drugs, food and other necessities.
- (4) Support was also given in capacity building for various communities.

Pro-Link has five permanent staffs, and have their Headquarters in Accra. They are into prevention and care. Most of their funding is received from external donors.

6.5 Western Region – Eikwe (Nzema East District)

The Western region has about fifty NGOs working in HIV and AIDS related programs. Twenty-five of them benefited from MSHAP's first call. Three were not screened and their names were therefore withheld. GAC sends funds directly to the providers who report back to them.

Mass Communication Activities in Western Region

FHI has comprehensive HIV and AIDS program in the region. It has a mobile VCT Van with trained personnel who do counselling and after that conduct the testing. In the Sekondi/Takoradi Metropolis they work with an NGO called Life Relief Foundation which is based in Lagos Town in the Shama Ahanta East Metropolitan Assembly (SAEMA). In April 2007 when they started, out of the three hundred people tested, one hundred and three were positive.

Eikwe site has the Eikwe Catholic Hospital, which is a Mission Hospital and known as St. Martins de Porres Hospital as its main support for prevention, care, treatment, and education. Other NGOs like (1) End Time Restoration Ministry, (2) Hand for Rural Development and (3) Association for the Development of the Vulnerable, sometimes work along side the Eikwe Catholic Hospital (St. Martins de Porres Hospital) in extending Advocacy, Behavioural change and other assistance to the PLWHs, OVCs and the general populace of the communities.

The St. Martins de Porres Hospital is also supported by the CRS who provided in 2005 and 2006 i.e. the years of Assessment thirty thousand each (30,000) to thirty (30) members of the PLWH Association and light refreshments at every socialization day. They also provided a hundred thousand cedis each to the staff of four each time they met for socialization to date. CRS also provides food items like wheat soy blend known as Tom Brown, Wheat, vegetable oil and rice both in the years of assessment and it is worth several millions of cedis.

HIV Prevalence

The Eikwe Site has a vibrant migrant population due to the fact that it is very close to the Cote d'Ivoire border. It is also on the route, where truck drivers drive through to Togo and elsewhere. This has led to HIV and AIDS pandemic increasing in the Nzema East District. It is one of the HIV Sentinel sites in Ghana and like the Obuasi site there has

been a reversal of the decreasing HIV prevalence rate experienced in 2004 and 2005. In 2006, the prevalence rate was 5.6 from 4.0 in 2005.

Finances

St. Martins de Porres Hospital in the years of Assessment had internally generated funds from their private Corn Mill and Flour Mill; a total of ¢7,200,000 in each year. Weanimix which is also a produce of the Hospital under PHC has a fluctuating type of funding and therefore has been hired out. CRS provides funding in kind i.e. provision of food items. The rest of the NGOs in Axim, listed below, sourced funds from GAC (MSHAP).

- (1) End Time Restoration Ministry,
- (2) Hand for Rural Development
- (3) Association for the Development of the Vulnerable

The three NGO's had funding from GAC in the year 2005. Unfortunately, they could not source funding in 2006 and therefore could not perform as expected in that year.

Peculiar Causes of HIV and AIDS

Peculiar cause of the spread of HIV and AIDS comes from the fact that the Site has been over run by Refugees from Sudan, Cote d'Ivoire, Liberia, Niger etc. It is also inhabited by migrants from Cote d'Ivoire. The low level of education and lack of access to information, poverty and unemployment can be attributed to the spread of the disease in this site. Most people took the HIV and AIDS for granted and it is mostly those who are 25 years and above.

Livelihood

Most people in the Eikwe Site are fishermen and fishmongers. The rest are farmers, drivers, unemployed and children. Incomes of these people are very minimal.

Superstition

Most people in this site do not know their status. They often deny that they have been infected even though one could observe the early symptoms of the disease on them. They do not believe that the HIV is in them but that it is witchcraft that has put those symptoms on them. One woman, Madam Grace Enyan, Head of the PHC Department of St. Martins de Porres Hospital narrated an event where a client who had come for series of tests and also had diarrhoea was complaining about witchcraft and that a witch had placed a crab in his stomach and that anytime the crab scratches then it makes him to have loose stool. A considerable number of people in Eikwe Site communities still have doubts about HIV and AIDS menace.

Profile of NGOs/CBOs Active in Eikwe

1. Association for the Development of the Vulnerable (DEVOR)

The above named NGO, used to be a CBO in the early 2004. It upgraded itself into an NGO in late 2004 and sourced funding from GARFUND (GAC) early 2005 and began work in earnest. Due to the increasing number of migrants and refugees in the area, DEVOR started an elaborate programme on education and awareness on HIV and AIDS. In conjunction with the District Assembly they organised women to build their capacity as peer educators. DEVOR also deals with women in general and women with HIV and AIDS, PLWHs and OVCs.

Funding has always been a challenge. Like most NGOs, it was unable to source funds from GAC in 2006 and had to fall on its own funds to implement any of its programs scheduled for that year.

2. End Time Restoration Ministry

The End Time Restoration Ministry is a faith based organization which also from GAC funding in 2005 (GARFUND, MSHAP). No funds were available from GAC in 2006 so it managed on own meagre funds. The End Time Restoration Ministry since inception undertaken the following activities:

- Supporting men and women in income generating activities, such as bakery, vegetables cultivation, bee keeping and others to earn daily income for living and reduce poverty in their lives.
- Collaborating with the District Health service to reduce the high rate of HIV and /AIDS activity in the District and to sensitize, care and support PLWHs and OVCs.
- Supplying educational materials for needy children to attend school.

3. Hands for Rural Development (HAFORD)

The above is virtually a new NGO which started operation in 2006. The target populations include PLWHs, youth in and out of school. In 2006 GAC (MSHAP) funded them with ø30,000,000 cedis. It is based in Axim and it is one of the active NGO's in Nzema East District Assembly. Its Intervention areas are as follows:-

1. Policy, advocacy and Enabling Environment
2. Treatment, Care and Support
3. Prevention and Behaviour Change Communication
4. Research, Surveillance, Monitoring and Evaluation.

ARV Sites

The ARV site is at the St. Martins de Porres Hospital at Eikwe. Seven males including one male child less than three years and the rest age above twenty-five years. They were started in August, 2006. There were nineteen females, who were started in October,

2006. They were also above twenty-five years of age. Before the treatment eighty-seven (87) tests were conducted but only twenty-six patients were put on ARV.

In total the number of HIV and AIDS patients who are being treated at the ARV Site is twenty-six (26) patients on ARV.

Cost involved for 7 males for 5 months

@ 50,000 each = 1,750,000

Cost involved for the 19 women for 3 months

@ 50,000 each = 2,850,000

¢4,600,000

=====

Cost of ARV for the 26 HIV and AIDS patients in different categories for the year 2006

i.e. ARV for 11 @ 6,435 units consumed = 2,750,000

ARV for 7 @ 3,150 units consumed = 1,750,000

ARV for 8 @ 7,200 units consumed = 2,850,000

¢6,500,000

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6.6 Northern Region – Nalerigu (East Mamprusi District)

HIV Prevalence

According to the 2006 sentinel sites survey, the district recorded a prevalence rate of 1 percent being the lowest among the urban sites in the country. In 2005, the District hospital at Nalerigu recorded 33 cases but this increased to 85 in 2006, representing an increase of 157.6 percent (Table 6.6.1).

Table 6.6.1 TB and HIV and AIDS Cases for 2005/2006

| Condition | 2005 | 2006 | % increase |
|-----------|---------|------|------------|
| STI | No data | 95 | - |
| TB | 39 | 48 | 23.2 |
| HIV/AIDS | 33 | 85 | 157.6 |

For PMTCT, 123 pregnant women received pre-testing counselling in 2005 for which 71 got tested (58 percent). The number rose to 169 in 2006 while 155 got tested (97 percent). The number that tested positive was quite negligible. For VCT, 27 received pre-testing counselling of which 13 got tested with 4 being positive in 2005. In 2006, 9 received pre-testing counselling and all got tested. 4 were positive.

Finances

Available records indicated that the DRI received a total of 95,629,000 cedis from the GARFUND for HIV and AIDS programmes for the period 2003-2005. Of this amount, 60,165,000 (62.9 percent) was spent in 2005. The Assembly did not receive any funding from the MSHAP in 2006 and therefore did not carry out any major HIV and AIDS activity in 2006.

Apart from the funds the CBOs received from the GARFUND for their activities between 2003 and 2004, none of them received funding for 2005 and 2006 from the GAC. As a result of this, many of the CBOs could not carry out HIV/AIDS activities in 2006. Due to the low capacity of these CBOs to operate effectively, the Christian Council of Ghana/Northern Sector Office (CCG-NSO, Tamale) in 2005 initiated the formation of a district coalition of CBOs as a way of strengthening them. A total of 14 CBOs formed this coalition. In all, the CCG-NSO has spent about 100 million cedis for its HIV and AIDS programme in the district (2005/06). The CBOs have received no funding besides the 2,000,000 cedis each that was given to a section of them for the STEPPING STONE project (Awareness creation through peer education) by the CCG-NSO in 2006.

The District coalition in 2006 received 6,000,000 cedis from the CCG-NSO for its activities. The amount was mainly spent on workshops for the CBOs towards the preparation of a district strategic action plan. In May, 2006, the CCG-NSO HIV and AIDS programme assisted in the formation of a District Support Group. The membership included all the identifiable stakeholders in the district including PLWH. The main aim of the Support Group was to pull resources together and also source funding to support

PLWH and other affected persons. The Support Group received 10 million cedis from the CCG-NSO late 2006. Only 1.2 million cedis was spent in 2006. The activities continued in 2007 and the funds had now been exhausted but an appeal to the DA for support is yet to receive any positive result.

The only visible NGO in the district is PARED but HIV and AIDS activities constitute just a small fraction of its programmes. It spent a total of 8,430,000 cedis (\$923) in 2005 from OXFAM (Ghana) and VSO (Ghana/Barclays Africa). In 2006, it spent 6.7 million cedis (\$734) for its HIV and AIDS activities.

Human Resources

The District hospital has the requisite personnel to carry out the relevant HIV and AIDS programs. The same can not be said about the CBOs/NGOs working in the field. Many limited their activities to awareness creation. As revealed by a training needs assessment study by the CCG-NSO in 2005, 'the needed skills for HIV and AIDS intervention are inadequate in the district'. Generally, facilitation, advocacy, lobbying, negotiation and resources mobilisation skills were observed to be quite low. The observation was that many of the personnel working with some of the existing CBOs were part-timers due to lack of activity as a result of inadequate funding.

The transfer of the District HIV and AIDS focal person (the Social welfare officer) from the Assembly sometime in 2006 has exacerbated the problem; everything seems to have come to a halt. Though the Deputy Co-ordinating Director is now the focal person, he does not have reports of previous activities (both soft and hard copies) at the office. The available files contain only correspondences from the GAC and the Christian Council of Ghana-Northern Sector Office (CCG-NSO) in Tamale. The only relevant report found was the GARFUND expenditure report.

Peculiar causes for the spread of HIV and AIDS

Though the HIV prevalence rate in the district is relatively low, the causes of its spread included high level of illiteracy, ignorance and poverty. The high level of illiteracy is

making it difficult for people to accept prevention and educational messages. The high level of poverty and deprivation in the district also compel the youth to migrate to urban areas in Ghana where they get exposed to risk factors. Finally, the high stigmatisation associated with the disease is affecting the willingness of the infected persons to declare their status so that they can receive any available support. It is also affecting people's willingness to go for VCT.

Livelihood

The district is generally rural and the main economic activity is subsistence farming. Major crops grown in the district include cereals, beans and groundnuts. Petty trading is also common in the district especially in the more urban towns like Gambaga and Nalerigu.

Challenges

The fight against the spread of the disease in the district is faced by major challenges as said by the stakeholders assessed during this study. The situation on the ground did not look good for most of the CBOs. The main problem mentioned was lack of adequate funding to carry out HIV and AIDS programmes. This was attributed to limited information about sources of funding for HIV and AIDS activities in the country. Currently, there is over reliance on the funds from the GAC. The support from the CCG-NSO has also not been adequate.

Secondly, the CBOs/NGOs do not have the requisite capacities to scale up their activities. They are poorly resourced and structured and have difficulty in preparing competitive proposals for funding. Record keeping among many of the CBOs and at the District Assembly was not encouraging. Many of the stakeholders spoke to also complained about the limited support from the District Assembly. For instance, the District Support group has run short of funds but an appeal to the DA for support is yet to receive any positive result. Again, no CBO/NGO in the district received funding from the MSHAP in 2006 though some claimed they presented their proposals to the DA. Finally, the strong

stigmatisation attached to the disease in the district is making the fight difficult as complained by many of the stakeholders.

Profile of Some Selected CBOs/NGOs

Over 15 HIV and AIDS related CBOs used to operate in the district. Most of them were formed after 2000 perhaps as a response to access the GARFUND but many now exist only on paper. Six of the 14 CBOs forming the District coalition were selected for this assessment. The District Coalition and the Support group were also added. The organisations were either located in Gambaga or Nalerigu but some operate beyond these communities. Details about the selected organisations are presented in Table 6.6.2 below. They were made up of CBOs working directly in the field of HIV and AIDS as well as those who have incorporated HIV and AIDS activities into their core mandates.

Table 6.6.2 Profile of Selected CBOs/NGOs in East Mamprusi District

| CBO/NGO | Core mandate | Area of intervention in HIV/AIDS | Beneficiaries | Sources of funding | Location |
|---|---|---|------------------------------------|---------------------------|-----------------|
| Women Dev't and Rehabilitation Project (WDRP) | Economic empowerment of women esp. the vulnerable | Awareness creation | General population | GARFUND, CCG-NSO | Gambaga |
| Gambaga AIDS Integrated project (GAIP) | Prevention of HIV/AIDS | Awareness creation, care & support | General pop. PLWHA Pupils/students | GARFUND, CCG-NSO | Gambaga |
| Gambaga Hair Dressers Association | Welfare of members | Awareness creation | Members & general pop. | GARFUND, CCG-NSO | Gambaga |
| Mothers' Support Group | Welfare of mothers/child care | Care & support | PLWHA, Affected persons | GARFUND, CCG-NSO | Nalerigu |
| CHACOE_Nalerigu | Charity, Welfare of members | Care & support | PLWHA, Affected persons | CCG-NSO | Nalerigu |

| | | | | | |
|---|---|------------------------------------|------------------------------|---|----------|
| Partners in Rural Empowerment & Dev't (PARED) | Food & income security, good governance, cross-cutting issues | Mainstreaming , awareness creation | General population, students | IBIS/DANIDA, OXFAM, CIDA, VSO/Barclays, | Nalerigu |
| District Coalition of CBOs/NGOs | HIV/AIDS | Advocacy & prog. coordination | General population | CCG-NSO | Gambaga |
| District Support group | HIV/AIDS | Care and Support | PLWHAs & Affected persons | CCG-NSO | Gambaga |

6.7 Upper East Region – Builsa (Builsa District)

HIV Prevalence

The District has an HIV prevalence rate of 2.8 in 2006 from a prevalence rate of 1.6 in 2005. The district hospital at Sandema recorded 53 HIV cases in 2005 and 43 in 2006 (Table 6.7.1).

Table 6.7.1 TB and HIV/AIDS Cases for 2005/2006

| Condition | 2005 | 2006 |
|-----------------|---------|---------|
| TB | 15 | 5 |
| HIV/AIDS | 53 | 43 |
| STI | No data | No data |

Finances

Funding for HIV and AIDS activities in the district is mainly from the GAC through the District Assembly. The support for the running of PMTCT and VCT centre at the district hospital also come from the NACP. The DHMT also received 75,448,000 million cedis

for the refurbishment of the PMTCT/VCT centre at the Waiga Clinic in 2006. Nothing was received in 2005.

Between 2003 and 2005, the District Assembly (DA) received a total of 145 million cedis from the GARFUND for its HIV and AIDS programmes. Of this amount, 50 million cedis was spent in 2005 and also provided a counterpart funding of 10 million cedis bringing the total to 60 million cedis. In 2006, the Assembly received a total of 111,240,000 cedis from the MSHAP from GAC. Eighty million cedis of the total was disbursed to two CBOs and two NGOs. Of the remaining 30,240,000 cedis, the DA spent 23,030,000 on its HIV and AIDS programmes in 2006. The DA also supported the DRI with 16 million cedis as a counterpart funding.

The 5 CBOs/NOGs which were assessed in the district spent a total of 147,890,000 in 2005 and 84,732,850 in 2006 with over 90% coming from the GAC (Table 6.7.2). The financial position of the CBOs/NGOs with respect to HIV and AIDS was found to be inadequate. The observation was that many of the CBOs were formed just to access the GARFUND which they succeeded but generally remained dormant in 2006 due to lack of funds. PACODEV and especially FISTRAD are still visible because they carry out other developmental programmes outside HIV and AIDS in the district.

Table 6.7.2 Total HIV and AIDS Spending of Selected CBOs/NGOs in Builsa District, 2005/2006

| CBO/NGO | 2005 | 2006 |
|----------------|--------------------|-------------------|
| RCD | 0 | 4,000,000 |
| SAFE LIFE | 15,000,000 | 0 |
| LUF | 12,000,000 | 0 |
| PACODEV | 65,890,000 | 47,732,850 |
| FISTRAD | 55,000,000 | 33,000,000 |
| Total | 147,890,000 | 84,732,850 |

Human Resources

The District hospital has the requisite personnel to carry out the relevant HIV and AIDS programs. PMTCT, VCT and other HIV and AIDS activities at the Public Health unit at the hospital is handled by 7 professionals including 2 nursing officers (Public health), 1 senior staff midwife, 1 principal community health nurse, 1 principal enrolled nurse, 1 community health nurse and a principal midwife superintendent. They have all received the relevant training in counselling, testing and care giving. Many of the CBOs currently exist only in name due to lack of funds to operate and therefore cannot maintain a high level personnel.

Peculiar causes for the spread of HIV and AIDS

- High level of illiteracy, ignorance and poverty
- Active cross-border activities among the youth, e.g. trading activities at the Paga border.
- Migration of the youth to urban areas of Southern Ghana and Burkina Faso
- High stigmatisation associated with the disease and the unwillingness for infected persons to declare their status.
- High dominance of males as part of the cultural orientation and the difficulty on the part of women to negotiate for sex.

Livelihood

The major economic activities in the district include farming and trading.

Challenges

The major challenges stated by the CBOs/NGOs in the fight against the disease in the district include:

- Limited information about sources of funding for HIV and AIDS activities. There is over reliance on the funds from the GAC.
- Low capacities of the CBOs. They are poorly resourced and structured and have difficulty in preparing competitive proposals for funding.
- Strong stigmatisation attached to the disease in the district

- Widow inheritance/ polygamy

Table 6.7.3 Profile of Some Selected CBOs/NGOs in Builsa District

| CBO/NGO | Core mandate | Area of intervention in HIV/AIDS | Beneficiaries | Sources of funding (HIV/AIDS) | Location |
|--|----------------------------------|---|------------------------|--------------------------------------|-----------------|
| Rural Capacity Developer (RCD) | Nutrition & health issues | Awareness creation | Gen. population/pupils | Own | Chuchuliga |
| Safe Life | HIV/AIDS | Awareness creation | Gen. population/pupils | GAC | Sinyangsa/Waiga |
| Life Unlimited Foundation (LUF) | HIV/AIDS | Awareness creation | Gen. population/pupils | GAC | Chuchuliga |
| Participatory Community Development (PACODEV) | Economic empowerment of women | Awareness creation/advocacy | Gen. population/pupils | GAC, PACODEV | Sandema |
| Foundation for Integrated and Strategic Devt (FISTRAD) | Advocacy in developmental issues | Awareness creation/advocacy | Gen. population/pupils | GAC, FISTRAD | Sandema |

Given that most of the districts complained about the inadequacy of funding for HIV and AIDS activities it will be difficult to equate the rate of prevalence of the disease to this. However, it is worth noting that areas which had little support or funding for HIV and AIDS project, experienced an increase in prevalence rate. Many of the NGOs complained of the lack of funding for the year 2006 and we see a subsequent increase in the prevalence rate. We agree that it would be erroneous to attribute the spread of the disease entirely to the lack of funding. There are other socio-economic factors that can also account for these trends.

Section 7

Summary and Recommendations

7.1 Summary

Ghana has made efforts over the past decade to decrease the HIV prevalence rate however there are reported cases of new infections every year. The financial burden on domestic economies in sub-Saharan Africa to combat the HIV and AIDS epidemic is enormous and although domestic public expenditure from governments in low-income sub-Saharan African countries has also significantly increased most of them heavily rely on external sources of funding. Hence the need to monitor resource flows for HIV and AIDS is critical given the scarcity of resources and the importance of effective allocation.

The National AIDS Spending Assessment (NASA) study for 2005 and 2006 confirmed the assertions that funding for HIV and AIDS activities were increasing. The total spending on HIV and AIDS activities in Ghana increased by 11.4 percent from 2005 to 2006. The results also show that in both years the large proportion of the funds was from international organizations. In 2005, most of the funds were spent on Prevention Programmes (35 percent); Programme development and strengthen health care systems for HIV and AIDS activities (32 percent) and Treatment and care (16 percent). A similar trend was repeated in 2006, most of the funds were spent on Programme development and strengthen health care systems for HIV and AIDS activities (40 percent); Prevention Programs (23 percent) and Treatment and care (22 percent). However, total expenditure on prevention programmes decreased from \$11,157,054 in 2005 to \$7,352,150 in 2006.

According to the APOW 2006, the largest proportion of the National Response budget which includes pooled, earmarked and direct funding was to be allocated to two intervention areas Prevention and BCC and then Treatment, Care and Support (33 percent and 53 percent respectively). Comparing this with the actual percentage share of total expenditure of these two components from the NASA estimates, the actual expenditure

on Prevention was 23 percent of total spending with Treatment and Care being 22 percent, showing a shortfall in funding for 2006. Comparing the total expenditure on HIV and AIDS in 2006 and what was budgeted in the APOW 2006, total expenditure in 2006 formed only 61.1 percent of budgeted.

The analysis by beneficiary group shows that the General Population group formed the largest beneficiary group in both 2005 and 2006. The General Population group received 77 percent and 56 percent of the total spending in 2005 and 2006 respectively. The share of funding to People Living with HIV (PLWH) increased from about 17 percent in 2005 to almost 30 percent in 2006. The other groups who benefited included accessible groups and vulnerable groups and most at risk groups. However, there was no reported spending on some of the most at risk populations, such as male commercial sex workers, men who have sex with men (MSM), and intravenous drug users (IUDs) in both years. Accessible population spending was primarily through school educational programmes and some targeting the police and defense forces. Programmes targeting women specifically were also limited. This spending pattern shows that Ghana is experiencing a generalized epidemic with interventions focused on the general population.

Results from the qualitative study conducted as part of the NASA showed that Non – Governmental Organisations face various challenges in securing funding for HIV – related programmes and activities. Among them are transfer problems and delay in getting the funds; long bidding process and the slow response by the GAC in the disbursement of their funds. On the part of Development Partners and UN Agencies they confirmed that the late submission of reports by NGOs also delayed subsequent disbursements of funds. Many NGOs lacked the requisite administrative capacity for an effective implementation of their programmes and they suggested that DPs should contribute in building the capacity of recipient organisations in financial planning, management and reporting.

As part of the National Aids Spending Assessment (NASA) study, seven sites were selected for special case studies on the basis of their peculiar HIV prevalence rates as well as rural and urban biases. Given that most of the districts complained about the inadequacy of funding for HIV and AIDS activities it will be difficult to equate the rate of prevalence of the disease in the different sites to this.

7.2 Recommendations

Recommendations from the study are structured around following issues:

- Information systems – There is the need to improve the quality and accuracy of data. There were cases where data from the same institution were not summing up to the total. This is not for only HIV and AIDS services but other activities.
- Financial reporting – needs improvement and feedback mechanisms (eg from recipients of GAC transfers, from district level services).
- Harmonise reporting mechanism (including financial) – currently there are varying reporting mechanisms and M&E activities. There is the need to harmonise reporting mechanism to conform to the Three Ones Principle of one national M&E framework.
- Standardisation of budget line items/codes and their reported expenditure, using main categories of NSF, and sub-categories of NASA.
- Direction on reporting format required, with regular accounting for received funds before further transfers are made.
- Expenditure according to the NSF priorities – The Ghana AIDS Commission should insist that institutions working in HIV and AIDS activities should present their expenditures according to the NSF priorities. This will help remove double counting and also make assessment of HIV and AIDS activities easy.
- GAC co-ordinating mandate – GAC need to be aware of all other funding going to HIV and AIDS activities that go directly from source to provider. A suitable mechanism is required to capture these funding flows.
- Improving the absorptive capacity of implementers of all service providers – to spend efficiently and effectively.

- There is the need for a follow-up on expenditure of funds transferred, site visits to service providers, technical support, etc. Most implementers of HIV and AIDS activities are required only to submit reports on how they are using funds. Most of the time, this is what is used to judge the success of a programme. This will help also in linking actual expenditure with outputs and compare with intended targets
- Implementation issues – Most NGOs lack the human resource capacity implement programmes either at district or national level. Also some of the districts do not have the human resource capacity to implement their programmes.
- Improvements to the funding flow mechanisms, channels, bottlenecks, etc. in the public sector and also by the development partners.
- Need to harmonise the NASA spending categories classified around eight programmatic areas and the NSF priority areas. This will help in making a more detailed comparison between the national response budget as against the actual expenditures obtained from the NASA.
- GAC should collaborate with the Ghana Business Coalition Association to identify all businesses in Ghana who are involved with HIV and AIDS activities (including work place HIV and AIDS programmes). This will help to estimate the major stakeholders and also help in the data collection for the next NASA for Ghana.
- Institutionalisation of NASA – the key issues that need to be addressed to facilitate the institutionalisation of the NASA in Ghana are (i) greater advocacy to all MMDAs, beneficiaries, etc and (ii) streamlining of financial disbursements and reporting mechanisms.

On the whole the commitment of the Government of Ghana as well as many of the Development Partners to reduce the prevalence rate of HIV in the country is quite evident in the increase of funds in this area and the introduction of a comprehensive way to deal with this problem. It is hoped that the results from this study will make an impact on the way future funds are dispersed among the various functions of the NSF and among the various groups of beneficiaries.

Appendix

Appendix 1

NATIONAL AIDS SPENDING ASSESSMENT DATA COLLECTION – FORM # 1 (SOURCES / AGENTS)

| | | | |
|--|--------------------------------------|--|------------------|
| Year of the expenditure estimate: _____ | | | |
| Objectives of the form: I. To identify the origin of the funds used or managed by the institution during the year under study. II. To identify the recipients of those funds. | | | |
| Indicate what currency will be used throughout the form with an "X": | Local currency | US\$ Exchange rate in Year of Assessment | Other (specify): |
| | | | |
| Name of the Institution: | | | |
| 1. Financial Year: (If not calendar year, please ask for quarterly expenditure reports) | | | |
| 2. Person to Contact (Name and Title): | | | |
| 3. Address: | | 4. E-mail: | |
| 5. Phone: | | 6. Fax: | |
| 7. Type of institution: Select category of institution with an "X". | 6.1 Public central government | | |
| | 6.2 Public regional government | | |
| | 6.3 Public local government | | |
| | 6.4 Private-for-profit national | | |
| | 6.5 Private-for-profit international | | |
| | 6.6 National NGO/CBO | | |
| | 6.7 International NGO | | |
| | 6.8 Bilateral Agency | | |
| 6.9 Multilateral Agency | | | |

If your institution is a SOURCE please jump to table 8, and following sections. If your institution is an AGENT please complete table 7 and 7a, and following sections.

For all AGENTS ask about their operational/ running costs/ overheads and capture these in form 2 under the identified activities.

8. Origin of the funds transferred: List the institutions from which your agency received funds during the year under study.

| Origins of the funds (Name of the Institution and Person to Contact) | Funds received |
|---|----------------|
| 7.1 Institution: Contact: | |
| 7.2 Institution: Contact: | |
| 7.3 Institution: Contact: | |
| 7.4 Institution: Contact: | |
| 7.5 Institution: Contact: | |
| TOTAL: | |

7a. Origins of non financial resources: List the institutions from which your agency received non financial resources, during the year under study.

| Origins of the non financial resources (Name of the Institution and Person to Contact) | Type of Goods donated | Quantity Received | Monetary Value in Year Assessment |
|---|--------------------------|----------------------|---|
| 7.6 Institution: Contact: | | | |
| 7.7 Institution: Contact: | | | |
| 7.8 Institution: Contact: | | | |
| 7.9 Institution: Contact: | | | |
| 7.10 Institution: Contact: | | | |
| TOTAL: | | | |

9. Destination of the funds:

- I. List the institutions to which funds were transferred during the year under study.
- II. Quantify the transferred funds.
- III. Quantify the transferred funds *reported as spent* during the period under study. If no information is available regarding the amount spent, state "No Data" in the cell.

| Destination of the funds (Name of the Institution and Person to Contact) | Funds transferred | Funds <u>spent</u> |
|--|-------------------|--------------------|
| 8.1 Institution: | | |
| Contact: | | |
| 8.2 Institution: | | |
| Contact: | | |
| 8.3 Institution: | | |
| Contact: | | |
| 8.4 Institution: | | |
| Contact: | | |
| 8.5 Institution: | | |
| Contact: | | |
| TOTAL: | | |

8a. Recipients of non financial resources: List the institutions to which your agency donated non financial resources, during the year under study.

| Recipients of the non financial resources (Name of the Institution and Person to Contact) | Type of Goods donated | Quantity Received | Monetary Value in Year Assessment |
|--|--------------------------|----------------------|---|
| 8.6 Institution: | | | |
| Contact: | | | |
| 8.7 Institution: | | | |
| Contact: | | | |
| 8.8 Institution: | | | |
| Contact: | | | |
| 8.9 Institution: | | | |
| Contact: | | | |
| 8.10 Institution: | | | |
| Contact: | | | |
| TOTAL: | | | |

10. Additional information on transferred funds reported as spent: Complete a Providers form (Form # 2) for each institution about which the Source / Agent has information regarding what the funds were used for, in order to gain information on Functions, Beneficiary Populations and Production Factors.

11. Consumption of the funds: If the institution consumed resources in producing services or goods, (i.e. administrative costs in managing the funds), complete a Providers form (Form # 2) regarding those funds.

Additional Qualitative Information (feel free to add as many rows as you need)

- a. Please describe how institutions apply and access funds from your institution. Please describe the funding flow mechanisms.

- b. What are the conditionalities that your institution insists upon in transferring funds to organizations?

- c. What are the reporting requirements for organizations receiving funds from your institution?

- d. What are the key difficulties faced by recipient organizations in efficiently spending the funds transferred to them by your institution?

- e. What are the key causes of bottlenecks in the funding mechanisms?

f. What are the other issues/ challenges related to funding for HIV/AIDS services?

g. Any other comments, suggestions etc?

| | |
|---------------------|------------------------------|
| 12.Surveyor: | 13.Date: / / 20__ |
|---------------------|------------------------------|

National AIDS Spending Assessment
DATA COLLECTION – FORM # 2 (PROVIDERS)

| | |
|--|-------------------------------------|
| Origin of the information: Select with an "X" the source of the information on the Provider | |
| A) Information given by the Provider itself. | |
| B) Information given by other institution than the Provider (i.e.: Agent or Financing Source) | |
| In case of B), complete: | |
| Institution: | Person to Contact (Name and Title): |
| Phone: | E-mail: |

| | | | |
|--|-------------------------------------|---|----------------------------------|
| Year of the expenditure estimate: _____ | | | |
| Objectives of data collection from the Provider: | | | |
| III. To identify the origin of the funds spent by the provider in the year understudy. IV. To identify in which NASA Functions/ activities the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function/ activity. | | | |
| Indicate what currency will be used throughout the form with an "X": | Local currency | US\$ Exchange rate in Year of Assessment | Other (specify): _____ |
| Name of the Provider: | | | |
| 14. Person to Contact (Name and Title): | | | |
| 15. Address: | | 16. E-mail: | |
| 17. Phone: | | 18. Fax: | |
| 19. Type of institution: Select category of institution with an "X". | 1. Public central government | | |
| | 2. Public regional government | | |
| | 3. Public local government | | |
| | 4. Private-for-profit national | | |
| | 5. Private-for-profit international | | |
| | 6. National NGO/CBO/CSO | | |
| | 7. International NGO/CSO | | |
| | 8. Bilateral Agency | | |
| | 9. Multilateral Agency | | |

20. Origin of the funds received: List the institutions that granted the funds spent during the year under study.

| Origin of the funds (Name of the Institution and Person to Contact) | Funds received during the year under study |
|--|--|
| 7.11 Institution: Contact: | |
| 7.12 Institution: Contact: | |
| 7.13 Institution: Contact: | |
| 7.14 Institution: Contact: | |
| 7.15 Institution: Contact: | |
| TOTAL: | |

7a. Origin of non financial resources: List the institutions that granted *non financial* resources during the year under study.

| Origin of the non financial resources (Name of the Institution and Person to Contact) | Type of Resource received | Quantity Received | Monetary Value in Year of Assessment |
|--|---------------------------|-------------------|--------------------------------------|
| 7.16 Institution: Contact: | | | |
| 7.17 Institution: Contact: | | | |
| 7.18 Institution: Contact: | | | |
| 7.19 Institution: Contact: | | | |
| 7.20 Institution: Contact: | | | |
| TOTAL: | | | |

21. Destination of the funds:

- IV. Identify and quantify the NASA Functions in which the funds were spent.
- V. Identify and quantify the NASA Beneficiary Population(s) of each Function.
- VI. Use NASA notebook to classify Functions and Beneficiary Populations, using the name and code as the figure in the notebook for their identification.

8.1 Expenditure of the funds received from "7.1"

| | | | | |
|---|-------|-------|------------|--------------|
| 8.1.1 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | | | |
| 8.1.1.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 8.1.1.2 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| Total spent on the Function: | | | | |
| 8.1.2 Function (Code and Name) | | | | Amount spent |
| Code: | 1.1 | Name: | Mass media | |
| 8.1.2.1 Beneficiary Population (Code and Name): | | | | |
| Code: | 6 | Name: | | |
| 8.1.2.2 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| Total spent on the Function: | | | | |
| 8.1.3 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.1.3.1 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| 8.1.3.2 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| Total spent on the Function: | | | | |
| Total Expenditure from the amount from '7.1' | | | | |
| Total un/overspent from the amount from '7.1' | | | | |

8.1.a If funds were un/overspent from '7.1' what were the key reasons for under/over-spending?

| 8.2 Destination of the funds received from "7.2" | | | |
|--|--|-------|--------------|
| 8.2.1 Function (Code and Name) | | | Amount spent |
| Code: | | Name: | |
| 8.2.1.1 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| 8.2.1.2 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| Total spent on the Function: | | | |
| 8.2.2 Function (Code and Name) | | | Amount spent |
| Code: | | Name: | |
| 8.2.2.1 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| 8.2.2.2 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| Total spent on the Function: | | | |
| 8.2.3 Function (Code and Name) | | | Amount spent |
| Code: | | Name: | |
| 8.2.3.1 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| 8.2.3.2 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| 8.2.3.3 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| Total spent on the Function: | | | |
| Total Expenditure from the amount from '7.2' | | | |
| Total unspent from the amount from '7.2' | | | |

8.2.a If funds were unspent from '7.2' what are the reasons for under-spending?

| 8.3 Destination of the funds received from "7.3" | | | |
|--|--|-------|--------------|
| 8.3.1 Function (Code and Name) | | | Amount spent |
| Code: | | Name: | |
| 8.3.1.1 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| 8.3.1.2 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |
| Total spent on the Function: | | | |
| 8.3.2 Function (Code and Name) | | | Amount spent |
| Code: | | Name: | |
| 8.3.2.1 Beneficiary Population (Code and Name): | | | |
| Code: | | Name: | |

| | | | | | | |
|--|--|---------|--|---|--|--------------|
| Code: | | 8.3.2.2 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Total spent on the Function: | | | | | | |
| ----- | | | | | | |
| 8.3.3 Function (Code and Name) | | | | | | Amount spent |
| Code: | | Name: | | | | |
| Code: | | 8.3.3.1 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Code: | | 8.3.3.2 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Total spent on the Function: | | | | | | |
| Total Expenditure from the amount from '7.3' | | | | | | |
| Total unspent from the amount from '7.3' | | | | | | |

8.3.a If funds were unspent from '7.3' what were the key reasons for under-spending?

| | | | | | | |
|---|--|---------|--|---|--|--------------|
| 8.4 Destination of the funds received from "7.4" | | | | | | |
| 8.4.1 Function (Code and Name) | | | | | | Amount spent |
| Code: | | Name: | | | | |
| Code: | | 8.4.1.1 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Code: | | 8.4.1.2 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Total spent on the Function: | | | | | | |
| ----- | | | | | | |
| 8.4.2 Function (Code and Name) | | | | | | Amount spent |
| Code: | | Name: | | | | |
| Code: | | 8.4.2.1 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Code: | | 8.4.2.2 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Total spent on the Function: | | | | | | |
| ----- | | | | | | |
| 8.4.3 Function (Code and Name) | | | | | | Amount spent |
| Code: | | Name: | | | | |
| Code: | | 8.4.3.1 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Code: | | 8.4.3.2 | | Beneficiary Population (Code and Name): | | |
| Name: | | | | | | |
| Total spent on the Function: | | | | | | |
| Total Expenditure from the amount from '7.4' | | | | | | |
| Total unspent from the amount from '7.4' | | | | | | |

8.4.a If funds were unspent from '7.4' what were the key reasons for under-spending?

| 8.5 Destination of the funds received from "7.5" | | | | |
|--|--|-------|--|--------------|
| 8.5.1 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.5.1.1 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| 8.5.1.2 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| Total spent on the Function: | | | | |
| 8.5.2 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.5.2.1 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| 8.5.2.2 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| Total spent on the Function: | | | | |
| 8.5.3 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.5.3.1 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| 8.5.3.2 Beneficiary Population (Code and Name): | | | | |
| Code: | | Name: | | |
| Total spent on the Function: | | | | |
| Total Expenditure from the amount from '7.5' | | | | |
| Total unspent from the amount from '7.5' | | | | |

8.5.a If funds were unspent from '7.5' what were the key reasons for under-spending?

22. Production Factors: In order to finish the form, complete ANNEX 1.

Additional Qualitative Information Required:

1. What are the major difficulties you face with regard to securing funding?

2. What are the major difficulties you face with regard to spending and reporting on funds?

3. What are the key bottlenecks to spending?

4. Are the funds you receive adequate to run your HIV/AIDS programmes? Explain your answer.

5. With regard to donor funds that you receive, what conditions (directions) are given for you to spend the donor money?

6. What are your thoughts regarding the reporting requirements for donor funds?

7. If you also receive government funding, are these funds more accessible than donor funds and if so, why?

8. What are your key challenges in implementing HIV/AIDS services?

9. How could these be addressed or reduced?

| | |
|-------------------------|-------------------------------|
| 23. Interviewer: | 24. Date: / / 20__ |
|-------------------------|-------------------------------|

TREATMENT AND CARE

The present tool presents basic situations for Treatment and Care on data availability and possible solutions for each circumstance in order to capture actual expenditure on the services delivered.

1. Example on Antiretroviral therapy.

FN 2.2. ***Antiretroviral therapy.*** The specific therapy includes a comprehensive set of recommended antiretroviral drugs, including the cost of supply logistics for either adults or children. The number of people being treated is based on country-specific evidence of current coverage.

FN 2.2.1. ***Antiretroviral therapy for adults***

FN 2.2.2. ***Antiretroviral therapy for children.***

2.1 Data available: Actual Expenditure.

- 1) With the information of actual expenditure complete a simple table where the Code and Name of the NASA Function is stated, and add the amounts on actual expenditure. It is also very important to complete the information identifying the source or informat:

| Code | Function | Expenditure |
|-------------------------------|--|-------------------------------------|
| FN 2.2.1. | Antiretroviral therapy by gender and age | |
| Source of information. | | |
| Institution: | | Person to Contact (Name and Title): |
| Phone: | | E-mail: |

- 2) Second step: complete data on NASA Production Factors; specify what comprehends the expenditure in the different Production Factors.

| FN 2.2.1 Antiretroviral therapy by gender and age | | |
|---|-------------------|-------------|
| Code | Profuction Factor | Expenditure |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| TOTAL | | |

3) Set up a table where the Beneficiary Population is identified:

| FN 2.2.1 Antiretroviral therapy by gender and age | | |
|---|------------------------|-------------|
| Code | Beneficiary Population | Expenditure |
| | | |
| | | |
| TOTAL | | |

2.2 No data on expenditure. Data available: ARV consumption.

1. List the ARV consumed during the year under study.
2. Define the unit (presentation, quantity, doze).
3. Complete data on the number of units consumed.
4. Complete data on the price of each ARV. (Consult the NASA notebook for a detailed explanation on prices and costs).
5. Calculate total expenditure using the PxQ approach (Prices by Quantities).
6. Identify the Source of the information.

| ARV | Unit definition | Number of Units Consumed | Unit Price | Expenditure (PxQ) |
|-------------------------------|-----------------|-------------------------------------|------------|-------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| TOTAL | | | | |
| Source of information. | | | | |
| Institution: | | Person to Contact (Name and Title): | | |
| Phone: | | E-mail: | | |

Since ARV treatment also includes the cost of supply logistics, the supply logistic activities should be captured in a table like next one, where the activities are related to one or more NASA production Factors.

| Activitie | NASA Production Factor (Code and Name) | Expenditure |
|-----------|--|-------------|
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|-------------------------------|-------------------------------------|--|
| | | |
| TOTAL | | |
| Source of information. | | |
| Institution: | Person to Contact (Name and Title): | |
| Phone: | E-mail: | |

The Beneficiary Population could be captured in a table as the one shown in 1.1.3).

2.3 No data on expenditure, nor on ARV consumption. The only data available is the number of people being treated based on country-specific evidence of current coverage.

In this case, one possible way of estimating actual expenditure is to multiply the number of people under ARV treatment by the cost of the country specific ARV average treatment.

Capture the number of adults and children under ARV therapy.

| | |
|---------------------------------------|-------------------------------------|
| Beneficiary Population | Quantity |
| Adults under Antiretroviral therapy | |
| Children under Antiretroviral therapy | |
| Source of information. | |
| Institution: | Person to Contact (Name and Title): |
| Phone: | E-mail: |

In a table similar to this one, the average ARV therapy should be detailed and its cost estimated using the PxQ approach. Note: One table should be done for adults and other one for children.

| ARV Therapy - Antiretroviral drugs and the cost of supply logistics. | | | | |
|--|-----------------|--------------------------|------------|-------------------|
| Activitie | Unit definition | Number of Units Consumed | Unit Price | Expenditure (PxQ) |
| | | | | |
| | | | | |
| | | | | |
| TOTAL | | | | |
| | | | | |

| Source of information. | |
|------------------------|-------------------------------------|
| Institution: | Person to Contact (Name and Title): |
| Phone: | E-mail: |

The activities of the ARV average therapy should be related to its corresponding NASA production Factors.

| Activitie | NASA Profuction Factor (Code and Name) | Expenditur e |
|------------------------|--|-----------------|
| | | |
| | | |
| | | |
| | | |
| TOTAL | | |
| Source of information. | | |
| Institution: | Person to Contact (Name and Title): | |
| Phone: | E-mail: | |

2. Example on Monitoring Tests.

FN 2.7 Laboratory monitoring. This includes expenses for the access and delivery of CD4 cell testing and viral load to monitor the response to antiretroviral therapy and disease progression among people living with HIV.

2.1 Data available: number of tests delivered.

Capture the number of tests done during the year under study, and the source of information.

| Number of CD4 Tests done in the year under study: | |
|--|-------------------------------------|
| Number of Viral Load Tests done in the year under study: | |
| Source of information. | |
| Institution: | Person to Contact (Name and Title): |
| Phone: | E-mail: |

Capture all the expenses for the access and delivery of each test, identifying the corresponding NASA Production Factors, and add the cost of each component.

| CD4 Test components | NASA Production Factor (Code and Name) | Cost |
|---------------------|--|------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| TOTAL | | |

Once the total cost of each test is estimated, multiply the cost of each test by the number of tests done. Sum both figures, and that is one way to estimate the expenditure in Laboratory Monitoring.

Institutional Role

| | |
|--|-------------------|
| Year/s of the expenditure estimate: _____ | |
| Objective of the Questionnaire: | |
| VI. To identify the role or roles of the institution to determine the most suitable form to use for data collection. | |
| Name of the Institution: | |
| 1. Person to Contact (Name and Title): | |
| 2. Address: | 3. E-mail: |
| 4. Phone: | 5. Fax: |

6. Questions to identify role of the institution in order to determine its role in the fight against HIV/AIDS during the year of the estimate.

| | | |
|---|-----|----|
| 6.1 Does the institution provide funds for HIV/AIDS (Source) | YES | NO |
| 6.2 Does the institution transfer funds to other institutions for activities connected with the fight against HIV/AIDS? (Agent) | YES | NO |
| 6.3 Does the institution produce goods and/or services for the fight against HIV/AIDS? (Provider) | YES | NO |

7. Institutional Status – select category of the institution with an ‘X’

| | |
|--------------------------------------|--|
| 10. Public central government | |
| 11. Public regional government | |
| 12. Public local government | |
| 13. Private-for-profit national | |
| 14. Private-for-profit international | |
| 15. National NGO | |
| 16. International NGO | |
| 17. Bilateral Agency | |
| 18. Multilateral Agency | |

8. Forms for the institution. According to the answers in item 6, choose the form to be completed for data collection:

- | |
|---|
| 7.1 If Institution is Source and/or Agent – complete form number 1 7.2 If Institution is a Provider – complete form number 2 7.3 If Institution is an Agent and Provider – complete forms 1 and 2 |
|---|

Forms:

1. Source / Agent
2. Provider

| | |
|------------------------|-----------------------------|
| 9. Investigator | 10. Date: / / |
|------------------------|-----------------------------|

Table 1 Selected Institutions and Status of Data Collection with Comments

| Institution | 2005 | 2006 | Primary | Second. | Source/ comments |
|------------------------------|-------------|-------------|-------------------------------------|----------------|---|
| <u>PUBLIC</u> | | | | | |
| Ghana AIDS Commission | ✓ | ✓ | ✓ | | Annual Audited Reports, GARFUND & MSHAP |
| NACP – hospital exp. | ✓ | ✓ | Weak | | NACP, underestimated |
| NACP – PMTCT exp. & nos | ✓ | ✓ | Weak | | NACP, underestimated |
| NACP - ARVs exp & nos. | ✓ | ✓ | Weak | | NACP, underestimated |
| NACP – STIs & TB exp & nos | ✗ | ✗ | Captured within OI costs | | |
| TB Control Program | ✗ | ✗ | What % to HIV? | | |
| MoH – CMS & procurements | ✓ | ✗ | | | Some for ARVs 2005 |
| MoH – Health Fund | ✗ | ✗ | What % to HIV? | | |
| MoH - Nat. Reference Lab | ✗ | ✗ | What % to HIV? | | |
| MoH - Salaries | ✗ | ✗ | What % to HIV? | | |
| GHS | | ✓ | ✓ | | GHS, needing outputs |
| MLGRDE (district resources) | ✓ | ✓ | ✓ | | MLGRDE intv. |
| MoESS | ✓ | ✓ | ✓ | | MOE intv. |
| MOWAC | ✓ | ✓ | ✓ | | MOWAC intv. |
| Dept.S.Welfare (MOMPYE) | ✓ | ✓ | ✓ | | |
| Trade Union Congress | | ✓ | ✓ | | Not spending on HIV/AIDS |
| Other Ministries (Workplace) | ✓ | ✓ | | ✓ | GAC records |
| Research Agencies | ✓ | ✓ | Weak | ✓ | GAC & USAID records |
| Regional & District Service | | ✓ | | | Site visits, purposive sampling |
| <u>STATUS OF DATA</u> | 2005 | 2006 | Primary | Second. | Source |
| <u>EXTERNAL</u> | | | | | |
| USAID (Int & Ghana) | ✓ | ✓ | ✓ | | USAID, not act.expend. |
| GLOBAL FUND | ✓ | ✓ | | ✓ | Thru NACP |
| DANIDA | ✓ | ✓ | ✓ | | DANIDA |
| UNICEF | ✓ | ✓ | ✓ | | UNICEF- limited disagg. |
| UNFPA | ✓ | ✓ | ✓ | | UNFPA |
| UNAIDS | ✓ | ✓ | ✓ | | UNAIDS |
| World Bank | ✓ | ✓ | ✓ | | WB and GAC records |
| WHO | ✓ | ✓ | Data not disaggregated sufficiently | | |
| UNHCR | ✓ | ✓ | ✓ | | UNHCR, not disaggreg. |
| UNESCO | ✓ | ✓ | ✓ | | UNESCO |
| WFP | ✗ | ✓ | ✓ | | WFP, waiting 2005 |
| ILO | ✓ | ✓ | ✓ | | ILO |
| JICA | ✓ | ✓ | ✓ | | JICA |
| GTZ | ✓ | ✓ | Weak | | GTZ intv, not act.expend.records |

| | | | | | |
|--|-------------|-------------|----------------|----------------|---|
| SHARP | x | x | Uncertain | | SHARP figures not incorporate DFID, variance w recipient data |
| DFID | ✓ | ✓ | ✓ | | |
| Royal Netherlands Embassy | ✓ | ✓ | ✓ | | RNE |
| WAPCAS | ✓ | ✓ | ✓ | | WAPCA |
| OICI (Int. & Ghana) | ✓ | ✓ | ✓ | | OICI |
| PLAN International | | | ✓ | | PI no expenditure records |
| Futures Group | ✓ | ✓ | ✓ | | Futures |
| Family Health Int. (& Ghana) | ✓ | ✓ | ✓ | | FHI |
| Other donors to GAC (MSHAP) | ✓ | ✓ | | ✓ | GAC records |
| STATUS OF DATA | 2005 | 2006 | Primary | Second. | Source |
| <u>NGOs</u> | | | | | |
| CARE | ✓ | ✓ | ✓ | | CARE |
| CRS | ✓ | ✓ | ✓ | | CRS |
| NAP + | ✓ | ✓ | ✓ | | NAP+ |
| GHANET | ✓ | ✓ | ✓ | | GHANET |
| ARHR | ✓ | ✓ | ✓ | | ARHP (what proportion HIV?) |
| AWARE | ✓ | ✓ | ✓ | | AWARE |
| GSCP | ✓ | ✓ | ✓ | | GSCP |
| GSMF | ✓ | ✓ | ✓ | | GSMF |
| ActionAid Int. & Ghana | | | | | To be collected |
| QHP | | | | | Still to be approached |
| Right to Play | | | | | Still to be approached |
| All MSHAP transfers to NGOs/CBOs (via GAC) | ✓ | ✓ | | ✓ | GAC records (aggregated) |
| <u>BUSINESS</u> | | | | | |
| Ghana Business Coalition | ✓ | ✓ | ✓ | | GBCA |
| Ghana Employers Assoc. | ✓ | ✓ | ✓ | | GEA |
| Chamber of Commerce | x | x | | | No HIV spending, work with GBCA |
| ANGLO GOLD | | | | | Pending, on strike |
| Lister Hospital | x | x | | | Data too weak to use |
| Nyaho Clinic | x | x | | | Data too weak to use |

Table 2 Prevention programs by Agents, 2006 (US\$)

| Prevention Program | Public sector | Private sector | International Organizations | Grand Total |
|---|----------------------|-----------------------|------------------------------------|---------------------|
| HIV- Related information and education | 1,670,165.00 | 55,276.00 | 1,988,487.00 | 3,713,928.00 |
| Community mobilization. | 4,544.00 | 27,638.00 | 77,878.00 | 110,060.00 |
| Voluntary counseling and testing. | 7,044.00 | | 446,805.00 | 453,849.00 |
| Programmes focused on female sex workers and their clients. | | 17,467.00 | | 17,467.00 |
| Programmes focused on male sex workers and their clients | | | | |
| Programmes focused on men who have sex with men (MSM). | | | | |
| Programmes focused on transgender individuals. | | | | |
| Harm-reduction programmes for injecting drug users (IDU). | | | | |
| Prevention programmes for people living with HIV. | | | 259,350.00 | 259,350.00 |
| Condom social marketing. | | | 598,987.00 | 598,987.00 |
| Public and commercial sector condom provision | | | 168,877.00 | 168,877.00 |
| Female condom | | | | |
| Improving management of STIs. | | | | |
| Prevention of mother-to-child transmission | | | 133,765 | 133,765 |
| Prevention programs for non-targeted populations | 15,591.00 | 55,276.00 | 1,825,000.00 | 1,895,867.00 |
| Grand Total | 1,697,344.00 | 155,657.00 | 5,196,507.00 | 7,352,150.00 |

Table 3 Prevention programs by Agents, 2005 (US\$)

| Prevention Program | Public sector | Private sector | International Organizations | Grand Total |
|---|----------------------|-----------------------|------------------------------------|----------------------|
| HIV- Related information and education | 1,118,815.00 | 126,084.00 | 2,139,184.00 | 3,384,083.00 |
| Community mobilization. | | 63,042.00 | 21,153.00 | 84,195.00 |
| Voluntary counseling and testing. | | | 87,183.00 | 87,183.00 |
| Programmes focused on female sex workers and their clients. | | | | |
| Programmes focused on male sex workers and their clients | | | | |
| Programmes focused on men who have sex with men (MSM). | | | | |
| Programmes focused on transgender individuals. | | | | |
| Harm-reduction programmes for injecting drug users (IDU). | | | | |
| Prevention programmes for people living with HIV. | | | 319,200.00 | 319,200.00 |
| Condom social marketing. | | | 535,393.00 | 535,393.00 |
| Public and commercial sector condom provision | | | 103,477.00 | 103,477.00 |
| Female condom | | | | |
| Improving management of STIs. | | | | |
| Prevention of mother-to-child transmission | | | 340,068.00 | 340,068.00 |
| Prevention programs for non-targeted populations | 4,377,371.00 | 126,084.00 | 1,800,000.00 | 6,303,455.00 |
| Grand Total | 5,496,186.00 | 315,210.00 | 5,345,658.00 | 11,157,054.00 |

Table 4 Beneficiaries by Agents, 2005 and 2006

| 2006 Agent-Beneficiaries | | | | | | |
|----------------------------------|------------------|---------------------------------|---------------------------|-------------------------------|--------------------|--------------------|
| Amounts in \$ | | | | | | |
| Agents | PLWHA | Most at risk populations | Vulnerable groups | Accessible populations | General Pop | Grand Total |
| Public sector | 4,860,605 | 17,467 | 114,845 | 1,164,500 | 5,168,965 | 11,326,382 |
| Private sector | | | | | 416,820 | 416,820 |
| International Orgs. | 4,651,625 | 175,244 | 916,901 | 2,143,629 | 207,830,909 | 20,973,711 |
| Grand Total | 9,512,230 | 175,244 | 1,031,746 | 349,875 | 18,481,476 | 32,716,913 |
| Percentages | 29.07 | 0.54 | 3.15 | 10.69 | 56.49 | 100 |
| | | | | | | |
| 2005 Agent -Beneficiaries | | | | | | |
| Amounts in \$ | | | | | | |
| Agents | PLWHA | Most at risk populations | Vulnerable groups. | Accessible populations | Gen. Pop | Grand Total |
| Public sector | 33,485 | | 183,834 | 842,552 | 7,227,437 | 8,287,308 |
| Private sector | | | | | 315,210 | 315,210 |
| International Orgs. | 4,908,166 | 305,901 | 1,102,807 | 1,433,057 | 11,843,221 | 19,593,152 |
| Grand Total | 4,941,651 | 305,901 | 1,286,641 | 2,275,609 | 19,385,868 | 28,195,670 |
| Percentages | 17.53 | 1.08 | 4.56 | 8.07 | 68.75 | 100 |

Table 5 Total Spending on OVCs, 2005 and 2006

| | |
|---|-------------------|
| 2006 Total Spending on OVCs | |
| Treatment and care components (OVC component) | 172,900.00 |
| Education. | 270,543.00 |
| Basic health-care support | 23,913.00 |
| Family/home support | 541 |
| Community support | 0 |
| Organization costs | 0 |
| OVC activities not classified elsewhere | 50,000.00 |
| | 344,997.00 |
| Programme development and strengthen health care systems for HIV and AIDS activities(OVC component) | 50,000.00 |
| Grand Total | 567,897.00 |
| 2005 Total Spending on OVCs | |
| Treatment and care components (OVC component) | 212,800.00 |
| Education. | 319,200.00 |
| Basic health-care support | 0.00 |
| Family/home support | 6,946.00 |
| Community support | 0.00 |
| Organization costs | 0.00 |
| OVC activities not classified elsewhere | 28,719.00 |
| | 354,865.00 |
| Programme development and strengthen health care systems for HIV and AIDS activities(OVC component) | 128,087.00 |
| Grand Total | 695,752.00 |