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Report No: 33917-GH

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED CREDIT
IN THE AMOUNT OF SDR 13.9 MILLION
(US$20 MILLION EQUIVALENT)
TO THE
REPUBLIC OF GHANA
FOR A
MULTI-SECTORAL HIV/AIDS PROJECT (M-SHAP)

October 18, 2005

Human Development II
Africa Regional Office

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CURRENCY EQUIVALENTS
(Exchange Rate Effective October 11, 2005)

Currency Unit	=	Cedis
9199 Cedis	=	US$1
0.651220 SDR	=	US$1
US$ 1.53558	=	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinics
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirals
BCC	Behavior Change and Communication
CAS	Country Assistance Strategy
CBO	Community-Based Organization
CRIS	UNAIDS country response information system
CSW	Commercial Sex Worker
DAC	District AIDS Committees
DANIDA	Danish International Development Assistance
DFID	Department for International Development (UK)
FBO	Faith-Based Organization
FP	Funding Partners
GAC	Ghana AIDS Commission
GARFUND	Ghana AIDS Response Fund
GDHS	Ghana Demographic and Household Survey
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
HIV	Human Immuno-virus
IEC	Information, Education and Communication
HSSP	Health Sector Support Program
MAP	Multi-Country HIV/AIDS Program
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOMY	Ministry of Manpower and Youth
M-SHAP	Multi-Sectoral HIV/AIDS Project

MSM	Men Having Sex with Men
MTR	Mid-term Review
NACP	National AIDS Control Program
NGO	Non-governmental organization
NSF II	National Strategic Framework 2006-2010
OM	Operational Manual
OVC	Orphans and Vulnerable Children
PAD	Project Appraisal Document
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
POW	Program of Work
PRSC	Poverty Reduction Strategy Credit
PSR	Project Status Report
SIL	Specific Investment Loan
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TAP	Treatment Acceleration Program
UNAIDS	Joint United Nations HIV/AIDS Agency
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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GHANA
MULTI-SECTORAL HIV/AIDS PROJECT (M-SHAP)

Project Appraisal Document

AFRICA

AFTH2

Date: October 11, 2005	**Team Leader:** Laura Rose
Country Director: Mats Karlsson	**Sector(s):** HIV/AIDS (100%)
Sector Manager: Alexandre Abrantes	**Theme(s):** Health/Nutrition/Population
Project ID: P088797	
Lending Instrument: Specific Investment Loan	

Project Financing Data

[ ] Loan [x] Credit [ ] Grant [ ] Guarantee [ ] Other

For Loans/Credits/Others:
Total Bank Financing (US$m): $20.0
Proposed terms:

Financing Plan

Source	Local	Foreign	Total
BORROWER/RECIPIENT	7.0	0.0	7.0
IDA	19.0	1.0	20.0
DfID (UK – Dept. for International Dev't.)[1]	7.0	1.3	8.3
Total:	33.0	2.3	35.3

Borrower/Recipient: REPUBLIC OF GHANA
Responsible agency: GHANA AIDS COMMISSION
Address: H/no 19c North Ring Ext., Labone, Accra,
P.O. Box CT 5169, Accra
Contact Person: Prof. Sakyi Amoa, Director-General, Ghana AIDS Commission
Tel: (233) 21 782262 Fax: (233) 21 782264 Email: sakyi_2000@yahoo.com

Estimated Disbursements (Bank FY/US$m):

FY	2006	2007	2008	2009	2010	
Annual	2.5	4.0	5.5	5.5	2.5	
Cumulative	2.5	6.5	12.0	17.5	20.0	

Project implementation period: January 2006 – December 2010
Expected effectiveness date: 01/01/2006 **Expected closing date:** 06/30/2011

[1] DfID's funding is only for 2006. Future flows to be confirmed by November 1, 2005

Does the project depart from the CAS in content or other significant respects? **Ref. PAD A.3**	**[ ] YES [x] nO**
Does the project require any exceptions from Bank policies? Ref. PAD Have these been approved by Bank management? Is approval for any policy exception sought from the Board?	[ ] YES [x] nO [ ] YES [ ] nO [ ] YES [ ] nO
Does the project include any critical risks rated "substantial" or "high"? Ref. PAD C.6	[X] YES [ ] nO
Does the project meet the regional criteria for readiness for implementation? Ref. PAD D.6	[x] YES [ ] nO

Project development objective Ref. PAD B.2

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

Project description Ref PAD B.4, Technical Annex 4

Policy, Advocacy and Enabling Environment. Reviewing, formulating and enforcing policies to protect the rights of persons living with HIV/AIDs and/or people affected by HIV/AIDS, including creating an enabling environment and carrying out activities to empower and assist persons living with HIV/AIDS, orphans and vulnerable children; coordinating and implementing the national response to HIV/AIDS; and decreasing vulnerability of target groups to infection through support and advocacy.

Coordination and Management of the Decentralized Multi-Sectoral Response. Coordinating and managing the Ministries, Departments and Agencies (MDAs), Regional AIDS Committees (RACs), Metropolitan, Municipal Assemblies (MMAs), and District AIDS Committees (DACs) in implementing their programs. This includes defining roles and responsibilities at central, regional, district and community levels; supporting key agencies to develop, implement and monitor activities; helping to develop HIV/AIDS sectoral plans, workplace interventions and staff training. The components also includes advocacy to increase political commitment through sensitization programs, development of annual plans of work and improved information flows at central, regional, district and community levels.

Mitigating Economic, Socio-Cultural and Legal Impacts. Carrying out of activities aimed at mitigating the impact of the HIV/AIDS epidemic on vulnerable social groups, including provision of educational support and training for orphans and vulnerable children, development of income generation activities for vulnerable households, provision of community-based and institutional care for orphans, and provision of psycho-social support for affected families, including legal support.

*P*revention and Behavior Change Communication. Developing and implementing activities aimed at bringing about behavioral change among at-risk groups, including in-school youth and mobile populations. Program would include: promoting utilization of quality sexually transmitted infection services, voluntary counselling and testing; and prevention of mother to

child transmission, encouraging private enterprise partnership, minimizing the risk of HIV transmission through blood and blood products, delaying the median age of sexual debut, promoting utilization of condoms during higher risk sexual encounters, and reducing occupational exposure to HIV and other infections. Treatment, Care and Support. Scaling up anti retroviral therapy, voluntary counselling and testing, management of sexually transmitted infections, opportunistic infections, home-based and community care and support to maintain health and well-being of persons living with HIV/AIDS, affected families, and orphans and vulnerable children. Research, Surveillance, Monitoring and Evaluation. Carrying out of activities to enable the effective assessment of the HIV/AIDS epidemic and national response, including carrying out of biological and behavioral surveys, poverty analyses, program activity and financial monitoring, and priority specialized studies. Resource Mobilization and Funding Arrangements. Establishing a flexible funding arrangement for mobilizing and channelling HIV/AIDS resources for the national response; streamlining the budgeting process for HIV/AIDS resources; establishing an effective targeting and resource allocation process; strengthening financial management and monitoring; and carrying out of procurement and financial audits.
Which safeguard policies are triggered, if any? Ref PAD D.5 Technical Annex 8 The project contains risks associated with the handling and disposal of medical waste and general health waste.
Significant, non-standard conditions if any, for: Ref. PAD D.7 Board Presentation: None Loan/Credit effectiveness: None Disbursement: None
Covenants applicable to project implementation: Ref. PAD D.7 (i) The Annual Program of Work for the respective fiscal year has been approved by IDA and other pooled funding partners. (ii) The Borrower shall: (a) not later than January 1, 2006, ensure that the national budget includes provisions for full funding of all non-salary operating costs of the GAC Secretariat; (b) not later than December 1, 2006, adopt a sustainability plan for the GAC, acceptable to the Association, and thereafter implement the measures identified in said plan and (c) not later than January 1, 2008, ensure that the national budget includes provision for full funding of all salary costs of the GAC Secretariat

A. STRATEGIC CONTEXT AND RATIONALE

1. COUNTRY AND SECTOR ISSUES

The first case of AIDS in Ghana was diagnosed in 1986, and by the year 2004 an estimated 380,000 adults and 14,000 children were HIV-positive (UNAIDS, 2004). By 2004, the cumulative number of people diagnosed with AIDS was 36,000. Prevalence rates increased from an estimated 2.6 percent in 2000, to 3.6 percent in 2003, and 3.1 percent in 2004 (National AIDS/STD Control Program, GHS, 2005).[2] The nature of the epidemic in the country has exhibited a different pattern from that found in Eastern and Southern Africa where prevalence rates have exceeded 25 percent within a short period.

Considerable variations also exist by geographic region, gender, age, occupation, and, to some degree, urban-rural residence. According to the 2003 sentinel surveillance report based on clients of antenatal clinics, prevalence rates in the country's ten regions varied from below 2 percent in the Upper West Region to around 4 percent in Greater Accra, to almost 7 percent in the Eastern Region. These regional data remain very similar in the 2004 Sentinel Survey. Eight of the 30 sentinel surveillance locations reported prevalence of more than 5 percent in 2003, and six of 35 sites in 2004. These pockets of high rates indicate that "severe epidemics, by Ghana standards, are raging in various non-contiguous parts of the Country" (Ghana AIDS Commission, 2002).

Females are estimated to be 1.3 times more likely to become infected than males. This sex ratio has declined sharply since the early stages of the epidemic when it was around 3:1, still indicating that the risk of infection for females is higher than males (National AIDS/STD Control Program, GHS, and MOH, 2003). The 2003 DHS found that females who are widowed, divorced or separated have significantly higher rates than those who were in marital unions. Similarly, the DHS found that females with two or more sexual partners in the last year had HIV infection rates three times higher than females with only one partner.

Cote et al. (2004) have estimated that transactional sex accounts for about 84 per cent of HIV infections among males aged 15–59 years in Accra. In addition to sex workers and their clients, other groups believed to have above-average prevalence rates include uniformed service personnel, teachers, and miners, prisoners, long-distance truck drivers, national service volunteers, cross-border traders, and female long-distance traders (Anarfi et al., 1997 cited in Ghana AIDS Commission, 2003). Female STI clinic attendees at Adabraka (in Accra), a clinic that also serves sex workers in Greater Accra Region, had a prevalence rate of 39 percent in 1999, reinforcing the well documented close association between HIV and other sexually transmitted infections. The 2003 GDHS results show high rates of infection among employed middle income groups. This differs from the prevailing view of the epidemic being associated with poverty. There is, therefore, an emerging trend which needs to be understood and which will require new thinking and strategies about target groups.

[2] In contrast, prevalence rates in Southern and Eastern Africa expanded much more rapidly over the same period, exceeding 25 percent in some countries. Neighboring Cote d'Ivoire has shown still another pattern, generally maintaining a rate between 10 and 15% for most of the period.

2. THE NATIONAL STRATEGY

Ghana is preparing its second poverty reduction strategy paper – known as the Ghana Poverty Reduction Strategy. The goal of the GPRS II is "to achieve accelerated and sustainable shared growth, poverty reduction, promotion of gender equality, protection and empowerment of the vulnerable and excluded within a decentralized, democratic environment."[3] Attention to the HIV/AIDS epidemic is a key part of that strategy both for growth and for addressing issues of vulnerability.

The attention to the growth in the GPRS II is along the lines with the new policy developed in the World Bank's Africa Action Plan. HIV/AIDS has a negative impact on productivity, loss of productive assets, high treatment costs and the break in the transfer of valuable livelihood knowledge from one generation to the next.

Ghana's strategy for addressing HIV/AIDS is presented in its National Strategic Framework. This project will support the national strategy as outlined in the NSF II. Implementation of the NSF II is referred to as the "national response" to distinguish the entire strategy from smaller, more targeted projects.

The second National Strategic Framework for combating HIV/AIDS has been prepared (NSF II 2006-2010) and sets the stage for an expansion of efforts, including creating a supportive environment, preventing new infections, targeting behavior change programs to specific vulnerable groups, and expanding treatment, care and support. The NSF II was developed using a participatory and consultative process which enabled partners and other stakeholders to "buy into" the program from the outset, therefore, ensuring a strong degree of commitment and support during its implementation.

The strategy is based on maximizing efforts to reduce the rate of new HIV infections among the general population, with appropriate attention to those at highest risk, while reducing HIV/AIDS morbidity and mortality by expanding access to care, support and antiretroviral treatment. The primary goal is to integrate HIV prevention and treatment activities in a comprehensive, combined response to maximize synergies.

Proven prevention interventions in Ghana that will continue to receive emphasis include mass media campaigns, VCT services, peer counseling for sex workers, school-, youth- and workplace-based programs, condom promotion and distribution, treatment for STIs, PMTCT, blood safety, and universal precautions to prevent infection. Since increased uptake of VCT services where HAART is available has been shown to enhance broader prevention effectiveness, special emphasis will be given to scaling up VCT services. By involving communities in the scale-up of treatment access, strengthening local NGOs and linkages to existing and planned community mobilization efforts, crucial opportunities will be created for increasing community involvement in prevention activities. These interventions will substantially reduce the resource needs for treatment in the long term.

[3] Ghana Poverty Reduction Strategy II, Final Draft, September 2005

3. STRATEGIC ALIGNMENT WITH THE CAS, PRSP, MDGS AND THE HEALTH SECTOR PROGRAM OF WORK

Current CAS: 27838-Gh Board Discussion date: March 16, 2004

As mentioned above, the proposed project is entirely consistent with the GPRS II. Ghana recognizes that HIV/AIDS, a public health priority, is also a development issue and that poverty reduction strategies must be linked if national development goals are to be reached. This is in line with the most recent CAS of providing services for human development and strengthening growth. The country's priorities match those of the UN MDG strategy, specifically Goal 6, which is to halt and begin to reverse the spread of HIV/AIDS by 2015. Under the WHO 3x5 initiative, Ghana has committed to treating 29,000 PLWHA, or 50% of people in need of treatment.

4. RATIONALE FOR BANK INVOLVEMENT

In Ghana, the Bank has several comparative advantages in the fight against HIV/AIDS. First, the Bank is a multi-sectoral institution which facilitates addressing the epidemic in the multi-sector approach as is required. The Bank's expertise in macro-economics and close relationship with the Ministry of Finance and Economic Planning are added advantages. The Bank is a leader in the movement towards donor harmonization and therefore best positioned to begin to develop a programmatic approach for addressing HIV/AIDS. This will be, however, the last project the Bank will finance that is especially targeted to HIV/AIDS.

5. COMPLIANCE WITH REPEATER REQUIREMENTS

Compliance with basic repeater requirements[4]. The on-going GHANA AIDS Response Fund (GARFUND) has been rated satisfactory for implementation progress and achievement of development objectives (DOs) in all Project Status Reports (PSRs) and Implementation Status and Results reports (ISRs) (see Annex 4B for more detail on this Project). Data show that the impact of the project has been consistent with those in the PAD. There are no unresolved fiduciary issues, or any identified environmental, social or safeguard problems. M&E has been rated highly satisfactory over the past two years.

A joint Government and Development Partner mid-term review of the 2000-2005 National Response was completed in June 2004. At the same time, the Bank was carrying out an Interim Review of the Multi-Sectoral HIV/AIDS Program (MAP) by visiting selected countries, one of which was Ghana. Both reviews found that the Ghana AIDS Commission (GAC), the implementing agency for the GARFUND, had effective capacity to expand its role beyond the goals and objectives of the GARFUND. The reports also suggested that further harmonization between development partners and stakeholders would improve the national response.

[4] OPCS Guidelines

Compliance with MAP repeater requirements[5]. Ghana satisfies the requirements to be a MAP repeater. The Ghana AIDS Commission (GAC), the main partner in this project, is coordinating the national response, leaving program implementation to stakeholders. The on-going GARFUND project has been identified as a good practice example of ensuring timely grant processing to implementing partners. A national strategic framework for 2006-2010 (NSF II) has been prepared along with a corresponding monitoring and evaluation (M&E) framework, a five-year program of work (POW) and an annual POW. The M&E system is fully operational and has been decentralized to each of Ghana's 138 districts. Decentralization of fiduciary management to the district assembly level is also envisaged under M-SHAP. This will be done in parallel to switching to output-based contracts for upcoming programs.

B. PROJECT DESCRIPTION

1. LENDING INSTRUMENT

- The M-SHAP is a Specific Investment Loan (SIL) under IDA's MAP for the Africa Region.

2. PROJECT DEVELOPMENT OBJECTIVES AND KEY INDICATORS

M-SHAP's development goals are those of the NSF II which are to:

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

3. KEY PERFORMANCE INDICATORS:

Ghana and its development partners are committed to using a single, unified set of indicators to monitor the HIV/AIDS activities. The objective is to harmonize the indicators and the monitoring and evaluation (M&E) systems used for the Global Fund, UNGASS, the GPRS, the Health SWAp, and the GAC-led national response. The following key performance indicators (KPIs) have been agreed upon.

Key Performance Indicators[6]

No.	Indicators
1.	HIV prevalence among people aged 15 – 19 years.
2.	HIV prevalence among young people aged 15 – 24 years.
3.	% of infants born to HIV – infected mothers who are infected.
4.	Median age at first sex.
5.	% of women and men who have had higher risk sex in the past 12 months.
6.	% of men and women aged 15 – 49 reporting the use of a condom during higher risk

[5] Africa Region MAP 2 repeater requirements, 2004.
[6] Data on sources, baselines, and targets for the KPIs are in ANNEX 2

	sex.
7.	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14.
8.	% of people with advanced HIV infection receiving antiretroviral combination therapy.
9.	% of total national HIV/AIDS funds spent on prevention activities for selected vulnerable groups (CSW, MSM, prisoners).
10.	Execution rate of total HIV/AIDS allocation of the key ministries, departments and agencies. (MOE, MOH, MOMP, MOLG, Dept of Social Welfare, MOWAC)

4. PROJECT INTERVENTION AREAS

The project will support the seven areas which comprise the national response as described in NSF II and 5-year POW. Namely:

Policy, Advocacy and Enabling Environment. Reviewing, formulating and enforcing policies to protect the rights of persons living with HIV/AIDs and/or people affected by HIV/AIDS, including creating an enabling environment and carrying out activities to empower and assist persons living with HIV/AIDS, orphans and vulnerable children; coordinating and implementing the national response to HIV/AIDS; and decreasing vulnerability of target groups to infection through support and advocacy.

Coordination and Management of the Decentralized Multi-Sectoral Response. Coordinating and managing the Ministries, Departments and Agencies (MDAs), Regional AIDS Committees (RACs), Metropolitan, Municipal Assemblies (MMAs), and District AIDS Committees (DACs) in implementing their programs. This includes defining roles and responsibilities at central, regional, district and community levels; supporting key agencies to develop, implement and monitor activities; helping to develop HIV/AIDS sectoral plans, workplace interventions and staff training. The components also includes advocacy to increase political commitment through sensitization programs, development of annual plans of work and improved information flows at central, regional, district and community levels.

Mitigating Economic, Socio-Cultural and Legal Impacts. Carrying out of activities aimed at mitigating the impact of the HIV/AIDS epidemic on vulnerable social groups, including provision of educational support and training for orphans and vulnerable children, development of income generation activities for vulnerable households, provision of community-based and institutional care for orphans, and provision of psycho-social support for affected families, including legal support.

Prevention and Behavior Change Communication. Developing and implementing activities aimed at bringing about behavioral change among at-risk groups, including in-school youth and mobile populations. Program would include: promoting utilization of quality sexually transmitted infection services, voluntary counselling and testing; and prevention of mother to child transmission, encouraging private enterprise partnership, minimizing the risk of HIV transmission through blood and blood products, delaying the median age of sexual debut,

promoting utilization of condoms during higher risk sexual encounters, and reducing occupational exposure to HIV and other infections.

Treatment, Care and Support. Scaling up anti retroviral therapy, voluntary counselling and testing, management of sexually transmitted infections, opportunistic infections, home-based and community care and support to maintain health and well-being of persons living with HIV/AIDS, affected families, and orphans and vulnerable children.

Research, Surveillance, Monitoring and Evaluation. Carrying out of activities to enable the effective assessment of the HIV/AIDS epidemic and national response, including carrying out of biological and behavioral surveys, poverty analyses, program activity and financial monitoring, and priority specialized studies.

Resource Mobilization and Funding Arrangements. Establishing a flexible funding arrangement for mobilizing and channelling HIV/AIDS resources for the national response; streamlining the budgeting process for HIV/AIDS resources; establishing an effective targeting and resource allocation process; strengthening financial management and monitoring; and carrying out of procurement and financial audits.

5. LESSONS LEARNED AND REFLECTED IN THE PROJECT DESIGN

The following recommendations from the 2004 Ghana MAP Interim Review and the Joint Review of Ghana's National HIV/AIDS Response (June 2004), have been taken into account in the design of M-SHAP.

Priority should be on targeted interventions for high risk groups. Currently, HIV prevalence in Ghana is highly concentrated among certain high-risk groups such as commercial sex workers, and those living in "hot spots." (e.g. border towns with bars and restaurants with a large transient population.) Evidence from other countries at the same stage of the epidemic shows that reducing the spread of the infection among these high risk groups significantly attenuates wider scale heterosexual transmission. Evidence from the GARFUND shows that targeting of high risk groups and high prevalence areas is feasible. For this reason, it is envisaged that activities proposed in the 2006 POW will focus on such groups.

MAP program implementation is more successful in countries where the national AIDS council has defined its role as "facilitation" and "coordination" rather than "control" and "implementation." Adequate management systems are critical to coordinate the national response. A major objective of this project is to assist the GAC to assume its appropriate role. Rather than being perceived as the implementing agency of a Bank financed project, it should be perceived as a Government Commission with the capacity to manage the national response. This would include monitoring and evaluation and budgeting for the epidemic.

Ex-posts audits are necessary. Due to the decentralized nature of sub-projects, it is important that at least 25% of projects are visited at random in order to determine if funds were spent for the intended purposes. This practice will be continued during M-SHAP not only to deter any possible misuse of funds, but also to collect data for decentralized program monitoring purposes.

Linkages with the Ministry of Health must be strengthened: Linkages with the Ministry of Health need to be strengthened in order to ensure a better coordinated national response. This includes improving the planning, financing and monitoring and evaluation of HIV/AIDs activities in order to improve complimentarity and reduce overlap. During preparation of this project, an MOU has been signed by the GAC and MOH.

Monitoring and evaluation systems need to be significantly strengthened if the project is to show results. The M&E system in Ghana, while relatively good compared with other countries, could be strengthened. Intensive work has recently gone in to improving the system. Details are below.

6. ALTERNATIVES CONSIDERED AND REASONS FOR REJECTION

Stop Supporting HIV/AIDS activities. The option of stopping World Bank support for HIV/AIDS was never seriously considered. However, this is the last "project" the Bank intends to finance. In the future the Bank will continue its support for HIV/AIDS via budget support. This will be addressed in more detail at the MTR in order to ensure a smooth transition from project funding.

Supplemental funding for GARFUND. One alternative considered was to request supplemental funding for the on-going GARFUND. However, the MTR of GARFUND and the MAP Interim Review in 2004 concluded that it was urgent to move towards a more harmonized approach in Ghana to ensure more efficient use of current and future resources, reduce transaction costs, and fully empower the GAC to coordinate the National Response. The reviews also advised that the GAC move into treatment.

Supplemental funding for the health SWAp. The health SWAp is well established in Ghana and the Ministry of Health has a demonstrated capacity to manage pooled funding as is proposed under the M-SHAP. However, the MOH does not have the capacity to administer the non-clinical activities managed by the GAC. In the future, one would expect that the MOH will strengthen its health promotion and disease prevention capacity and use of local community organizations through the CHPS program in order to assume more responsibility for managing the epidemic.

Funding of HIV/AIDS programs through general budget support (PRSC). The PRSC dialogue has addressed issues such as trends in prevalence rates, targeting, decentralization of interventions and fiscal issues. However, the PRSC is most effective in those areas where there is a mature dialogue between the GOG and the partners. While this dialogue is rapidly improving in Ghana, there are still advantages to working more at the program level rather than elevating the entire HIV/AIDS program to general budget support. None the less, it is very likely that in the future financing for HIV/AIDS activities will be channelled through the general budget.

C. IMPLEMENTATION

1. PARTNERSHIP ARRANGEMENTS: PROGRESS TOWARDS ACHIEVEMENT OF "THE THREE ONES"

The "three ones" are meant to harmonize and align donor and multi-lateral activities in support of HIV/AIDS. The first of these principles – adoption of a single HIV/AIDS action framework that provides the basis for coordinating the work of all partners – has largely been achieved. The preparation of the NSF II was done is such a way that all key stakeholders participated. There is, however, no signed agreement aligning all development partners behind the NSF II. Efforts to develop one national AIDS coordinating authority, with a mandate for HIV/AIDS overall policy and coordination, has also largely been achieved with the formation of the GAC. However, a separate Country Coordinating Mechanism (CCM) which supports the implementation of the Global Fund activities continues, and responsibilities between the GAC and MOH have not always been clear. The third of the "three ones", agreement on a country level monitoring and evaluation system, was achieved for NSF I and continues for NSF II. There is a high level of commitment of the donors in all sectors in Ghana to rally around one set of government procedures. This includes not only the harmonization of donor M&E requirements, but also amongst reporting requirements in Ghana such as the GPRS and MDBS.

On-going efforts in harmonization are in line with the recent R*eport of the Global Task Team for Improving AIDS Coordination Among Multilateral Institutions and International Donors* which was completed in June 2005 outlining the way forward to address many of these harmonization and alignment problems.

2. INSTITUTIONAL ARRANGEMENTS

The following institutions, all of which had similar responsibilities in implementing MAP I, will be involved in the implementation of the M-SHAP.

The Ghana AIDS Commission (GAC). The GAC was created by Parliamentary Act No. 613 in January 2002 as a supra-ministerial and multi-sectoral advisory body to direct and coordinate the involvement of all ministries, the private sector and NGOs, and other civil society groups, in the fight against HIV/AIDS. The GAC, as the highest policy making body in HIV/AIDS, is responsible for formulating national policies and strategies, and establishing program priorities. The GAC is also responsible for mobilizing, controlling and managing resources and monitoring their allocation and utilization. The President of the Republic of Ghana and the Vice President are Chairman and Vice Chairman respectively of the GAC which consists of 47 members from line ministries, trade unions, NGOs, and other civil society organizations.

The GAC Secretariat. M-SHAP will be implemented by the GAC Secretariat which was established to implement the policy decisions of the GAC and to coordinate HIV/AIDS programs. It is the executive arm of GAC and as such is the focal point in HIV/AIDS policy research, program planning, oversight and monitoring for national, regional and district level organizations. The GAC Secretariat is divided into the following four divisions: (1) technical services, (2) policy planning, research, M&E, (3) finance, and (4) administration. It is likely that

during the implementation of the NSF II, the GAC will change as more of its functions are mainstreamed into the work of the MDAs. The project will assist with this transition, while at the same time ensuring that the GAC continue to exist, performing the fundamental activities as outlined in the Act.

The Ministry of Health. The MOH has the mandate to oversee all clinical aspects of the NSF II. The GAC and the MOH have signed an MOU in order to better define their respective roles to ensure better linkages between treatment and prevention programs.

Regional AIDS Committees (RACs). The RACs maintain oversight responsibility for the region's local level responses to HIV/AIDS in line with the National Strategic Framework as well as ensures that the district needs (such as capacity gaps) are addressed.

District AIDS Committees (DACs). The DACs are responsible for preparing and implementing their plans to address HIV/AIDS. This responsibility includes having oversight of NGOs, faith-based organizations (FBO), and CBO.

District Response Management Team (DRMT). The DRMT which is part of the DAC is an important link for the successful implementation of local level interventions to HIV/AIDS. It includes five (5) members namely district M&E focal person, District Directors of Education, Health, Social Welfare and one other, district assembly staff. DRMTs will be responsible for providing technical assistance to the DAC in the development of district HIV/AIDS plans and district program implementation, evaluation and selection of projects submitted by NGOs, FBOs and CBOs and make recommendations for funding to the DAC.

3. IMPLEMENTATION ARRANGEMENTS

Common implementation arrangements described in an MOU will allow the IDA and DFID to further streamline support and reduce transaction costs by pooling funds in a common Pooled Account managed by the GAC. A second Earmarked Account will be set up to accommodate those Funding Partners who prefer to earmark some of their funds. Both the Pooled Account and the Earmarked Account will be managed by the GAC. Only partners who contribute to the Pooled Account will be allowed to sign the MOU.

The Annual Program of Work, based on the 5-year program of work, will describe which activities are to be financed for that year. At that time, it will also be decided who will be the implementing agency. The main implementation agencies will be one of the following: MDAs, Districts, Regions, CBOs, FBOs, NGOs, or the private sector. Details of these arrangements are in Annex 6. A GAC Operational Manual, agreed to by the Funding Partners, describes specifically how these agencies will be selected, what they can finance, procurement rules, and how results will be measured.

A Partnership Forum will take place twice a year. This Partnership Forum will include development partners, stakeholders, line Ministry staff from the central, regional and district levels, NGOs and GAC. It will help to establish the priorities for the coming year, review and

endorse the annual POWs and budgets, and oversee the implementation of the annual POWs using agreed upon performance indicators as a basis for oversight.

4. MONITORING AND EVALUATION OF OUTCOMES/RESULTS

As part of the NSF I and in line with the "three ones" principles, Ghana has developed an excellent national M&E system with a corresponding National M&E Plan[7]. Monitoring and evaluation under the MAP I was consistently rated as highly satisfactory.

Institutional arrangements for M&E are in place at the regional and district levels. At the regional level, Regional Coordinating Councils (RCCs) have responsibility for M&E. At the district level there are M&E focal point (138 in all) who are responsible for visiting all funded programs in their districts and reporting back to the regional and central levels. At the community level, stakeholders are involved and participate in M&E activities through the community networks and operational research. The GAC also relies on information from other sectors (primarily health) and NSF II presents an opportunity for the GAC to strengthen sector-wide M&E by ensuring technical assistance for capacity in developing M&E plans, guidelines and tools; and collection, aggregation and use of M&E data for program refinement. The institutional arrangements for M&E are described in more detail in Annex 6.

NSF II intends to build on these achievements to further harmonize and strengthen the national M&E system. Although the data collections system is well developed, not all partners at national or sub-national levels routinely and systematically share the data they collect. Under NSF II, guidelines for reporting to GAC will be established. A central repository for M&E data will be established at GAC. Country Response Information System (CRIS) may serve as a tool. The piloted system will be expanded, and modified where necessary, to suit the country needs. CRIS will also serve as a tool for effective information sharing between the different levels, and by making information available to all stakeholders and the public. The GAC intends to explore linkages and opportunities created through other Health Information strengthening initiatives such as using planned activities of the Health Metric Network to further strengthen national HIS for HIV/AIDS care and treatment.

Indicators in the national M&E plan will be reviewed annually as part of preparation of the annual POW. The MTR of M-SHAP will take an in-depth look at a large number of completed projects to obtain some preliminary information on the impact of various programs vis a vis the National Response. Baseline data are available for all of the indicators selected for monitoring NSF II. (see Annex 1)

5. SUSTAINABILITY

Financial sustainability. GOG funding available for the health sector, which comprises most of the expenses for HIV/AIDS, is likely to increase significantly over the next five years. Ghana

[7] Ghana AIDS Commission. The National Monitoring and Evaluation Plan for HIV/AIDS in Ghana, 2001-2005 (2002)

has already increased health sector spending from 9% in 2000 to 13% in 2004[8]. The National Health Insurance Levy is expected to contribute an additional $147 million to the national health budget in 2005, its first year of operation. Another reason frequently given to demonstrate financial sustainability of these programs is that the costs of drugs is likely to continue to dramatically decrease. Finally, while the Bank and other MDBS partners may pool their existing HIV/AIDS programs into the general budget, there will other donors who will not and for whom HIV/AIDS will remain a priority.

None the less, the HIV/AIDS epidemic is unlikely to end in five year's time and earmarked donor financing is unlikely to be available at its current levels. The GPRS II and other policy documents of the GOG indicate that the level of commitment is very high. The GOG has agreed to assume the full cost of non-salary operating expenditures of the GAC starting January 1, 2006; adopt a sustainability action plan for the GAC by December 1, 2006, and finance GAC salaries starting January 1, 2008.

Institutional sustainability. The intent of the GOG is to gradually mainstream the implementation of activities of the GAC into the line ministries and district assemblies. The GAC would not be abolished, rather, it would become a lean secretariat responsible for monitoring and reporting on the national response. The GAC and DFID have supported programs for District Assemblies to improve technical and fiduciary skills in order to enable them to implement a substantial part of this program by the end of the project.

6. CRITICAL RISKS AND POSSIBLE CONTROVERSIAL ASPECTS

Risk	Risk Rating	Risk-Mitigating Measures
GAC has difficulty in assuming additional responsibilities	M	As part of the GPRS II, Government has indicated a strong commitment to continuing to build the capacity of the GAC.
GOG is unable to finance the operating costs and staff salaries of GAC Secretariat, causing implementation to slow and achievement of PDO's more difficult.	S	A sustainability plan, outlining precisely the actions that will be taken to ensure the continued functioning of the GAC following the end of the project, will be prepared. This plan will address risks such as moral hazard in GAC employees for the first two years of project implementation
Plans to integrate the activities of the GAC and MOH prove to be more difficult than expected.	M	A MOU between the GAC and MOU has been signed. And the MOH will participate in annual POW preparation
Districts lack the capacity to assume the role of administering and monitoring the small grants that have been such a		Several Development Partners provide direct financing for building the capacity of districts. The M&E system will be

[8] It is projected that government spending on health will achieve 15.1% of total government spending in 2005. Ministry of Health. The Ghana Health Sector 2005 Program of Work, January 2005 (in press).

successful part of the GARFUND. In particular, they may not have the technical capacity to ensure that programs adequately respond to needs or control misuse of funds.	M	substantially strengthened during the first year to help districts monitor progress. Pressure from the population and press to improve transparency of grant mechanisms are likely to assist Districts in monitoring of programs.
The GAC adopts a broad, population based approach rather than focusing on high risk groups/areas which diminishes the probability that the number of new infections is reduced.	S	KPIs will be closely monitored and program changes made as necessary in the preparation of the annual programs of work.
The financial commitment of some of the Funding Partners does not extend beyond two years.	N	These partners are confident that if the M-SHAP performs well, they will be able to continue financing at the same or higher levels.
Overall Risk of M-SHAP	M	

Risk Rating – H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk)

D. APPRAISAL SUMMARY

1. FINANCIAL AND ECONOMIC ANALYSIS

The five year cost for implementing the NSF II is US$ 575 million. The current commitment of the two Funding Partners is US$ 28.3million. This is expected to rise as DFID approves additional funding for 2007-2010 and other development partners, such as UNAIDS, sign the MOU and join the pool.

The "Economic Analysis of HIV/AIDS" contained in the Second Multi-Country HIV/AIDS Program (MAP2) (APL) for the Africa Region (Report No P7497) provides the economic justification for the Ghana M-SHAP. As the report indicates, HIV/AIDS undermines the three major determinants of economic growth, namely physical, human, and social capital. Most economic analyses show that the benefit of prevention and treatment of HIV/AIDS exceeds the cost, thereby meeting one objective of an economic analysis. In Ghana, there has been no analysis that compares the use of funds for HIV/AIDS as opposed to some other intervention such as malaria. However, modeling does suggest that by 2015, nearly half of the total deaths amongst 15-49 year olds will be due to AIDS. Furthermore, data indicate that HIV/AIDS in Ghana the infection has taken on a new pattern and those who are employed, middle income, and with primary or secondary education were disproportionately infected. These people are in their economically productive period and HIV infection among this population has implications for the national economy.

HIV/AIDS in Ghana also has a poverty dimension. While prevalence is highest in the second, third, and forth income quintiles, HIV/AIDS does push many either into poverty or deeper into poverty. One study showed that if poverty reduction were to continue at the same rate until 2015 as it did between 1991/92 and 1998/99, 20% of that reduction would be lost due to HIV/AIDS.

2. TECHNICAL

M-SHAP is built on the principles of internationally-accepted best practices for HIV/AIDS, taking into account Ghana's specific socioeconomic circumstances and epidemiological situation. The proposed approach is one of addressing a concentrated epidemic which will focus on targeting groups most at risk such as commercial sex workers, truck drivers, etc. In this case, experience from other countries demonstrates the effectiveness of HIV/AIDS programs that focus intensively on the core transmitters and hot spots which are driving the epidemic with an emphasis on prevention programs. Standard protocols, as recommended by UNAIDS and the World Health Organization (WHO), are being used for the provision of voluntary counseling and testing and other related counseling programs.

3. SOCIAL

Data from the National AIDS/STI Control Program show that almost two-thirds of the AIDS-reported cases are females. This imbalance may occur for a number of reasons, including the fact that women are more biologically prone to infection than men during unprotected sexual intercourse. Similarly, women are more vulnerable to other reproductive tract infections/sexually transmitted infections (RTIs)/STIs, the presence of which greatly enhances the risk of HIV infection. The project will address gender issues by ensuring that behavior change and communication programs are sensitive to gender and ensuring that messages are cross cutting and provide overlap between groups (e.g. messages on transaction sex for women's groups). Procedures have been reviewed to ensure that when districts are reviewing project proposals, a higher degree of priority will be given to those projects that will ensure participation from women and other marginalized groups.

The selection of patients to access services will be based on the principles of serving the most needy first, and ensuring that cost and other obstacles, for example, lack of transport, are not barriers. In the case of VCT services, a special effort will be made to reach out to young men, a target group that has traditionally been reluctant to access VCT services. Strategies being tested to encourage men to participate include men's nights and incentives for couples to attend. Concerted efforts will be made to facilitate access to PMTCT sites for pregnant women in rural and other deprived areas by providing transport or other incentives to make it easier for them to access services. Services for PMTCT and antenatal care and delivery for all pregnant women seen in public health facilities are free. Strategies for ensuring equity in access to services are contained in the PMTCT Manual (December 2003). The proposed targets of at least one VCT and PMTCT site per district, with additional VCT and PMTCT centers planned for purposively selected sites within high prevalence communities, described in this proposal as "hot spots," will ensure that the vast majority of Ghanaians have access to VCT and PMTCT services.

Criteria for the selection of patients in need of HAART are outlined in the national guidelines[9]. Criteria for the enrolment of patients if ARVs have been developed and feature in the guidelines and national scale-up plan. Patients with the lowest CD4 counts or in the greatest need for HAART, i.e., with one or more AIDS-defining opportunistic infection(s), will be treated first if ARVs or other resources are limited. Clinical and social criteria developed for screening patients

[9] Ministry of Health. Guidelines for Antiretroviral Therapy in Ghana (Updated March 2005).

accessing HAART will be applied equally to all clients. These strategies will guarantee equal access and ensure that cost does not constitute a barrier. The National Health Insurance Scheme will provide support for the treatment of opportunistic infections (OIs).

Participatory approach in project design and implementation. The NSF II was prepared with considerable up front stakeholder consultation. The draft was circulated throughout the country to most districts which have had an opportunity to provide feedback. In addition, GAC secretariat staff have been holding meetings in many areas of the country to engage local governments, NGOs, CBOs, and FBOs into discussions on HIV/AIDS and their potential participation.

4. ENVIRONMENT

The proposed project has been classified as category "B" for environmental screening purposes given the risks associated with the handling and disposal of medical waste and general health waste. As a repeater project, M-SHAP will make use of the existing arrangements for safeguard issues which have been designed and successfully implemented under the Health Sector Support Program (HSSP). A Health Care Waste Management Plan was developed by the MOH and approved by the Bank prior to appraisal of the HSSP. This document has been re-disclosed in the country and at the Bank Info Shop in May 2005.

Implementation of the Health Care Waste Management Policy began in 2005. Its recommendations are being piloted in two districts. In addition, standard waste management procedures have been developed for district hospitals. These procedures describe the necessary stages of managing waste (e.g. point of generation of waste, point of disposal of waste). Training modules are also being developed for health facility staff and staff of other relevant public, private and philanthropic organizations on waste segregation and disposal procedures. The Ministry of Health (MOH) has drawn up comprehensive capacity development programs on health care waste management and this covers HIV/AIDS-related generated wastes. A key element will be on public education. M-SHAP will take lessons from the implementation of the National Environmental and Sanitation Policy developed under the auspices of the Ministry of Local Government and Rural Development. The project will draw on existing capacities (e.g., within the Occupational Health and Environmental Unit of the Ghana Health Services, Environmental Protection Agency, Health and Sanitation Sub-committees of municipal and district assemblies, etc) for managing waste and ensuring compliance and enforcement of safeguard systems. The project can help minimize the danger of poor segregation and disposal of health care waste by financing the procurement, installation and monitoring of equipment and facilities.

5. SAFEGUARD POLICIES

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[ ]	[x]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[x]

6. READINESS FOR IMPLEMENTATION

The Project meets the following readiness for implementation criteria. The following documents have been prepared and cleared by Bank staff:

- The NSF II
- 5-year POW
- 2006 POW
- M&E Framework;
- Accounting and Administrative Manual
- Procurement Manual
- Procurement plan for the first 18 months of the M-SHAP
- GAC Operational Manual
- MOU between the MOH and GAC
- National Health Care Waste Management Policy and Action Plan

Key management staff are also in place and an MOU agreeing to pooling arrangements has been agreed with IDA, DFID, and GOG.

7. CREDIT CONDITIONS AND COVENANTS

Conditions of Effectiveness:

- *There are no effectiveness conditions as it is a repeater project other than the Standard General Conditions requirement for a legal opinion after signing of the DCA.*

Covenants:

- *The Annual Program of Work for the respective fiscal year has been approved by IDA and other pooled funding partners.*

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* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

- *The Borrower shall: (a) not later than January 1, 2006, ensure that the national budget includes provisions for full funding of all non-salary operating costs of the GAC Secretariat; (b) not later than December 1, 2006, adopt a sustainability plan for the GAC, acceptable to the Association, and thereafter implement the measures identified in said plan and (c) not later than January 1, 2008, ensure that the national budget includes provision for full funding of all salary costs of the GAC Secretariat.*

ANNEX 1: RESULTS FRAMEWORK, MONITORING AND EVALUATION

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

PDO	Outcome Indicators	Use of Outcome information
Reduce new infection among vulnerable groups and the general population	HIV prevalence among people aged 15-49	*To assess progress towards reducing HIV infection*
	HIV prevalence among young people aged 15-24	
	% of infants born to HIV-infected mothers who are infected	*To assess progress towards eliminating mother-to-child HIV transmission*
Mitigate the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	*To assess progress towards securing educational opportunities of orphaned children*
	% of people with advanced HIV infection receiving antiretroviral combination therapy	*To assess progress towards providing ART to all people with advanced HIV infection*
	% of total national HIV/AIDS funds spent on prevention activities for selected vulnerable groups (CSW, MSM, prisoners)	*To track national HIV/AIDS resource allocation for vulnerable groups*
Promote healthy life-styles, especially in the area of sexual and reproductive health	Median age at first sex	*To assess progress in maintaining the age at first sex in current levels*
	% of women and men who have had higher risk sex in the past 12 months	*To assess progress in reducing the percentage of people who have had higher risk sex*
	% of men and women aged 15-49 reporting the use of a condom during higher risk sex	*To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners*
All	Execution rate of total HIV/AIDS allocation of the key MDAs (MoE, MoH, MoMP, MoLG[10], Dept. of Social Welfare, MOWAC)11	*To track national HIV/AIDS budget allocations*

Intermediate results by component	Results indicators for Each Component	Use of Results Monitoring
Component 1. Policy, Advocacy and Enabling Environment		
Laws and policies on rights of the vulnerable groups operationalized	1. National composite policy index: • strategic plan • political support • prevention	These indicators are used to ascertain national commitment to HIV and AIDS

[10] Ministry of Education, Ministry of Health, Ministry of Manpower, Ministry of Local Governments.

11 Availability of data on denominator (total budget for the sector), measuring the expenditure.

[12] Ministry of Education, Ministry of Health, Ministry of Manpower, Ministry of Local Governments.

[13] Availability of data on denominator (total budget for the sector), measuring the expenditure.

	• care and support • human rights • civil society involvement • monitoring and evaluation 2. # of MDAs implementing the sector strategic plans 3. Execution rate of total HIV/AIDS allocation of the key MDAs (MoE, MoH, MoMY, MoLG[12], Dept. of Social Welfare)[13]	
Component 2. Coordination and Management of the Decentralized Response		
Intermediate results of component	*Result indicators for component*	*Use of results Monitoring*
Strengthened national and decentralized levels to coordinate, monitor and implement interventions	4. % of total national HIV/AIDS funds spent on prevention activities in selected vulnerable groups 5. % of districts using at least 1% of common funds for HIV/AIDS activities	These indicators measure commitment at the decentralized levels
Component 3. Mitigating the Social, Cultural, Legal and Economic Impacts:		
Intermediate results of component	*Result indicators for component*	*Use of results Monitoring*
Positive socio-cultural practices and beliefs that help reduce transmission identified and negative ones eliminated	6. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14 7. % of young people aged 15-24 who reject major misconceptions about HIV/AIDS transmission (stigma & discrimination); HIV can be transmitted: by sharing meals with an infected person, through mosquito bites who believe that a healthy-looking person can have HIV/AIDS 8. % of large enterprises/companies employing 30 or more people that have HIV/AIDS workplace policies and programs.	These indicators are used to ascertain stigma and discrimination
Component 4: *Prevention and Behavioral Change Communication*		
Intermediate results of component	*Result indicators for component*	*Use of results Monitoring*
Decreased risky sexual behaviors	9. Average number of sexual partners among people aged 15-49 during the last 12 months 10. % of people reporting the consistent use of a condom during sexual intercourse with a non-regular partner (aggregation by gender, residence and age (15-24, 25-49))	These indicators are used to determine sexual behaviors such as Condom use Rate of change of sexual

	11. The median age at first sex among 15-24 year-olds (by gender, residence) 12. % of sex workers with new HIV infection (past 12 months) at SW sentinel sites	partners
Intermediate results of component	*Result indicators for component*	*Use of results Monitoring*
	13. % of blood samples taken from female commercial sex workers within commercial sex worker communities that test positive for HIV on their first visit to selected sentinel sites 14. Syphilis prevalence among pregnant women (by age group (15-24, 25-49), and residence) 15. % of people aged 15-49 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (aggregation by location, gender and age (15-24, 25-49)) 16. % of teachers trained in life-skills-based HIV education and who taught it during the last academic year 17. # of clients tested for HIV at VCT sites and receiving their serostatus results in the past 12 months (by age (15-24, 25-49), district and gender) 18. % of respondents aged 15-49 who have knowledge of mother to child transmission of HIV ("Can be reduced by taking drugs during pregnancy") 19. # of centers providing PMTCT services	
Component 5: *Treatment, care and support*		
Intermediate results one per component	*Result indicators for component*	*Use of results Monitoring*
Rapidly upscale treatment care and support	20. % of HIV positive pregnant women who receive a complete course of antiretroviral therapy to prevent mother to child transmission in the last 12 months 21. # of members of PLWHA associations (proxy for number of people receiving home based care)	These indicators measure the rate of ART utilization in pregnant women and include the number of people benefiting from home based care interventions

Component 6: Research, Surveillance, Monitoring and Evaluation		
Intermediate results one per component	*Result indicators for component*	*Use of results Monitoring*
Provision of periodic status trends and changes in inputs, outputs and outcomes	22. # of HIV and AIDS researches completed and disseminated 23. % of districts submitting timely quarterly monitoring reports to GAC 24. # of districts that have undergone the PLACE methodology for identifying high transmission areas (HTA) or priority prevention areas (PPA)	These indicators measure commitment to reporting research and monitoring
Component 7: Mobilization of Resources and Funding Arrangements		
Intermediate results one per component	*Result indicators for component*	*Use of results Monitoring*
Enhanced resource mobilization	25. % of annual GOG funds allocated to HIV/AIDS 26. % of funds mobilized by GAC from external sources and disbursed over the last 12 months	These indicators measure GOG financial commitment

ANNEX 2: KEY PERFORMANCE INDICATORS: BASELINE AND TARGETS

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

LEVEL	INDICATOR	DATA COLLECTION TYPE	FREQUENCY OF COLLECTION	RESPONSIBLE ORGANIZATION	BASELINE (YEAR)	2006	2007	2008	2009	2010	REFERENCE	DEVELOPMENT GOAL [14](NSF II)
Impact assessment	HIV prevalence among people aged 15-49	Sentinel Surveillance	Annual	GHS	3.1% (2004)	3.0%	3.0%	3.0%	3.0%	3.0%	GHS/GAC	1
	HIV prevalence among young people aged 15-24	Sentinel Surveillance	Annual	GHS	2.5% (2004)	2.3%	2.2%	2.1%	2.0%	1.9% *(25% reduction)*	UNGASS global target	1
	% of infants born to HIV-infected mothers who are infected	Routine data collection system	Annual	GHS	30% (2004)	26%	24%	22%	18%	15% *(50% reduction)*	UNGASS global target	1
Outcome indicators	Median age at first sex	GDHS BSS	Every 2,5 years Biennial	GSS	F- 18.3 M-20.2 (2003)	F-18.4 M-20.3	F-18.5 M-20.35	F-18.6 M-20.4	F-18.8 M-20.45	F-19 M-20.5	GDHS	3
	% of women and men who have had higher risk sex in the past 12 months	GDHS BSS	Every 2,5 years Biennial		F – 50% M – 83% (2003)	F – 46% M – 78%	F – 44% M – 74%	F – 42% M – 70%	F – 40% M – 65%	F - 38% M - 62% *(25% reduction)*	UNGASS global target	3
	% of men and women aged 15-49 reporting the use of a condom during higher risk sex	GDHS BSS	Every 2,5 years Biennial	GSS	Adults: F-33% M-52% Youth: F – 32% M - 52% (2003)	Adults: F-34% M-54% Youth: F – 32% M - 58%	Adults: F-36% M-56% Youth: F – 32% M - 60%	Adults: F-38% M-60% Youth: F – 32% M - 62%	Adults: F-40% M-63% Youth: F – 32% M - 64%	Adults: F- 42% M-65% Youth: F - 40% M – 65% *(25% increase)*	GDHS, UNGASS for 15-24	3
Programmatic indicators	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	DHS MICS	Every 5 years Biennial	GSS GSS	0.80 (2003)	0.82	0.84	0.86	0.88	0.90	UNGASS	2
	% of people with advanced HIV infection receiving antiretroviral combination therapy	Routine reporting system	Annual	GHS	3.2% (2005)	13%	26%	42%	50%	66%	UNGASS / 3 by 5	2
	% of total national HIV/AIDS funds spent on selected vulnerable groups, excluding ART (CSW, MSM, prisoners)	National AIDS Accounts survey	Biennial	GAC	0.4% (2003)	3%	4%	6%	8%	10%		2
	Execution rate of total HIV/AIDS allocation of the key MDAs (MoE, MoH, MoMP, MoLG, Dept. of Social Welfare)	National AIDS Accounts survey	Biennial	GAC	2005 70%	75%	80%	85%	88%	90%		All

[14] Three development goals: 1) Reduce new infection among vulnerable groups and the general population; 2) Mitigate the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; 3) Promote healthy life-styles, especially in the area of sexual and reproductive health.

ANNEX 3A: SECTOR BACKGROUND[15]
GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

1. Background of the HIV/AIDS Epidemic in Ghana

The first case of AIDS in the country was diagnosed in 1986, and by the year 2004 an estimated 380,000 adults and 14,000 children were HIV-positive (UNAIDS, 2004). By 2004, the cumulative number of people diagnosed with AIDS was 36,000 (Figure 2). Prevalence rates increased from an estimated 2.6 percent in 2000, to 3.6 percent in 2003, and 3.1 percent in 2004 (National AIDS/STD Control Program, GHS, 2005).[16] The nature of the epidemic in the country has exhibited a different pattern from that found in Eastern and Southern Africa where prevalence rates have exceeded 25 percent within a short period.

Considerable variations also exist by geographic region, gender, age, occupation, and, to some degree, urban-rural residence. According to the 2003 sentinel surveillance report based on clients of antenatal clinics, prevalence rates in the country's ten regions varied from below 2 percent in the Upper West Region to around 4 percent in Greater Accra, to almost 7 percent in the Eastern Region (Figure 1). These regional data remain very similar in the 2004 Sentinel Survey. Eight of the 30 sentinel surveillance locations reported prevalence of more than 5 percent in 2003, and six of 35 sites in 2004. These pockets of high rates indicate that "severe epidemics, by Ghana standards, are raging in various non-contiguous parts of the Country" (Ghana AIDS Commission, 2002).

Females are estimated to be 1.3 times more likely to become infected than males. This sex ratio has declined sharply since the early stages of the epidemic when it was around 3:1, still indicating that the risk of infection for females is higher than males (National AIDS/STD Control Program, GHS, and MOH, 2003). The 2003 DHS found that females who are widowed, divorced or separated have significantly higher rates than those who were in marital unions. Similarly, the DHS found that females with two or more sexual partners in the last year had HIV infection rates three times higher than females with only one partner.

The 2004 Sentinel Survey showed that there was a decline in mean HIV prevalence among the 15 to 24, 20 to 24, and 15 to 49 age groups. The 15 to 19 and 25 to 29 years age group recorded a slight increase of 0.1% from the prevalence of 2003 from 1.9% to 2% and 4.4% to 4.5% respectively. The 25 to 29 year group is the age group with the highest prevalence and in the 45 to 49 age year group, out of 53 samples collected, no one was HIV positive hence the dramatic drop to 0% prevalence recorded. Among age groups 30 to 34, 35 to 39 and 40 to 44, decrease in mean HIV prevalence was observed.

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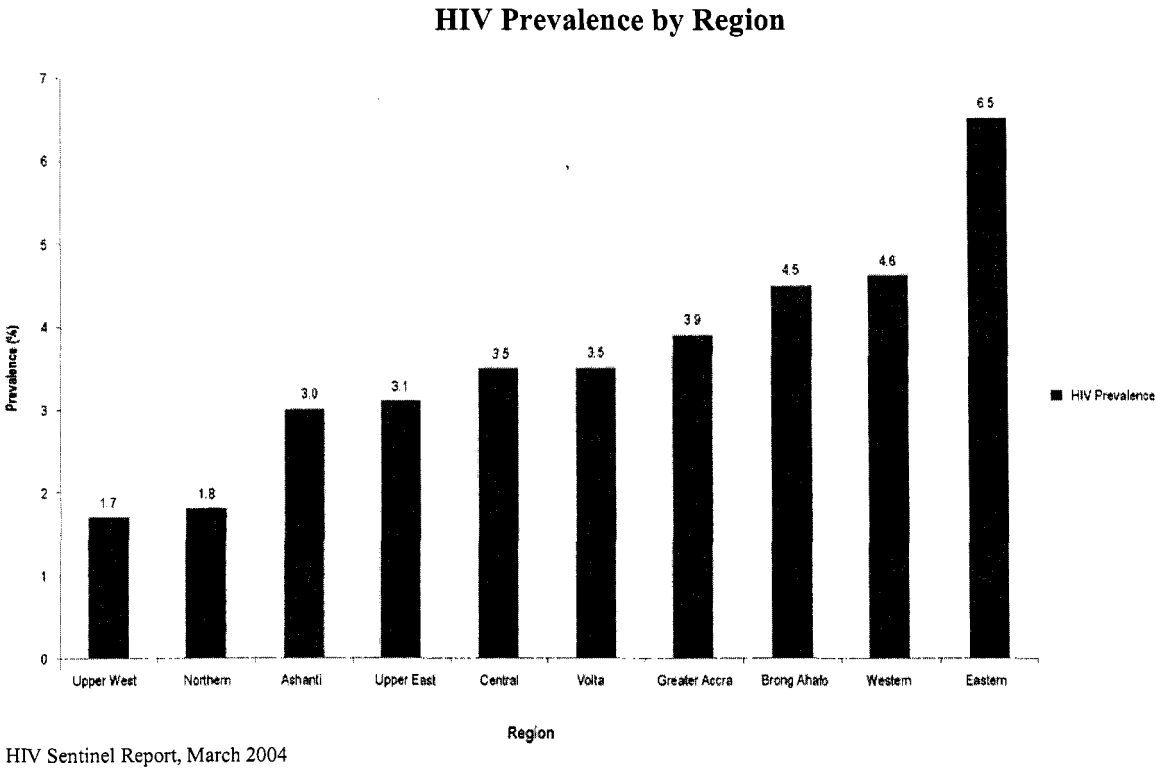
[15] This section is from the NSF II

[16] In contrast, prevalence rates in Southern and Eastern Africa expanded much more rapidly over the same period, exceeding 25 percent in some countries. Neighboring Cote d'Ivoire has shown still another pattern, generally maintaining a rate between 10 and 15% for most of the period.

Cote et al. (2004) have estimated that transactional sex accounts for about 84 per cent of HIV infections among males aged 15–59 years in Accra. In addition to sex workers and their clients, other groups believed to have above-average prevalence rates include uniformed service personnel, teachers, and miners, prisoners, long-distance truck drivers, national service volunteers, cross-border traders, and female long-distance traders (Anarfi et al., 1997 cited in Ghana AIDS Commission, 2003, p. 9). Female STI clinic attendees at Adabraka (in Accra), a clinic that also serves sex workers in Greater Accra Region, had a prevalence rate of 39 percent in 1999, reinforcing the well documented close association between HIV and other sexually transmitted infections. The 2003 GDHS results show high rates of infection among employed middle income groups. This differs from the prevailing view of the epidemic being associated with poverty. There is, therefore, an emerging trend which needs to be understood and which will require new thinking and strategies about target groups

Figure 1.



HIV Sentinel Report, March 2004

The observed patterns of high rates of five per cent or more in some areas, the male-female variations, the extremely high rates among some sections of the population and the emerging increasing rates among people in the middle income group have formidable implications for the socio-economic development of the country. As an epidemic affecting people in their productive

and reproductive ages, it will affect the number of people available for work, health, and the economy, and create an orphan population with which the existing social system may be unable to cope. Thus, if not checked, the effects of the epidemic can negate developmental efforts.

Behavioral Factors in the HIV/AIDS Epidemic

One of the clearest findings from research in the country is that there is near-universal awareness of the HIV/AIDS epidemic and this has been the case for more than a decade now. Furthermore, results from the Ghana Demographic and Health Surveys (GDHS) of 1998 and 2003 have shown that 88 percent of men and 81 percent of women knew that condoms could be used to avoid HIV/AIDS infection (Ghana Statistical Service and MacroInternational, 1999; 2004). In the 2003 GDHS survey, more than 80 per cent of men knew that a healthy-looking person could be HIV/AIDS positive. Despite widespread and generally correct information on HIV/AIDS, the majority of Ghanaians do not feel personally vulnerable to HIV infection (Ghana Statistical Service and MacroInternational, 2004) in part because many do not think of themselves as promiscuous, and do not realize that their vulnerability is related to infidelities of their spouse or partner (Appiah, Afrane, and Price, 1999). As Hochbaum (1958) demonstrated almost 50 years ago, a belief in personal vulnerability is essential to ensure appropriate preventative health behavior.

Although Ghanaians are aware of HIV/AIDS issues, knowledge of how to prevent HIV was frequently inadequate, including among some high-risk populations such as sex workers in Accra and Obuasi, male police officers in Accra, and male miners in Obuasi (Research International and Family Health International, 2001).

Results from the 2003 GDHS indicate that although some women reported being aware of the protective effect of condoms, they were not able to influence their partners to use a condom during sex due to poor bargaining power. Some women have been found to be *overconfident* in relying on fidelity as a strategy to avoid HIV/AIDS infection. Two-thirds of women indicated that AIDS can be avoided by "sticking to one partner." However, monogamous women may underestimate the threat from husbands who may not be monogamous. The cultural pattern of postpartum sexual abstinence for women, *but not for men*, promotes multiple partnerships and sexual networking which are contributing factors to the spread of HIV. Other cultural practices, such as early marriage, genital cutting, subordination of women to men, relative powerlessness in sexual decision-making, and inadequate sex negotiation skills, all contribute to women's vulnerability to HIV infection.

The proportion of men aged between 15 and 49 years who reported not having had sex in the entire year prior to the DHS survey increased from 21 percent in 1993 to 34 percent in 1998. Of those cohabitating, 79 percent of women and 62 percent of men reported they were faithful during the past 12 months. Among those who were married, 96% of women and 84% of men had no extra-marital sex over the same 12 month period. These results point to some possible behavioral changes taking place and the next generation of HIV/AIDS information and communication will include messages that aim at reinforcing these positive changes.

The Demographic Context and HIV/AIDS

Since the start of the HIV/AIDS epidemic in the 1980s, the number of people infected with HIV in Ghana has risen steadily. In 1994, an estimated 118,000 Ghanaians were living with HIV and the number more than tripled to about 400,000 by 2004. Population growth is expected to increase the incidence of HIV/AIDS over the next six years. In addition, improvement in the care and treatment of PLWHA, especially with the use of ART and HAART, will lead to improved survival. Thus, the number of PLWHA is expected to increase to about 500,000 by 2015 even if new strategies are developed to reduce the spread of the virus.

The number of new AIDS cases has increased dramatically over the last 10 years – from an estimated 5,500 in 1994 to 36,000 in 2004 (Figure 2). Both the annual number of new AIDS cases and the annual number of AIDS deaths are projected to increase to over 45,000 by 2015. In addition, the estimated number of AIDS orphans (children under the age of 15 who have lost one or both parents to AIDS related causes) is likely to double over the next 10 years – increasing from 132,000 in 2004 to 291,000 by 2015.

The results from the 2000 Population and Housing Census indicated that the country had a population of 18.9 million. Between 1984 and 2000, the population grew at an annual rate of 2.7 percent. Population density doubled from 36 persons per square kilometer in 1970 to 70 in 2000 (Ghana Statistical Services, 2002). Since 1960, the proportion of the population in urban areas has increased substantially. The proportion increased from 23 per cent in 1960, to 29 percent in 1970, to 44 percent in 2000. The increase in urban population is worth noting because, with a few exceptions, HIV prevalent rates are higher in urban areas, such as regional capitals, than rural areas.

Young people aged 10-24 years account for 30 per cent of the population while the proportion of the population aged 65 years and above is about five per cent. Life expectancy has increased from 50 years for males in 1984 to 55 years in 2000, and from 54 years for females to 60 years during the same period. These overall changes reflect persistently high but declining fertility, improvement in health conditions -- apart from HIV/AIDS – and progress in socio-economic development. These positive achievements in socio-demographic conditions can be eroded by high rates of HIV/AIDS infection.

The demographic context has implications for HIV/AIDS programming. Prevention efforts are required almost everywhere, but urban areas and other "hot spots" require additional targeted efforts. The provision of treatment, which requires substantial expansion, can reasonably start in large urban centers, and regions with higher prevalence, and spread to District Capitals and beyond as experience and resources become available. The population aged 5-14 years is frequently referred to as a "window of hope," and will require concerted effort to ensure that they remain uninfected.

The Socio-Economic Context

Ghana has made some progress in reducing poverty levels in the 1990s. Between 1991/92 and 1998/99, the proportion of the population in extreme poverty declined from 37 per cent to 27 per cent (Ghana Statistical Service, 2000). Within this national pattern, considerable poverty still exists in some areas and in pockets around the country. For instance, eight out of ten persons in the three northern regions were classified as poor in 1998/99. Within regions and urban areas, pockets of extreme poverty exist. The general observation is that poverty and other economic pressures on individuals constitute pre-disposing factors for HIV infection. For example, unemployment, limited job opportunities and the rising cost of living are aspects of the poverty cycle that promote rural-urban migration of young people, transactional sex and early sexual relations (Tanle, 2003).

The available evidence indicates that over 70 per cent of HIV/AIDS infected persons are aged 20-39 years due mostly to high sexual risk-taking behavior by individuals or their partners/spouses. Results from the 2003 GDHS also points to a new pattern of infection. According to the results, employed, middle income persons and those with primary or junior secondary education were disproportionately infected (Ghana, 2004). These are people in their economically productive period and HIV infection among this population has implications for the national economy. It will affect the proportion of the population available for work, training, and the pace of work. The economic costs of HIV/AIDS to employers in terms of care, absenteeism and retraining, is high and will continue to increase if the trend is not reduced. Thus, the current pattern of HIV/AIDS infection poses a threat to the economy of the country.

HIV/AIDS also impacts on both the supply and demand aspects of education. The gains made in the education sector, such as an increase in the proportion of children in school will be difficult to sustain if an increase in HIV/AIDS cases among teachers reduces their availability. HIV/AIDS among teachers can put adolescent females at risk due to sexual relationships between male teachers and female students (Social Surveys Africa and Health Development Africa, 2004). As more adults become infected, their children are likely to drop out of school because these children will be required to care for sick family members and/or may not be able to pay for their up-keep in school.

Ghana has a highly mobile population. Rural-urban migration, particularly by young people in search of non-existent jobs, leaves them stranded in cities and thus further exposes them to the risk of transactional sex. Street children are vulnerable as transactional sex is common among them (Anarfi, 1997). There is also rural-rural migration which exposes migrants to new lifestyles, including transactional sex, if they are young adults who travel alone. Long distance drivers, uniformed service personnel and itinerant traders are believed to be particularly exposed to the risk of casual sex (and sex as a component of business deals), and hence HIV/AIDS infection.

The country has a diverse ethnic and cultural composition, leading to differing cultural practices and perspectives on social issues. In spite of these differences, there are common features such as strong communal and family support based on the extended family system. In recent times, particularly with urbanization and the consequent rural-urban migration and Westernization,

these systems are breaking down, resulting in the development of nuclear families. A side-effect of this process emerging in some parts of the country is the inadequate social and family support for PLWHA and people affected by HIV/AIDS.

Gender issues are basic to confronting the HIV/AIDS epidemic. Women frequently suffer from relative powerlessness compared with men. As a result, women and girls are often subjected to humiliating practices, while some experience subjugation from relations, boyfriends, partners, and husbands. This powerlessness makes it difficult for girls to decline sexual advances from older males, such as teachers, without facing coercion, violence or retaliation (Health Development Africa, Social Surveys Africa, 2004). The conditions also limit women's ability to access a wide range of services or make decisions about their lives. Therefore, gender equity is critical to assuring women's empowerment in sexual and economic matters, as well as full access to information and services that can help reduce vulnerability to infection or mitigate the effects of AIDS.

Other socio-cultural factors such as stigma, discrimination, and denial make the care and support for PLWHA and those affected by HIV/AIDS a daunting challenge. Polygamy, and sexual attitudes and beliefs which underlie gender inequalities, make it difficult for women to negotiate on issues about sex, reproduction and condom use, or to influence the sexual networking of their partners . Prevailing belief systems about the causes of the epidemic also have implications for the reporting and management of infection. For example, people immediately associate HIV/AIDS infection with a promiscuous lifestyle even in cases of faithful wives infected by their husbands (Appiah, Afrane, and Price, 1999).

The costs of providing health care for opportunistic infections for AIDS patients, and increasingly for antiretroviral therapy, will make substantial demands on the health care system which will affect health care for the general public. In rural areas especially, the rising number of AIDS orphans will put enormous pressure on households and communities. Thus, HIV/AIDS infection will put severe stress on families, the social system, the health sector and the economy.

5. The Political and Policy Environment

The country has the benefit of continuing political commitment to HIV/AIDS issues. The President serves as Chairman of the Ghana AIDS Commission (GAC), providing it the highest mandate. The Commission consists of the President as Chairman and up of 15 Ministers of State and other stakeholders, and is serviced by a Secretariat. A Steering Committee provides the technical backstopping for the activities of the Secretariat. The GAC regularly conducts its work through technical committees which are composed of experts and representatives from stakeholders, including MDA, development partners, NGO, and Civil Society organizations (CSO).

The establishment of the GAC followed the development of the first National HIV/AIDS Strategic Framework of 2001-2005. GAC was set up in 2001 by Act 613 of Parliament as a supra-ministerial body under the Office of the President to coordinate the multi-sectoral national

response to HIV/AIDS. Since its creation, the GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation, research, and has provided strategic vision for the coordination of the national response. Much of these have been achieved through strong political support to the national response, the establishment and use of decentralized institutional structures, enactment of supportive policies and legislation and widespread participation of civil society.

The 1992 Fourth Republican Constitution guarantees the protection of the right to life (Act 13); the right to the protection of personal liberty (Act 14); the right to respect for human dignity (Act 15); and the right to equality and freedoms. Article 37(4) also mandates the Government to enact laws on population whenever necessary. The Ghana Poverty Reduction Strategy of 2003 (Government of Ghana, 2003), which is the blueprint for the country's human and socio-economic development, also highlights the need for improved quality of life and expansion of opportunities for all members of society under its human development component.

The National Population Policy (Revised Edition, 1994) emphasizes the harmful effects of STD/HIV/AIDS and calls for the institution of appropriate measures to prevent and control the epidemic. Numerous other policies make an explicit or implicit reference to HIV/AIDS in Ghana. These include: the National Youth Policy which identifies the provision of services to young people living with HIV/AIDS as a priority; Adolescent Reproductive Health Policy that has as one of its objectives the implementation of programs aimed at reducing STD/HIV/AIDS; the Reproductive Health Standards and Protocols; the Labor Bill; the National HIV/AIDS/STI Policy, Policy Guidelines on Orphans and Vulnerable Children, Gender and Children Policy, the National Work Place HIV/AIDS Policy; draft Policies on Ageing and Gender; and Affirmative Action Policy Guidelines to facilitate a process of ensuring gender equality and empowerment of women in all aspects of life. Finally, experiences from NSF I and a Joint Review Report on the National Response have inspired the development of this new NSF II (Ghana AIDS Commission, 2004b).

6. Ghana and Its International Commitments in the Context of HIV/AIDS

The Government has either signed or subscribed to a number of continental and international treaties, conventions and declarations on HIV/AIDS. It has endorsed The Abuja Declaration of 1998 and The Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. As a signatory to the two Declarations, Ghana re-affirmed its commitment to HIV/AIDS, including protection of PLWHA from discrimination under the section on HIV/AIDS and Human Rights. In fulfillment of its commitment to UNGASS, indicators on HIV/AIDS activities have been submitted to UNAIDS. At the 2003 African Union Meeting in Maputo, all Heads of State, including Ghana's, renewed their commitment to reduce the impact of the epidemic. Commitments to these obligations have informed some of the strategies that have been adopted so far.

Among the international conventions which have implications for the management of HIV/AIDS and which Ghana has endorsed are the Universal Declaration of Human Rights, the International

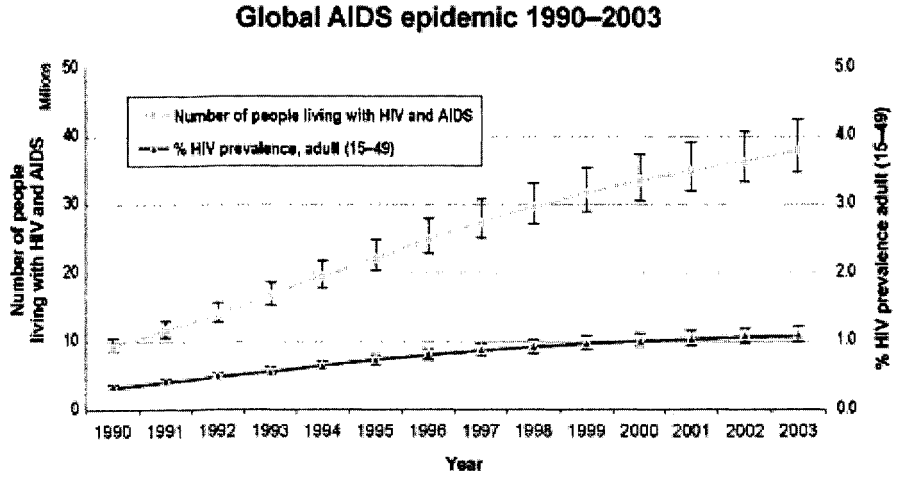
Convention on Economic, Social and Cultural Right, the African Charter on Human and People's Rights, Convention on the Elimination of all forms of Discrimination against Women (CEDAW), NEPAD Declaration, and the Convention on the Rights of the Child (CRC). Ghana was the first country to sign the latter, indicating strong commitment to the rights of children.

7. The Challenge of HIV/AIDS

UNAIDS reports that, in 2004, there were 4.9 million new HIV infections, which was more than in any year before. Some 39.4 million people are living with HIV/AIDS, which killed 3.1 million in 2004, and over 20 million since the first cases of AIDS were identified in 1981 (UNAIDS, 2004a). Available evidence indicates that about 60 percent of infected persons and nearly 80 percent of all new infections are in sub-Saharan Africa. The infection is at its peak in a continent which is the least developed, making it an epidemic associated with poverty and under-development. It is partly within this context that the Millennium Goal 6 seeks to address the problem of HIV/AIDS, malaria and other diseases.

Since 2002, both multilateral and bilateral agencies have renewed their commitment to fighting the epidemic. Donors have considerably increased their funding and are also exploring innovative ways to channel resources to where they are most needed to combat HIV/AIDS more quickly and efficiently. The cost of antiretroviral medicines has decreased considerably, and concerted efforts are being made to extend treatment to millions of people in low- and middle-income countries. Together, many of these approaches are making a difference in curbing the spread of HIV and restoring quality of life to infected people and their families.

Figure 2.



Source: UNAIDS/WHO, 2004

Experience has shown that the natural course of the epidemic can be changed with the right combination of leadership and comprehensive action. Forthright national leadership, widespread public awareness and intensive prevention efforts have contributed to decline in new HIV infections in some countries. At the same time, we now have antiretroviral medicines that can prolong life and reduce the physical effects of HIV infection. Coordinated national and international action has greatly reduced the prices of these medicines in low- and middle-income countries. Associations of people living with HIV have become global force and are providing leadership in responding to the epidemic in a number of countries (UNAIDS, 2004a).

Recognizing the possible impact of HIV/AIDS on health and socio-economic development generally, Government seeks to respond to the epidemic through this Second National Strategic Framework for the period 2006-2010.

ANNEX 3B: MAJOR RELATED PROJECTS FINANCED BY THE BANK AND/OR OTHER AGENCIES

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

World Bank

The World Bank has helped finance or co-finance three HIV/AIDS programs to date in Ghana.

1. World Bank MAP 1 (Ghana AIDS Response Fund 1, GARFUND 1)
2. World Bank Abidjan-Lagos Corridor Project
3. World Bank Treatment Acceleration Project (TAP)

World Bank MAP 1 (Ghana AIDS Response Fund 1, GARFUND 1) - $27.8 million (2001-2005)
Credit

This 4-year program aims to reduce the spread of HIV infection and reduce the impact of AIDS on those infected and their families through a balanced, diversified, multi-sector response, engaging all government sectors, non-government organizations, and grassroots initiatives, civil society organizations, including NGOs, CBOs, trade and professional associations, PLWHA associations, districts, and key line ministries other than MOH to complement MOH's ongoing program and ensure a rapid, multi-sector scaling up of activities in all regions of the country and at all administrative levels. Main activities are prevention, care and support activities for those affected, and prioritizing community-level responses. The MAP 1 program is being implemented by the Ghana AIDS Commission. The bulk of activities are being conducted by NGOs and civil society organizations.

World Bank Abidjan-Lagos Transport Corridor Project - $12.9 million (2003-2007)
Grant

This 5-year, multinational, 5-country program targets high-risk groups and mobile populations that travel or live beside the heavily traveled coastal corridor that runs between Abidjan-Accra-Lomé-Cotonou-Lagos. The program reaches people in border towns, drivers, traders, and commercial sex workers, especially people who frequent bars and restaurants in "hotspots" and other stopover sites, providing STI services, VCT services, using health sector facilities with management by fourth or fifth year leading to ART.

World Bank Treatment Acceleration Project (TAP) - $14.9 million (2004-2007)
Grant

TAP is a 3-year, 3-country, World Bank regional program involving Burkina Faso, Ghana and Mozambique designed to test approaches for 1) scaling up HIV/AIDS care and treatment service delivery at the country level, 2) strengthening institutional capacity for expanding HIV/AIDS

care and treatment, and 3) facilitating regional learning from TAP country experiences via WHO and UNECA. The program is being implemented in four high HIV prevalence regions in Ghana (Eastern, Ashanti, Western, Greater Accra). The bulk of financial support is for scaling up service delivery ($9.9 million) via sub grants to NGOs and IPs (63%), with $5.7 million (37%) allocated to strengthening institutional capacity and piloting approaches for scaling up, knowledge sharing and information dissemination.

Global Fund Round 1 - $14,170,222 (January 2003-December 2007)

Ghana's Round 1 proposal for accelerating access to prevention, care, support and treatment of all persons affected by HIV/AIDS was approved by the Global Fund at $14.2 million over 5 years, with a 2-year grant agreement of $5.0 million. Year 1-2 disbursements received to date from the Global Fund, $3.6 million of $5.0 million, have enabled Ghana to scale up HIV/AIDS services, especially HAART, at the first 4 sites, especially Korle-Bu and Komfo Anokye teaching hospitals. Receipt of the balance of Year 1-2 disbursements for Round 1, $1.4 million, combined with $9.2 million for the 3-year Phase II extension, 2005-2007, will enable Ghana to procure additional ARVs and commodities and extend the scale-up to 10 regional hospitals. ARVs will account for 37%, 47% and 76% of planned expenditures in 2005, 2006, and 2007, as treatment is scaled up, while training costs will decrease from 16%, 14% to 5% during the same period. DFID and JICA are also supporting the expansion of HIV/AIDS services to regional hospitals, DFID with $6.4 million for systems support, 2004-2005, and JICA with $870,000 for CD4 machines and consumables. However, this expansion of HAART to regional hospitals would not be possible without Global Fund support for the purchase of ARVs.

Other multilateral programs

The majority of other multilateral programs for HIV/AIDS currently underway or planned in Ghana are conducted by U.N. agencies, especially UNICEF, UNDP, UNFPA, UNAIDS and WHO. In 2005, it is estimated that these agencies will invest $5 million of their own resources in the national response to HIV/AIDS, an increase of 10% over 2004. Many U.N. programs in Ghana are co-financed by bilateral donors. Contributions by bilateral donors towards activities sponsored or undertaken in whole or in part by U.N. agencies are counted separately.

Bilateral donors

Financial support for HIV/AIDS activities in Ghana from bilateral donors totaled $25 million in 2005, with major support from DFID ($12.5 million), USAID ($7 million per year), Dutch ($2 million), JICA ($1 million), CIDA ($400,000), European Union ($300,000), GTZ ($300,000), and DANIDA ($200,000). Many of these countries, especially DFID, Dutch, DANIDA, and European Union, are important contributors to the Ghana Health Fund, another resource for HIV/AIDS[17]. JICA and USAID also provide additional support for the national health budget

[17] Donor inflows to the Health Fund for 2005 are projected at $66.7 million. Ministry of Health. The Ghana Health Sector 2005 Program of Work, January 2005 (in press).

with earmarked funds. Despite many programs targeted to scaling up HIV/AIDS services, including VCT, PMTCT, STI services, and HIV/AIDS treatment, care and support, no bilaterally-funded HIV/AIDS program to date in Ghana has provided for the procurement of ARVs or other HIV/AIDS drugs, a key funding gap which needs to be filled. On the other hand, current and planned activities funded by bilateral donors will be essential to supporting the "pull through" of scaling up HAART and other HIV/AIDS services, such as the USAID-financed SHARP program (Strengthening HIV/AIDS Response Partnerships).

ANNEX 4: DETAILED PROJECT DESCRIPTION

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

The M-SHAP will support the areas of intervention outlined in the 2006-2010 NSF, as defined and budgeted for in the Annual POWs. The main goals of the 2006-2010 NSF II are to reduce new infections among vulnerable groups and the general population; mitigate the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; and promote healthy life-styles, especially in the area of sexual and reproductive health. These goals will be met by focusing on seven key intervention areas (see below), for which the GAC Secretariat acts either as a coordinator/implementer or as a financier through the HIV/AIDS grants making windows where the majority of M-SHAP funding will go. Funds from DFID, and IDA will be disbursed into the Pooled account, to finance those elements of the annual POW that are **not** being funded by earmarked funding, or through the parallel financing of interventions outside of GAC. Distribution of funding among the key intervention areas is indicative, since final allocations will depend on the priorities as identified in the annual POW.

Project Component 1: Policy, Advocacy and Enabling Environment – US$ 4 million

The favorable socio-political environment within the country inspired the development of NSF I and NSF II. The 1992 Constitution recognizes and affirms the basic rights of citizens. The President also serves as the Chairman of the Ghana AIDS Commission, and the involvement of key Ministries, the private sector, traditional and religious leaders and civil society have helped to create a favorable response to the epidemic. One of the challenges is the utilization of this social and political commitment in the development and implementation of effective programs and activities. Some of the intended programs are likely to be controversial and require social and attitudinal change in diverse areas such as enforcement of laws against stigma and discrimination, norms regarding transactional sex, and multiple sexual partnerships. NSF II recognizes the need to develop and operationalize laws and policies to protect the rights of PLWHA, meet the challenges posed by stigma and discrimination, as well as new demands involved in expanding prevention, treatment, care and support. Advocacy and social mobilization will constitute important tools in addressing socio-cultural issues such as eliminating stigma and discrimination against PLWHA and improving the rights and status of women, orphans and other vulnerable persons.

PLWHAs will play an important role in the development and execution of many of the activities under this component partly because they are the main beneficiaries and partly because they can provide the information necessary to identify areas requiring attention. The component will also empower PLWHAs and people affected by HIV/AIDS through activities to improve their skills and self-development, and to support the formation of associations or groups that can provide community support in tackling the various issues. This would also support policymakers' direct and personal involvement in the fight against HIV/AIDS, urging them towards public statements and debate on the issue. Therefore, this component will support all activities that can improve

and enforce the overall national policy environment, as well as advocacy activities, that can contribute to bringing a change in Ghanaian society for these vulnerable groups.

This intervention area will focus on the review, formulation and enforcement of policies that protect and affect the rights of PLWHAs and/or people affected by HIV/AIDS. It will also promote activities to empower PLWHAs, OVCs and other vulnerable groups by ensuring a continuous supportive socio-political environment to address the challenges faced by the vulnerable groups.

Project Component 2: Coordination and Management of the Decentralized Multi-Sectoral Response – US$ 6.8 million

Coordination and management of the national response through the decentralized system constitute key components of HIV/AIDS program implementation. The Ghana AIDS Commission (GAC) as the national coordinating body blends both political focus and technical dimensions to ensure a harmonized national response. Among the strategies needed to achieve an effective decentralized response will be the strengthening of the Ghana AIDS Commission, establishing clearly defined roles and responsibilities for all implementers and stakeholders, and capacity building of all participants – National, Regional and District levels, NGO, CBO and the private sector – to implement and monitor all the steps necessary to combat the HIV/AIDS epidemic. In NSF II the private sector, civil society, organized labor, religious and traditional leaders will be mobilized for programs and to ensure that HIV/AIDS is kept at the centre stage of the political aspects of coordination, policy direction and guidance, and the development of partnerships.

This component will promote the coordination and management by GAC to harmonise efforts and guide the various Ministries, Departments and Assemblies (MDAs), Regional AIDS Committees (RACs), Metropolitan, Municipal Assemblies (MMAs), and District AIDS Committees (DACs) in implementing their sectoral mandates and responsibilities that will compose part of the national HIV/AIDS response. This component will cover activities to strengthen the arrangements and decentralized institutional frameworks for multi-sectoral coordination of the response to the epidemic by ensuring there are clearly defined roles and responsibilities identified for all implementers and stakeholders at each level: central, regional, district, and community level. This will also include support for capacity building of key agencies to develop and implement their policies and programs in line with the 2006-2010 NSF II priorities.

Activities will include, but not be limited to: (a) the development and revision of HIV/AIDS sectoral plans for effective mainstreaming and monitoring of progress under the M&E framework; (b) workplace interventions and training of staff; (c) strategic communication for behavior change and advocacy to increase political commitment through sensitization programs; (d) and training in HIV competence for high level MDA staff; (d) the development of the annual POWs by GAC in partnership with the MDAs, MMAs, RACs, DACs, and donors; (e) provision of technical support to MDAs in mainstreaming and implementing HIV/AIDS programs for their

internal and external clientele; (f) provision of support to the RACs, MMAs, and DACs to build their capacity to coordinate and monitor activities being implemented by both government, private, and NGOs, within their region or district; and (g) improved information flow between the GAC and the different stakeholders at each level to ensure that there are no gaps in the national response.

Support will also be provided to the GAC to improve their coordination role in tracking and monitoring the HIV/AIDS activities of partners outside the decentralized government mechanism, such as international NGOs and donors, and to build GAC's capacity to mobilize resources to meet the needs of the national response.

Project Component 3: Mitigating the Social, Cultural, Legal and Economic Impacts – US$ 2.6 million

The HIV/AIDS epidemic poses a developmental and social challenge to Ghana. The spread of HIV is strongly influenced by the social, cultural and economic environment. The sexual, social and spatial milieus in which people operate, and the political structures which provide the framework for governance, have implications for the pattern of spread and the nature of responses to the epidemic. Affecting the most active, productive and the reproductive members of the society, HIV/AIDS impacts on a country in diverse ways. At the economic level it lowers productivity and increases the cost of business. The challenges involve identifying and enhancing the positive social aspects that may help to reduce transmission and mitigate the effects of the epidemic, such as reinforcing and supporting strong families and communities. At the same time, the program will identify and eliminate negative social aspects, such as the subjugation of women and other gender issues that have implications for the spread, prevention and mitigation of the impact of the epidemic. The economic impact of the epidemic is large and growing, and it will affect the national economy in many ways. Mitigating the impact of the epidemic at the societal level will involve mainstreaming HIV/AIDS into a number of national programs -- the Poverty Reduction Strategy, addressing gender-based vulnerability, domestic violence, coercion and marginalization of women -- and harmonizing some national laws with the international laws that various Governments of Ghana have signed and which have implications for the management of HIV/AIDS and rights of persons. Programs will also be pursued that will provide PLWHA with resources (e.g. micro credit) to improve their wellbeing and survival.

This component will support activities geared towards reducing the economic impacts of HIV/AIDS on infected and affected households, as well as OVCs and other vulnerable groups. It will also enhance the mechanisms for social mobilization to support activities meant to reduce the socio-cultural burden of HIV/AIDS on vulnerable and high-risk groups. The identification and adoption of socio-cultural practices, which promote relevant HIV prevention, care and support and reinforce positive behavioral change, will be critical to this component.

Activities under this component will include: (a) raising nationwide awareness of the socio-economic impact of HIV/AIDS households, families, communities, and companies; (b)

empowerment through micro-financing, education and skill development for women, PLWHAs and their families, other affected and vulnerable groups; (c) the promotion of increased private sector involvement in AIDS programming, as well as enforcement of workplace AIDS policies; (d) identification and development of strategies to mitigate or raise awareness of socio-cultural practices that have positive and negative implications for the prevention, transmission of HIV; and (e) improved attention and protection for the rights of vulnerable groups such as women and children, including legal support.

Project Component 4: Prevention and Behavior Change Communication- US$ 3.2 million

One of the challenges of the national response is developing the next generation of interventions, including Behavior Change Communication (BCC), which focus on changing individual risky sexual behavior as well as community perceptions and attitudes about HIV/AIDS and PLWHA. Such programs will target the general population, specific vulnerable groups, such as sex workers and their clients, STI clinic attendees, migratory populations, youth (particularly those on the street), itinerant traders, women (especially subgroups that suffer disproportionately from the disease such as those not currently in marital unions) and middle class employed persons. Also geographic areas where there is high prevalence, and places such as bars, markets, border towns and truck stops where unprotected, casual sex takes place will be targeted in a non-stigmatizing manner.

Under this component, the GAC will advance its prevention efforts to maintain the low prevalence rate in Ghana and reduce the number of new infections in high risk groups to a large extent. Activities for the general population will be focused on reducing the stigma associated with group-specific targeting, which limits the effectiveness of interventions. This component will further address new prevention issues that have arisen over time, as well as promoting more efficient measures to bring about behavior change in the populations. In particular, the introduction of ART services encourages the emergence of new attitudes to HIV transmission because people on ARV may either abandon or become lax in taking preventive measures, so it will be critical to support and emphasize the prevention message as part of the provision of ART.

Activities under this component will also deal more specifically with identification of interventions and implementation for behavior change among at-risk groups that can be captured in well-packaged programs, such as in-school youth and mobile populations. In particular, communication and other prevention activities would focus on: (a) the development, implementation and management of targeted behavior change and communication (BCC) and other prevention programs; (b) promoting the utilization of quality STI, VCT, PMTCT, and PEP services to vulnerable groups and the general population; (d) minimizing the risk of HIV transmission through blood and blood products; (e) promotion of programs to increase the median age of sexual debut and utilization of condoms during higher risk sexual encounters; and (f) reducing the incidence of occupational exposure to HIV and other infections.

Project Component 5: Treatment, Care and Support – US$ 2.2 million

Opportunities for comprehensive treatment, care and support have expanded rapidly within the last five years. For example, antiretroviral drugs have become increasingly accessible and affordable and are currently being supplied to an increasing number of people. ARV therapy has been simplified and funding has become increasingly available in developing countries as a result of stronger bilateral and multi-lateral partnerships and strengthened international commitments to the fight against HIV/AIDS. These developments set the stage for a rapid scaling-up of treatment programs. Adopting this plan implies working towards the goal of providing treatment to all people who require it. This may lead to substantial shortages in the availability of drugs at some period during the scaling-up. Therefore it will require the development of access policies which include gender and age equity. At the same time, care and support programs for PLWHA will require substantial expansion of institutional, community, and family efforts, and an appropriate manpower mix which is feasible, affordable, and meets the needs of all who require care and support. The solution will be a combination of professional personnel and volunteers, all of whom will require substantial training and continuing support.

Under this component, the GAC aims to build upon the success experienced to date in provision of ARV therapy to people in the Manya and Yilo Krobo districts of the Eastern region by scaling up treatment efforts nationwide. In addition, the component also covers the broad continuum of treatment, which includes VCT, management of STIs and OIs, provision of ART when it becomes necessary, and the home-based and community care and support that is necessary as well to maintain the overall health and well-being of PLWHAs and their affected families. Communities have been providing care and support, including home-based care, but the GAC intends to take this a step further by ensuring that this care and support is monitored to ensure the highest quality and linked to health facilities so that medical treatment can also be provided to PLWHAs. Under this component, the GAC will work more closely with the MOH to ensure that the areas of expertise of each institution are clearly recognized and that activities are complementary to each other and carried out in tandem, where applicable.

Proposed activities will include: (a) strengthening of infrastructure and human resources capacities necessary to rapidly scale up the provision of treatment, care and support for PLWHAs, OVCs, and other vulnerable groups in public and private institutions at all levels; (b) promotion of early diagnosis of HIV through use of VCT; (c) improved access to quality management of OIs, including the availability of adequate laboratory support for clinical care services at all levels; (d) universal access to ARVs; (e) ensuring high standards for community and home-based care for PLWHAs and OVCs; (f) promoting psychosocial support as an integral part of a comprehensive care and support package for vulnerable groups; (g) strengthening linkages and referrals between the community and clinical and preventive services, and promoting public-private partnerships for accelerated treatment, care and support for PLWHAs and other affected groups; and (h) promoting adequate nutrition for PLWHAs and mothers as part of the treatment and care programs.

Project Component 6: Research, Surveillance, Monitoring and Evaluation – US$ 1.2 million

Under this component, the GAC will ensure that it has all the available epidemiological, biological, behavioural information on the trends in the epidemic in Ghana which can be used to guide and amend the direction of the national response. The data on indicators collected from monitoring and evaluation of the activities carried out by various implementing partners and agencies at all levels, will provide information to the GAC on the geographic coverage of and scale of activities being implemented, in order to allow the GAC to transfer attention to areas or issues being missed in the national response.

In addition, this component will continue to support the existing national M&E system in Ghana to capture the overall national AIDS response, in keeping with the Three Ones. GAC's M&E system is decentralized. Each of Ghana's 138 districts has an M&E focal point trained to collect data at the district level. This district data is then captured and aggregated at the regional and national levels to provide information for evaluating the outcome and impact of the 2006-2010 NSF. GAC's M&E systems will continue to be strengthened at all levels to ensure that these systems can continue to provide timely disaggregated information on the types of sub-projects, service providers, etc. to inform the Partnership Forum. The revision of performance indicators for 2006-2010 as part of the NSF II is critical to the continued development of the M&E system through the 2006-2010 M&E Framework. Every development partner and all stakeholders have bought into the concept of one M&E system that they will all contribute to and provide data.

Activities will include: (a) the development of a monitoring database on HIV/AIDS indicators, programs and research, based on the UNAIDS country response information system (CRIS); and (b) the continued strengthening of the M&E system for the decentralized response.

Project Component 7: Resource Mobilization and Funding Arrangements – US$ 0.0 million[18].

While not a specific component in the true project sense, the NSF II includes research mobilization and funding arrangements as one of its seven priority activities. Resource mobilization and utilization are critical elements in meeting the huge human, financial and material resources required for the expanded and diversified programs envisaged. Under NSF II, resource mobilization and funding will be enhanced and effectively coordinated through a partnership forum under the leadership of GAC. The objective is to ensure that resources committed to HIV/AIDS activities from all sources are pooled into an integrated system to support the national response. In addition, the Framework will ensure sustainable availability of resources to implement national HIV/AIDS priority activities. Strategies for accomplishing this will include re-engineering the GARFUND into a coordinated multi-donor funding arrangement, strengthening the transparent and consultative mechanism for the disbursement of funds developed under NSF I, as well as mechanisms for monitoring disbursed funds, and improving the capacity of staff at all levels.

[18] Total cost of this component is only $50,000, in which case IDA's portion is miniscule.

This PAD follows the structure of the NSF II. This component includes establishing common funding arrangements for mobilizing and channelling HIV/AIDS resources to the national response. The GAC aims to mobilize additional resources for the Ghana national AIDS response, and to encourage all donors providing financial support through the GAC to pool their funds in the common arrangements accepted by the Funding Partners. However, the GAC may also mobilize support for HIV/AIDS resources related to the national response, even if they are channelled through one of the larger MDAs for mainstreaming of HIV/AIDS activities in that sector.

Activities under this component will include: (a) the establishment of a flexible funding arrangement for mobilising and channelling HIV/AIDS resources for the national response; (b) streamlining the budgeting process for HIV/AIDS resources; (c) the establishment of an effective targeting and resource allocation process; and (d) strengthening the financial management and monitoring system.

ANNEX 5: ESTIMATED PROJECT COSTS

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

Table 1: Funding Available through M-SHAP, 2006-2010, US$ million

						TOTAL	% total
Funding Partner	**2006**	**2007**	**2008**	**2009**	**2010**		**M-SHAP**
World Bank	2.5	4.0	5.5	5.5	2.5	20.0	56.7%
DFID	8.3					8.3	23.5%
GOG	1.0	1.5	1.5	1.5	1.5	7.0	19.8%
TOTAL	11.8	5.5	7.0	7.0	4.0	35.3	100.0%
NSF II	80.4	96.7	114.5	131.1	153.2	575.9	
M-SHAP as % of NSFII	14.7%	5.7%	6.1%	5.3%	2.6%	6.1%	

Table 2: Cost by Project Component and % of Bank Financing
Indicative Figures Only

No.	Component	NSF II Cost (US$M)	% NSF	Pooled M-SHAP (US$M)	Earmarked M-SHAP (US$M)	Total M-SHAP (US$M)	% M-SHAP	WB (US$M)
1	Policy, Advocacy and Enabling Environment	17	2.96%	5.9	0.0	5.9	20.0%	4.0
2	Coordination and Management of Decentralized Response	23	4.00%	10.1	0.0	10.1	34.0%	6.8
3	Mitigating the Social, Cultural, Legal, and Economic Impacts	121	21.04%	3.9	0.0	3.9	13.0%	2.6
4	Prevention and Behavior Change Communication	259	45.04%	4.8	3.8	8.6	16.0%	3.2
5	Treatment, Care, and Support	109	18.96%	3.3	1.5	4.8	11.0%	2.2
6	Research, Surveillance, M&E	46	8.00%	1.8	0.3	2.1	6.0%	1.2
7	Resource Mobilization and Funding Arrangements	0	0.00%	0.0	0.0	0.0	0.0%	0.0
	TOTAL	575	100.00%	29.7	5.6	35.3	100.0%	20.0

ANNEX 6: IMPLEMENTATION ARRANGEMENTS

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

1. Implementation

M-SHAP implementation will be guided by the time frame of the 2006-2010 National Strategic Framework. M-SHAP implementation is expected to begin on January 2, 2006 and continue through December 31, 2010.

The M-SHAP will be implemented by public, private, and civil society organizations, coordinated by the Ghana Aids Commission (GAC) based on national procedures and guidelines. It will support institutions at national and at decentralized levels.

Implementing Partners. These will include: 1) Ministries, Departments and Agencies (MDAs) and Regional Coordinating Councils (RCCs); 2) District Assemblies, Municipal and Metropolitan Assemblies (MMAs); 3) NGO's, CBO's, umbrella organizations and FBO's; 4) Private sector; 5) International NGO's, Research and Academic Institutions.

Program Oversight and Policy Guidance. The Ghana AIDS Commission (GAC) is a supra-ministerial and multi-sectoral advisory board attached to the Office of the President and formed by Act 613, 2002 of the Ghanaian Parliament. The members of the GAC include: key line Ministries, representatives from labor and PLWHA organizations, NGOs, FBO's, and civil society. The GAC is the highest policy making body on HIV/AIDS and provides effective and efficient leadership in the coordination of the National Response to HIV/AIDS. The GAC Secretariat has been established to provide technical and administrative support to the Commission. The GAC Secretariat will hereafter be called the GAC, as this is how it is referred to in Ghana. It is the responsible body for the management of the coordination of National Response. One of the technical committees established under the GAC is the Steering Committee which approves and guides the work of GAC.

GAC Organizational Structure. In addition to the coordination of the National Response, GAC will be responsible for overseeing the implementation of the national response and other programs where donors will have earmarked funds for GAC to oversee the implementation of specific projects (e.g. teacher training on HIV/AIDS awareness). GAC's organizational structure is being re-visited to ensure that it will be able to carry out concurrently these two highly visible and important functions.

5 year Program of Work (POW). A 5 year POW and budget has been derived from the 2006-2010 NSF. This 5-year POW is the "operational" aspect of the 2006-2010 NSF and will translate intervention areas into proposed programs, activities, targets and corresponding budgets.

Annual Program of Work (POW). The annual POW will be the key operational document guiding the implementation of the 2006-2010 NSF. GAC will be responsible for the preparation of the Annual POW which will include key intervention areas, indicators, partnership arrangements, financing provisions for key stakeholder programs supporting the national response. This would enable GAC as the coordinating entity for the National Response to have an overview of upcoming key interventions and would provide some insight as to areas and activities which are either over funded, under funded. This would also be the basis for GAC to go back to the stakeholders and recommend certain modifications to their programs to ensure optimum use of resources in support of the 2006-2010 NSF.

Partnership Forum. The Partnership Forum will be responsible for the exchange of information and promote a strong policy dialogue between GAC, MOH, development partners and other stakeholders on matters related to the implementation of the 2006-2010 NSF. This Partnership Forum would also review and endorse the Annual POW and budget and provide an opportunity for partners and stakeholders to further buy-into the sector wide approach.

Business Meetings. The Business Meetings will be held quarterly and include the development partners supporting the 2006-2010 National Response, either financially or through technical assistance, as well as the MOH. At these meetings, issues related to the progress of the implementation of the Annual POW, orientations of interventions for upcoming POWs based on newly available data and epidemiological trends will be discussed and development partners will confirm their financial contributions to the Annual POW.

Operational Manual. The GAC has revised its Operational Manual to take into account the sector wide approach concept which M-SHAP will support, particularly for pooled and earmarked funding arrangements. The Manual details the key steps, with an emphasis on the consultative process which GAC will need to follow to come up with an Annual POW encompassing partner and stakeholder activities. This Manual also describes the types of activities and organizations which can be funded through pooled or earmarked funds in support of the annual POW and other projects which GAC will be administering.

Allocation of funds is made annually for each of the seven components of the NSF II, depending upon priorities. Once activities have been agreed upon, a "window" for funding is selected for most activities. The four windows change slightly depending upon who is the implementing agency. In addition, funding may be earmarked to specific activities as agreed in the Annual Program of Work. The windows are defined 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.
>
> **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 PLWHAs or groups of these

entities (including affiliation networks) within the district for activities as described in the approved District HIV/AIDS Strategic Plan.

Window C will fund proposals from the private sector, including trade and professional associations.

Window D will cater for funding of proposals such as national programs that can only be directed and controlled at the national level (e.g. national condom distribution, curriculum development and network programs) as well as innovative projects to address the changing and evolving trends of the epidemic. Other sub-projects 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 programs and activities identified by GAC. They would also include specific projects and activities to be funded by a Funding Partner through earmarked funds and outside the pooled funding mechanism. Sub-projects to be financed under this Window may extend beyond one (1) year.

MSHAP will also fund consultancies, workshops, conferences, advocacy materials, etc in accordance with the Procurement Plan and Procurement Manual.

The implementation of the M-SHAP will be carried out through decentralized structures down to the district level that will support the GAC in management of funds and the monitoring of activities. Funding Partners. All changes will be reflected in the Operational Manual.

MSHAP will make funding allocation by the various windows in line with the priorities of the National Strategic Framework, 20006-2010, and as approved in the Annual Program of Work. GAC will also identify specific activities for entities in line with the Annual Program of Work for them to submit proposals for funding.

MSHAP will give priority to proposals that:

- Focus on vulnerable groups like youth in and out of school, commercial sex workers, women, long distance drivers, orphans, street children, mobile and migrant populations and the physically challenged and impaired.
- Focus on high incidence and high risk areas like mining towns, border towns, entertainment centers and market centers.
- Focus on voluntary counseling and testing
- Focus on PLWHAs
- Focus on provision of nutritional supplements to PLWHAs.
- Focus on giving assistance to institutions to assist in testing herbal preparations that can be used by PLWHAs, e.g. Centre for Medicinal Research, Mampong, Noguchi Memorial Institute for Medical Research.
- Promote BCC

The priority areas shall be reviewed annually by the Partnership Forum.

Project Review and Approval Committee (PRAC): A PRAC will be established to review and evaluate the proposals for funding under windows A, B, D and E. The PRAC will consist of experts within different fields. The PRAC will work and report directly to the Director-General to whom they will refer their final decision for confirmation. Its scope of work will be to assess the technical and operational feasibility of the proposals submitted and review financing requirements.

Regional AIDS Committee (RAC): The (RAC) is a multisectoral group constituted of 10–20 members comprising the heads of key decentralized MDAs, representatives of religious and traditional leaders, NGOs and CBOs including the regional monitoring and evaluation focal person. Its main role is to coordinate HIV/AIDS interventions at the regions local levels, aggregate M&E data and prepare semi-annual reports to the GAC, and facilitate capacity building initiatives within the region.

District AIDS Committee (DAC): The DAC is a crucial link in the implementation of all decentralized programs described in the 2006-2010 NSF. The DAC is a multi-sectoral group constituted of 8 – 12 members comprising the heads of key decentralized MDAs in the district, district assembly staff including the district M&E focal person, private sector and civil society representatives and representatives of PLWHAs groups working in the district. Its main responsibility is to formulate and operationalize the district strategic HIV/AIDS plans in a participatory manner, approve the recommendations on proposals for funding of NGOs, FBOs and CBOs made by the DRMT (see below), and be responsible to the GAC for the management of funds and reporting.

District Response Management Team (DRMT). The DRMT which is part of the DAC is an important link for the successful implementation of local level interventions to HIV/AIDS. It includes five (5) members namely district M&E focal person, District Directors of Education, Health, Social Welfare and one other, district assembly staff. DRMTs will be responsible for providing technical assistance to the DAC in the development of district HIV/AIDS plans and district program implementation, evaluation and selection of projects submitted by NGOs, FBOs and CBOs and make recommendations for funding to the DAC.

Regional and District M&E Focal Persons: A Regional M&E Focal Person as well as a District M&E Focal Person report to their superior: the Regional Minister and the District Chief Executive respectively on the progress of implementation of HIV/AIDS interventions in their areas. They will support the RAC, the DRMT and the DAC as member/secretary. They are also responsible for visiting the NGOs, FBOs and CBOs working in their district to monitor progress of implementation, gather M&E data. The Regional M&E focal person will aggregate the M&E data at the regional level and transmit it to GAC.

Grants Facility. The GAC will have the overall management responsibility for the grants facility, which will make grants to the above implementing partners. Calls for proposals will

take place twice a year. Additional technical support is expected to be provided to implementing partners who need help in preparing project proposals. The Operational Manual provides standard formats for sub-grant agreements which specify the eligible activities and expenditures, outputs, and implementation and reporting arrangements.

The PRAC will review the proposals submitted under window A, B, and C and make recommendations for funding to be approved by the Director-General of the GAC, while the DRMT will review the proposals submitted under window C and make recommendations for approval by the District Chief Executive. The GAC will fund the implementing agencies directly under the windows mentioned.

Transfers of Funds. The GAC will inform the DAC of their level of funding before the submission date of proposals. When the DAC has decided on the proposals to finance, the GAC will transfer the funds to the DAC bank account. The DAC will then release the funds to the NGOs, FBOs and CBOs and be responsible for reporting on the progress and the monitoring of the financial management to the GAC.

MSHAP Quarterly Monitoring. GAC will be responsible for preparing quarterly M-SHAP Monitoring Reports (financial, technical, M&E and procurement) will be prepared according to the format described in the Operational Manual, based on the World Bank Financial Monitoring Report format. The M-SHAP Monitoring Reports will be used as a basis for quarterly disbursements by Funding Partners. Annual M-SHAP Implementation reports will be prepared on the implementation of the M-SHAP during the previous year.

2. Community Mobilization

The capacity of PLWHA groups, NGOs, CBOs and community treatment supporters to promote treatment adherence, support food and nutrition education, and provide home-based care will be strengthened to support the scaling up of HIV/AIDS services at the regional and district level. Starting in 2006, trained PLWHA will expand their public advocacy efforts, support for ARV treatment education, and community information efforts. The training will focus on key components of the ARV treatment program, such as treatment adherence, HIV/TB patient management, counseling and HIV testing. Special emphasis will be placed on referral and patient monitoring to district HAART services by home-based care givers. Throughout the training the linkage with district and community groups will be emphasized to support the high performance of health workers in health facilities. Specific initiatives will address stigma and gender imbalance in demand for services.

3. Monitoring and Evaluation of Outcomes/Results

3.1 National M&E system

In line with the "three ones" principles, Ghana has developed a national M&E system. The system is described in the National M&E Plan[19], which was developed under NSF I.
Institutional arrangements for M&E are in place at the regional and district levels. At the regional level, the Regional AIDS Committees (RACs) exist in each of the 10 regions under the auspices of the Regional Coordinating Councils (RCCs). The committees are charged with monitoring community HIV/AIDS activities within their region, lobbying for resources and funding, advocating for HIV/AIDS policies that address local challenges, establishing communication and knowledge transfer amongst districts and between national, regional, district and local level, and facilitating the development of district level capacity. The RACs include M&E officers who collate regional data for activities implemented.

District AIDS Committees (DAC) are established in all 138 districts. MDAs, NGOs, FBOs, traditional leaders, youth and women associations, PLWHA, and other relevant community groups are represented on the DACs. At the district level the focus is on three functions: (i) formulation and operationalization of district strategic HIV/AIDS plans, (ii) monitoring of HIV/AIDS programs focusing on program inputs, outputs and tracking activities implementation as per the plan, and (iii) provision of data relevant for district-level monitoring and evaluation, e.g. monitoring the trends in behavior change and use of services, such as VCT, PMTCT, and STI services, allowing for fine-tuning of interventions.

There is a trained M&E focal point in all 138 districts. This person is responsible for visiting all funded programs in their districts and reporting back to the regional and central levels on achievements, beneficiary concerns, pace and efficiency of implementation, number of beneficiaries reached, value added of the activities, etc. This process will be continued with greater emphasis on the quality and effectiveness of activities implemented and steps will be taken to aggregate this information in a timely fashion to inform stakeholders on the quality and effectiveness of programs.

At the community level, the beneficiaries of this program are the sexually active population in the target districts, family care-givers and volunteers, health workers, community-based groups and voluntary/private agencies that will be supported to undertake specific care and support activities, and PLWHA and HIV/TB clients in the project area. These stakeholders will be involved and participate in M&E activities through the community networks and operational research. By agreeing to access and use care and support services provided through this program, the target population and PLWHA and HIV/TB clients will actively contribute to the M&E process by reporting on the quality of services, including reported instances of stigma in the community. A feedback mechanism will be established linking all partners to share experiences through community network groups and a website to be created by MOH.

[19] Ghana AIDS Commission. The National Monitoring and Evaluation Plan for HIV/AIDS in Ghana, 2001-2005 (2002)

Program Monitoring. Over the past four years, systems have been in place to track key outputs such as the number of projects underway and completed (by district), the NGOs which are involved, the types of interventions funded, the approximate number of beneficiaries reached, and the cost of each activity. This process has proven useful as it enables comparisons of unit costs of specific programs. For example, OVC programs have been compared in order to obtain information on the yearly cost of funding an orphan. The data collection system is well developed. However, not all partners at national or sub-national levels routinely and systematically share the data they collect. It has been noted that guidelines for reporting to GAC, with timeframes, should be established and commitment to adhere to them should be received from all key data sources.

3.2 Assessment of national M&E system

Ghana has achieved considerable success with monitoring and evaluation being rated as highly satisfactory within the last two years. The progress report of the national M&E Plan in 2004 recognized the considerable advances in the M&E system. Recognizing the successes already achieved, there are several challenges which need to be addressed and opportunities that could be utilized to further harmonize and strengthen the national M&E system. National and sub-national systems M&E for GAC implemented activities need to be strengthened without undermining the monitoring and evaluation of the national response.

NSF II provides an opportunity to further harmonize M&E systems between the GAC and other sectors, especially the Ministry of Health. GAC is revising and updating the national HIV/AIDS M&E plan and this is expected to be ready by end December 2005. The plan will clearly articulate the M&E strategy for the national response in Ghana; describing (i) partner, sector, national and sub-national roles and responsibilities; (ii) agreed indicators and guidelines for reporting to GAC; (iii) utilization of existing capacity developed during NSF I; and (iv) harmonization of M&E capacity building including standardization of training manuals, alignment with M&E systems of other national development strategies, reporting requirements of all partners, funding sources and timelines. Regional and district level guidelines for M&E would derive from the national M&E manual.

As the national response evolves and new interventions are introduced, the indicators in the national M&E plan will be reviewed. Annual review of indicators will take place concurrently during the preparation of yearly POW, however, ensuring consistency and continuum in indicator selection over the period of implementation of the NSF II.

Quality assurance and service utilization for care and treatment remains a critical issue. In addition to relying on the MOH for epidemiologic and behavioral data, the GAC will continue joint planning for ongoing collection of additional data on service quality and utilization for example Service Provision Assessment (SPA). The GAC will explore linkages and opportunities

created through other health information strengthening initiatives such as using planned activities of the Health Metric Network.

NSF II presents an opportunity for the GAC to strengthen sector-wide M&E by ensuring technical assistance for capacity development of sectors specifically in developing M&E plans, guidelines and tools; and collection, aggregation and use of M&E data for program refinement.

The GAC will institutionalize periodic meetings with all data providers to keep track of implementation and to provide backstopping services where required. This may require capacity building on data use and institutions may need to modify their data collection forms or reporting forms so that the data are available in a format that is more user-friendly.

A central repository for M&E data will be established at GAC. Country Response Information System (CRIS) may serve as a tool. The piloted system will be expanded, and modified where necessary, to suit the country needs. CRIS will also serve as a tool for effective information sharing between the different levels, and by making information available to all stakeholders and the public.

Baseline data are available for monitoring NSF II.

The MTR of M-SHAP will take an in-depth look at a large number of completed projects to obtain some preliminary information on the impact of various programs vis a vis the National Response.

At the national level, the Monitoring and Evaluation unit is headed by the Director of Policy Planning, Research, Monitoring and Evaluation. She has over 10 years experience in this field. She was responsible for the Monitoring and Evaluation Systems of NSF I and of the first Bank funded HIV/AIDS MAP project in Ghana, the GARFUND. She is assisted by a Monitoring and Evaluation Coordinator, a qualified Information Management Systems expert. They both worked on the first MAP project providing guidance to regional and district levels in setting up their RACs and DACs and are therefore conversant with the Bank's Monitoring and Evaluation procedures

ANNEX 7A: FINANCIAL MANAGEMENT AND DISBURSEMENT ARRANGEMENTS

Financial Management and Disbursement Arrangements

1. Executive Summary

The objective of the Financial Management Assessment is to determine whether the entity identified to implement the MAP-II HIV/AIDS project, the Ghana AIDs Commission (GAC) has acceptable financial management systems in place that can be used for the financial management of the project. These include the entity's system of accounting, reporting, internal controls and auditing. The entities' arrangement are acceptable if they are considered capable of recording correctly all transactions and balances, supporting the preparation of regular and reliable financial statements, safeguarding the entities' assets, and are subject to auditing arrangements acceptable to the Bank.

Financial management assessment of the Finance Directorate of Ghana AIDs Commission was carried out in 2005. The assessment was undertaken jointly by a World Bank Financial Management team and the GAC's finance team. FM Assessment Internal Control Questionnaires were not used. The Finance Directorate is currently responsible for the on going World Bank funded GARFUND project, the MAP-I HIV/AIDS project, and our assessment therefore involved the review of the current systems and discussions on the improvements required.

The assessment also took into account the fact that under the current project, one other partner expects to pool their financial resources with that of the World Bank to fund the implementation of the project. The pooled arrangements have been detailed out in a Memorandum of Understanding between the partners and the GOG/GAC.

The Director of Finance is a professionally qualified accountant who was responsible for the GARFUND project. He is assisted by an accounts manager and 3 other accounting staff, who have all received training on World Bank financial management and disbursement procedures. GAC has revised its financial procedures manual to take account of the use of its system as basis for managing the pooled funds as well as other funds GAC may receive, and have put in place mechanism for the audit of all GAC resources including the Bank's funds.

In conclusion our assessments have found the financial management arrangements put in place, as documented in GAC's financial procedures manual, for the purpose of managing the pooled financial resources from partners, including the World Bank's funds and all resources that may be received by GAC, are adequate and meet the Bank's minimum financial management requirements for Bank funded projects.

Country Issue

The Government of Ghana has implemented several reforms in response to the findings of the Country Financial Accountability Assessment (CFAA) for Ghana, carried out in 2001 and updated in June 2004. Some of the key actions taken include the enactment of;

i) Financial Administration Act 2003, in response to the identified weakness of the fragmented legal structures that governed public financial management;
ii) the Internal Audit Agency Act 2003, in response to the setting up of the non existence of modern internal audit for government departments;
iii) the Public Procurement Act, to improve the efficiency of public procurement systems and practices.

The summary risk analysis is based on the country work and knowledge of the systems of Ghana AIDS Commission, the institution responsible for the management of the second phase of the AIDS project.

2. Summary of Financial Accountability Risk Analysis

Risk	**Risk Rating**	*Risk Mitigation Measure*
Inherent Risks: *Country*		
a) Non-effective implementation of New Financial Administration Act (FAA).	S	Government has introduced a new comprehensive legal framework for public financial Management- the Financial Administration Act (FAA), with related regulations for implementation. There is need for close monitoring to ensure effective implementation of this Act.
b) Non-compliance of statutory regulations and non-enforcement of penalties.	H	Government needs to institute measures that ensure the systematic review, update and enforcement of penalties for non-compliance.
c) MDA may not fully comply with new Internal Audit Agency Act, in the establishment of internal audit units within their offices.	S	Government has passed legislation, Internal Audit Agency Act (CIAA), for all MDAs to establish internal audit function within their offices. Assistance will be provided to strengthen the Internal audit of GAC to meet the Act's requirements.
Overall Inherent Risk	S	
Control Risks		

Staffing at the GAC and Implementing Partners (IPs)		
a) Accounting staff at the GAC may leave or resign from employment.	M	GAC will be assisted to recruit qualified staff as replacement of any staff who resigns or leave.
b) That IPs may not employ required caliber of accounting staff, thereby affecting the quality of financial reporting.	M	GAC will institute a rigorous review process to ensure that only IPs with adequate staff and systems are selected to implement interventions. IPs will also be subject of monitoring and financial reviews to enhance overall controls to ensure the efficient use of funds.
Funds Flow		
a) Delays in releasing of funds from the GAC to the IPs.	M	GAC will be assisted to effectively plan for their resource needs. The partners pooling their funds will ensure that funds will be released on the basis of GAC realistic cash flow projects.
b) Difficulties in the timely submission of accounting returns from the Assemblies to the center to facilitate preparation of withdrawal applications.	M	Funds will only be released to IPs that meet an agreed minimum financial criteria, including the existence of financial procedures and adequate accounting staff, to enable them manage their project funds. This will make each IP responsible and accountable for funds received.
Internal Audit		
a) No professional internal audit (IA) function exists at Ministry and Assembly levels. b) Government IA is limited to pre-auditing, with no added value.	S	Government is in process of setting up a modern IA unit within Government, with assistance from donors. Ministry of Local Government will be assisted to strengthen its IA unit to perform checks and reviews as part of implementing arrangements. Project will also hire independent audit or financial consultancy firms to carry out routine and periodic financial reviews as a mechanism to strengthen financial systems within the DA. Findings of weaknesses will provide input into the design of further FM training for DA finance staff. The project will also provide assistance to the DAs in the establishment of their internal audit

		units as required by the new Internal Audit Act and help fund the related training cost.
External Audit		
Project audit reports likely to be submitted late.	M	GAC will institute mechanism where the audit program for the relevant year are agreed with the auditors prior to year end and monitored to ensure compliance. Auditors' contract will be limited to one year and renewal will be contingent on timely completion and submission of their audited reports.
Reporting and Monitoring		
a) Delays in the submission of agreed Financial monitoring reports (FMRs), and other relevant reports.	M	Since disbursement is based on the submission of FMR, there is incentive for the preparation and submission of the required reports. There will be support provided by the partners to improve overall FM of GAC.
Information Systems		
.		
Overall Control Risk	M	

Ratings: H – High; S – Substantial; M – Modest; N – Negligible

3. Implementing Arrangements

(The detailed implementation arrangements are described in Annex 6).

4. Accounting Systems at GAC

The mission reviewed the present financial management system in place at the GAC secretariat. These systems have been adapted to cover multi-donor participation.

The key financial arrangements and requirements under the SWAp are detailed in the Memorandum of Understanding (MOU) signed by the participating partners.

The current financial management system of GAC has been revised and documented in a procedures manual, the Administrative and Accounting Manual, and will be used for the purpose of managing the M-SHAP project.

The Accounting and finance unit of GAC is headed by a Director of Finance and Administration. He is a professionally qualified accountant, with previous experience in managing Bank funded projects. He was responsible for the financial management of the first Bank funded HIV/AIDS MAP project in Ghana, the GARFUND. He is assisted by an accounts manager also a qualified staff and 2 other accounting officers. All the current accounting staff worked on the first MAP project and are therefore conversant with the Bank's financial and disbursement procedures.

5. Flow of funds

It has been agreed that the Funding Partners will enter into a "disbursement pooling arrangement" for the purpose of funding the implementation of the project.

GAC will operate a special account denominated in US dollars, into which funds from the credit account (World Bank Funds) will be paid. Funds from the other participating partners will also be paid into this same account for the purpose of funding the M-SHAP activities.

On approval of proposals from implementing partners (IPs) for the various windows, GAC will release funds to them in tranches as follows:

i) approved proposals will include the required budget and the cash flow statements to indicate the timing of their cash needs;
ii) GAC will release the first tranche based on the cash flow requirements, but should not exceed 40% of the required funds. This will ensure that moneys received are accounted for prior to receiving subsequent tranches;
iii) IPs will receive their subsequent tranches on submission of their financial reports and other technical reports;
iv) GAC will ensure that prior to paying the last tranche, the IP's statement of accounts has been fully reconciled and the last payment will be the balance of the IP's proposal.

These proposals are to ensure that GAC is able to submit the required financial monitoring reports under the project on timely basis.

Periodic requests for funds will be made by the GAC to the World Bank. The request shall be made on quarterly or six monthly or from time to time, by submitting a withdrawal application duly authorized by the recognized signatories. The withdrawal application shall be supported by the GAC's quarterly Financial Monitoring Reports (FMRs) duly certified by the Director of Finance and Administration.

Although the funds provided by the World Bank for the M-SHAP project will not be earmarked for any specific activities, the other participating partners have indicated that they will earmark some of their funds for specific activities. The overall arrangements for this type of funding are be covered in the MOU signed by the partners, the Operational Manual, and the Administrative and Accounting Manual. Additional specific requirements will be covered by the particular partners.

6. Auditing Arrangements

Independent and qualified auditors acceptable to the Partners would carry out the annual financial audit of the program. The financial auditors would be in place by effectiveness of the program. It is recognized that it is the responsibility of the Auditor General of Ghana to audit these government entities, as a result, the selection of these independent auditors will be done in collaboration with the Auditor General.

The auditors' reports and opinions including the Managements letter of the annual financial audit would be furnished to the World Bank and all partners within six months of the close of each fiscal year.

An additional mechanism for periodic financial reviews of all participating Implementing Partners, will be established for effective monitoring purposes. The GAC will institute a system of financial procedural reviews, including compliance with all agreed procedures including sub-project eligibility criteria and efficient use of resources. The selection of all financial consultants shall be on competitive basis in accordance with the GOG guidelines.

In order to reduce transaction costs, the procurement audit will be combined with the financial management and take place at the same time.

7. Reporting and Monitoring

The Bank requires projects to prepare quarterly financial monitoring reports (FMRs) in the areas of finance, procurements including contract details and project progress. The quarterly FMRs include;

The Quarterly Financial Reports; consisting of Sources of funds and their Uses, Statement of Uses of Funds by Project Components and Activities, Special Account Reconciliation statement and a six months Project Cash Forecast where need be;

Quarterly Project Progress Report; consisting of Output Monitoring Report on contract Management and on Unit of Output by project activity;

Quarterly Procurement Report; consisting of procurement process monitoring and contract expenditure reports for goods, works and consultants' services. The report compares procurement performance against the plan agreed at negotiations and appropriately updated at the end of each quarter. The report should also provide any information on complaints by bidders, unsatisfactory performance by contractors and any contractual disputes.

GAC will be responsible for preparing and submitting the FMR required to be produced under the program. GAC will be responsible for preparing one set of reports both technical and financial and as such will coordinate, collate and consolidate these reports into a project wide

FMR and submit copies to the Bank and partners within 45 days of the end of each quarter (or six months).

8. Disbursement Arrangement

GAC will maintain a separate control account in its books to record the financial resources contributed by each Partner to the Program. The financial resources allocated to the Pooled Special Account will be used only for agreed purposes under the Annual Program of Work. The contributions of the Partners will be drawn down into the Pooled Account in accordance with the progress of the Program and according to the budgetary and disbursement mechanisms of the Co-operating Partners.

GAC will maintain two special deposit accounts in "commercial bank" (to be agreed with MOFEP) for donors' contributions to and disbursement from the Pooled Account. The first special deposit account will be in US dollars. Contributions from Partners, including IDA, to the MAP-II Account will be made into the US dollar account. Draw-downs in Cedis, from the pooled dollar account will be credited periodically to the cedi account to meet forecast expenditures as a result of approved proposals.

IDA would replenish the US dollar account in accordance with Report Based disbursement mechanisms, using quarterly financial monitoring report prepared by the GAC. These reports would be supported by a bank reconciliation of the Pooled Account, together with copies of the bank statements. The content and format of these reports would be agreed at negotiations.

Use Statement of Expenditures (SOEs)

The project will not use the SOE method of disbursement. All disbursements will be report based, and will not be strictly quarterly but as and when the GAC request for such funds.

ANNEX 7 B: PROCUREMENT ARRANGEMENTS

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

1. General

Procurement through International Competitive Bidding (ICB) and selection of consultants estimated to cost more than US$ 200,000 for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement Under IBRD Loans and IDA Credits" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Development Credit Agreement. All other procurement and selection of consultants will be carried out in accordance with the Ghana Public Procurement Act 663 of 2003. The various expenditure categories for items to be finance through M-SHAP are described below. For each contract to be financed by the credit, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the Bank project team on behalf of all Funding Partners in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Procurement of Works: No major works contracts are expected to be procured under this project. Minor works include: rehabilitation of offices of the Ghana Aids Commission. The procurement will be done using the Bank's Standard Bidding Documents (SBD) for any ICB and National Standard Tender Documents as stipulated in Schedule 3 of the Public Procurement Act.

Procurement of Goods: Goods procured under this project would include: computers, a few vehicles, office equipment, stationery, IEC materials, software, spare parts and accessories using Bank's SBD for all ICB and National Standard Tender Documents.

Procurement of non-consulting services: Non –consulting services procured under this project include surveys, workshop facilitation services and IEC services. These contracts are expected to cost less than US$ 100,000 and National Standard Tender Documents satisfactory to IDA will be used for non-consulting services

Selection of Consultants: Consulting services to be procured under the project will include various studies for prevention, treatment, care and support, research, monitoring and evaluation, of HIV/AIDS related activities. Short lists of consultants for services estimated to cost less than US$ 200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Operational Costs: which would be financed by the project would be procured using the procedures in the Public procurement Act 663 and the GAC Operational Manual which were reviewed and found acceptable to IDA

Subprojects: The detailed procurement procedures to be followed under the Grants are described in the GAC Operations Manual. Public entities which obtain grants will be required to follow the provisions of the Public Procurement Act in their procurement.

2. Assessment of the agency's capacity to implement procurement

Procurement activities will be carried out by the GAC, MDAs and MMDAs. The GAC Procurement unit is staffed by a procurement specialist who reports to the Director of Finance.

An assessment of the capacity of the Implementing Agency to implement procurement actions for the project was carried out by Kofi Awanyo in February 2005 and also by independent procurement auditors. The assessment reviewed the organizational structure for implementing the project and the interaction between the Procurement Specialist and the GAC's unit for administration and finance.

Most of the issues/risks concerning the procurement component for implementation of the project have been identified and include poor consultant selection practices as a result of not fully utilizing the skills of the GAC Procurement specialist. The corrective measures which have been agreed are formation of the GAC tender committee and continuous procurement training for key staff of the GAC.

The overall project risk for procurement is average.

3. Procurement Plan

The procurement plan for the first 18 months of the project has been prepared by the Borrower, reviewed during appraisal, and signed by the Borrower during negotiations. The procurement plan will be available in the World Bank Ghana Country Office. It will also be available in the Project's database and in the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

4. Frequency of Procurement Supervision

In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended one supervision mission every year to visit the field to carry out post review of procurement actions. The procurement post review will supplement the annual independent procurement audit to be carried out by procurement auditors hired directly by GAC in consultation with the Public Procurement Board and the Auditor General. The intent is to conduct the procurement and financial audit concurrently, thereby reducing the transaction costs for the GAC.

Table 1: Thresholds for Procurement Methods and Prior Review

Expenditure Category	Contract Value (Threshold) US$	Procurement Method	Contracts Subject to Prior Review
Works	>= 2,000,000	ICB	All Contracts
	>=50,000 – < 2,000,000	NCB	Contracts >= US$ 500,000
	< 50,000	Shopping	None
	All values	Direct contracting	All contracts
Goods and non-Consulting Services	>= 250,000	ICB/LIB	All contracts
	>= 30,000 – < 250,000	NCB/LIB/UN	None
	< 30,000	Shopping/UN	None
	All values	Direct Contracting	All contracts
Consulting Services	>= 100,000 firms	QCBS	All contracts
	Below 100,000 firms	QCBS/LCS/FBS/CQS	None
	>= 50,000 individuals	Individual	All contracts
	< 50,000 individuals	Individual	None
	All values	Single Source Selection	All contracts

MULTISECTORAL HIV/AIDS PROJECT
DETAILS OF PROCUREMENT ARRANGEMENT FOR 18 MONTHS

1. Goods and Works and non Consulting Services

a. List of Contract Packages which will be procured following ICB NCB and Direct Contracting:

1	2	3	4	5	6	7	8	9	10	11
Ref. No.	Contract Description	Estimated Cost (US$)	Procurement Method	P-Q	Domestic Preference	Review by Bank (Prior/Post)	Expected Bid Opening Date	Contract Signing Date	Contract Completion Date	Comments
G.1	Rehabilitation of GAC New Offices	219,780.00	NCB	No	No	Post Review	14/06/06	13/08/06	12/08/07	
G.2	Vehicles	299,200.00	ICB	No.	No	Prior Review	20/05/06	16/07/06	15/10/06	4no. (4 X 4) 5no. (Saloon)
G.3	Computers, Photocopiers and Printers	108,000.00	NCB	No	No	Post Review	18/03/06	14/05/06	13/08/06	For Proposed new Staff
G.4	Communication Equipment (VSAT)	54,000.00	NCB	No	No	Post Review	02/06/06	29/08/06	28/11/06	Equipment & Technical Services
G.5	Equipment for Documentation Centre	135,000.00	NCB	No	No	Post Review	09/07/06	09/05/06	05/07/06	Audio-visuals, F & F, On-line journals, etc
	Total	**815,980.00**								

b. Contracts estimated to cost above US$500,000.00 for Works and US$250,000.00 for Goods per contract and all Direct Contracting will be subject to prior review by IDA on behalf of all Development Partners.

2. Consulting Services

a. List of Consulting Assignments with shortlist of international firms: **None**

b. Selection of Consultants by QCBS Method is not planned. However the following methods will be used.

1	2	3	4	5	6	7	8	9
Ref. No	Description of Assignment	Estimated Cost (US$)	Selection Method	Review by Bank (Prior/Post)	Expected Proposal Submission Date	Contract Signing Date	Contract Completion Date	Comments
Sub 1	Policy, Advocacy & Enabling Environment (All Windows) VARIOUS PROPOSALS	2,720,110.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/03/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	Outsourcing to MDAs
Sub 2	Coordination & Management of the Decentralized Response (GAC/MMDAs) VARIOUS PROPOSALS	1,391,210.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/03/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	In-house and Outsourcing
Sub 3	Mitigating the Economic, Socio-cultural and Legal Impacts VARIOUS PROPOSALS	1,908,790.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/03/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	Outsourcing to Windows A, B C & D
Sub 4	Prevention & behavior Change (Windows A, B, C & E) VARIOUS PROPOSALS	1,589,835.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/03/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	Outsourcing to 4 Windows
Sub 5	Treatment, Care & Support VARIOUS PROPOSALS	586,810.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/06/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	Outsourcing to Private Sector (HBC)
Sub 6	Research, Surveillance, M & E VARIOUS PROPOSALS	728,570.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/06/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	In-house & Outsourcing to Window B
Sub 7	Resource Mobilization & Funding Arrangements (GAC/RCCs/MMDAs)	63,940.00	Fixed Budget	Post Review	30/03/06 29/08/06 30/06/07	04/05/06 01/10/06 02/04/07	04/05/07 01/10/07 02/04/08	In-house & Outsourcing to Windows A, B
	Sub-total	**8,989,265.00**						
PM. 1	Statutory Financial and Procurement Audit of MSHAP for 2006/2007	180,000.00	LCS	Prior Review	01/06/06	30/09/06	01/05/07	Private Audit Firm

Consulting Services (continued)

1	2	3	4	5	6	7	8	9
Ref. No	Description of Assignment	Estimated Cost (US$)	Selection Method	Review by Bank (Prior/Post)	Expected Proposal Submission Date	Contract Signing Date	Contract Completion Date	Comments
PM 2	Selection of Field Investigators (Various)	120,000.00	ICs	Post Review	01/09/06	31/10/06	30/11/06	Aggregate
PM 3	Advocacy Area 1-Selection of Consultants for Review of Laws, Research into Stigma and Best	29,100.00	LCS/IC	Post Review	01/04/06	30/05/06	31/07/06	Firms & Individuals
PM 4	Coordination Area 2-Selection of Consultants Review HIVAIDS Strategic Plans of MDAs & RCCs Annual Program Review, Partnership Fora, Technical Support for New Districts	61,050.00	IC	Post Review	20/02/06	19/04/06	18/06/06	Conference & Workshop services
PM 5	Socio-Econ Area 3- Various Impact Studies, Micro-finance Capacity Building design of interventions	76,480.00	LCS/IC	Post Review	02/04/06	01/06/06	01/08/06	
PM 6	Prevention & BCC Area 4-TA for IEC/BCC/Media Strategy, Technical Support for Documentation Centre Capacity Building	157,780.00	LCS/CQ/IC	Post Review	24/02/06	23/04/06	22/06/06	
PM 7	Treatment, Care & Support-5 Technical Support for training Traditional Leaders & Herbalists, HBC & monitoring treatment	44,340.00	CQ/IC	Post Review	27/04/06	25/05/06	30/06/06	
PM 8	Research, & M & E Area 6-TA for Development of Dbase and Consultancy for Evaluative & Social Science Surveys, PLACE, CRIS, Dissemination of information, etc (Various consultancies)	506,080.00	LCS/CQ	Post Review	23/02/06	22/04/06	20/06/06	
PM 9	Resource Mobilization & Funding Arrangements-conferences 7 Workshops for Funding Partners, Implementing Partners & Business Meetings	46,730.00	IC	Post Review	15/05/06			

Consulting Services (continued)

1	2	3	4	5	6	7	8	9
Ref. No	Description of Assignment	Estimated Cost (US$)	Selection Method	Review by Bank (Prior/Post)	Expected Proposal Submission Date	Contract Signing Date	Contract Completion Date	Comments
PM 10	Evaluation of NSF 1	75,000.00	IC	Post Review	20/06/06	18/08/06	17/10/06	
PM 11	TA for Preparation of Annual POW	30,000.00	IC	Post Review	20/08/07	19/10/07	18/12/06	
PM 12	Selection of Events Organizer for National HIV/AIDS Conference for 2007	120,000.00	CQ	Prior Review	18/11/06	17/01/07	20/02/07	
	Sub-Total	1,446,560.00						
	GT Consultancy & Technical Services							

c. Consultancy contracts with firms estimated to cost US$100,000 or more per contract, Consultancy contracts with individuals estimated to cost US$ 50,000 or more and all Single Source Selection will be subject to prior review by IDA on behalf of Development Partners.

1. Rate of Exchange US$1 = ¢9,100.00

Budgeted figures for Thematic Area interventions have been multiplied by a scale factor of 1.5 to cater for the 18month period

Summary	**$**	**18 months ($)**
Goods and Civil Works	815,980.00	815,980.00
Sub-Projects	5,992,843.00	8,989,265.00
Consultancy/Technical Services	1,446,560.00	1,446,560.00
Total	**8,255,383.00**	**11,251,805.00**

ANNEX 8: SAFEGUARD POLICY ISSUES

GHANA: MULTI-SECTORAL HIV/AIDS PROGRAM

1. Background

Like other Bank-financed projects, health projects must comply with the 10 Safeguard Polices and the policy on Disclosure of Operational Information because implementation of project activities could cause adverse environmental, health, and social impacts.

2. Findings

A preliminary screening of the project's potential environmental and social impacts was carried out at the early stage of project identification and revealed that OP 4.01 (Environmental Assessment) may be triggered. This was based on the premise that project would provide comprehensive treatment, care and support through the expansion of ARV therapy, VCT, OI and STI . This initial screening failed to show the likelihood that other Safeguard Policies could be triggered. Based on these outcomes, the preliminary screening report recommended that a study be undertaken to assess the nature, extent and severity of any perceived potential environmental and social impacts and to illustrate time-bound and costed preventive and mitigative measures for addressing these effects if they do occur. A crucial element of any such a management plan would include an elaborate institutional arrangement for effective implementation and a set of indicators for measuring progress in remediation.

3. Public Disclosure and Stakeholder Consultations

Earlier during the preparation of the closed Ghana Health Sector Project (a sector-wide approach) an environmental assessment was carried out that recommended the development of a National Health Care Waste Management Policy and Action Plan (NHCWMP). This was done and implementation of action plans derived from the policy framework was adopted by Government of Ghana for implementation throughout the country's health facilities, both public and private. Led by the Occupational Health and Environmental Unit of the Ministry of Health implementation of the health care waste management plans has been ongoing, resulting in full buy-in at all levels. The NHCWMP is a comprehensive policy document, covering indeed the management of all nature of health care and treatment waste generated including those associated with the treatment of HIV/AIDS, care of and support to people living with the disease. Its comprehensiveness and successful implementation during the lifetime of the Health Sector Project convinced the Bank to accept it as a practical response to the screening exercise carried out during M-SHARP preparation. Based on lessons learnt during previous implementation of the NHCWMP, the policy has been further refined and re-disclosed in-country and re-submitted to the Bank's InfoShop. In collaboration with key stakeholders in health care delivery including the Ghana Aids Commission (GAC), the Ministry of Health has conducted extensive countrywide stakeholder consultations and sensitization on the NHCWMP since its adoption. In

addition, personnel from few public health care facilities have been trained in health care waste management. The Borrower's implementing agencies, particularly the Occupational Health and Environmental Unit of the Ghana Health Service, Inspectorate Division of the Ministry of Employment and Manpower Development, Ministry of Local Government and Rural Development and Environmental Protection Agency and the Health and Sanitation Sub-committees of the various District Assemblies will continue the consultation and sensitization process with all groups throughout the country.

4. Institutional arrangement for safeguard due diligence

The Ministry of Health is currently mobilizing support to formulate legislation to strengthen the implementation and monitoring of the NHCWMP and has set a target date of 2006 for commencement of the exercise. It is expected that a lot of consultation and sensitization about the subject matter will be carried out even during the formulation stage. This indeed will strengthen the hands of the supervising Ministry to enforce compliance with the management of health care waste. It is also expected that the re-introduction of environmental and sanitation monitors into community set-ups will raise consciousness among communities and health facility personnel about the proper disposal of waste.

Capacity development has been identified as a key factor in the improvement in health care delivery system within the country and deliberate efforts have been made in the past to lift this up. Formal and informal training will be supported under the M-SHARP and it has been agreed that funds will be made available to assess gaps and train health personnel and staff of other relevant agencies (e.g., municipal and district assemblies) at the national, regional, district and community level (and within both public and private facilities) in health care waste management. The Occupational Health and Environmental Unit of the Ghana Health Service is advocating strongly for mainstreaming health care waste management into in-service curricula for health personnel. Although the project is a direct response to the National HIV/AIDS agenda, it has also been agreed that training and public education will not be limited to only how to manage HIV/AIDS-related generated waste but a comprehensive program will be drawn to cover the training and education in the management of all waste types generated across the country's health care facilities. Under the leadership of the Occupational Health and Environmental Unit of the Ghana Health Service and expert advice of the Environmental Protection Agency (EPA), the NHCWMP will be implemented in a collaborative and consultative manner. It is also planned that knowledge in screening, assessment, auditing and monitoring of environmental and social impacts, management and mitigation plans will be transferred to key actors through targeted training and experience gathering. The project will be implemented within the context of existing prescribed national waste management and sanitation policy alongside the Bank's Safeguard Policies and WHO guidelines.

GAC, in consultation with the Occupational Health and Environmental Unit of the Ghana Health Service, the EPA, the Environmental and Sanitation Sub-committees at the district assembly level and other relevant organizations will monitor and report, within the broad framework of project M&E on (i) ensuring due diligence with regard to the remediation measures on the basis

of findings and results from assessments done on specific project interventions, (ii) status of implementation of remediation measures, and (iii) attainment of remediation indicators as check on achievement of mitigation objectives. The M&E system for tracking progress in implementing the health care waste management plan and assessing impacts on the project and beneficiaries will form an integral part of the project's overall design, budget, implementation, monitoring and evaluation system.

5. Installation of basic equipment

The project can help minimize the danger of poor disposal of health care waste by providing funds to finance the procurement and installation of simple but efficient disposal and packaging infrastructure as well as storage equipment at the sites of waste generation. In addition, project funds should be used to provide needed capacities to manage the packaging, storage and disposal facilities and ensure efficient monitoring of the performance of these systems. Heads of health care institutions in both public and private health set-ups will be held responsible for the environmentally-sound performance of such systems.

ANNEX 9: ECONOMIC AND FINANCIAL ANALYSIS

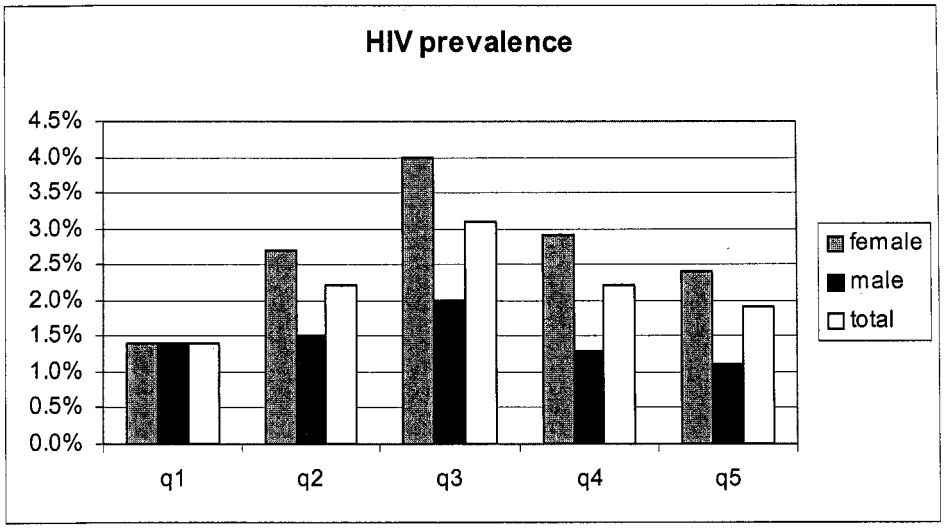
GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

1. Economic Analysis

There are two studies now showing that HIV/AIDS currently has no appreciable impact on the macro-economy in Ghana: a 2004 study on Economics and AIDS in Ghana by DFID and a 2005 study on health and the cocoa industry study.

The main economic impact of HIV/AIDS in Ghana is reflected at household level. Studies have been carried on HIV prevalence by wealth quintile (quintile 1 denotes the poorest quintile, while quintile 5 is the richest).

Figure 1: HIV/AIDS prevalence by wealth quintile



Source: Study of the Social and Economic Impacts of HIV/AIDS in Ghana: Facilitative Studies. 2004

Figure 1 shows that quintile 2 and 3 have the highest prevalence rates, although HIV/AIDS prevalence is registered in all quintiles. The figures also confirm the evidence that women have a much higher prevalence than men, except in the poorest quintile. The same study has shown that when the impact of HIV/AIDS is considered, households with a PLWHA in the poorest three quintiles will fall below the poverty line. HIV/AIDS in Ghana, as in most other developing countries, is closely linked to poverty, with poverty increasing the vulnerability to infection and

HIV infection increasing the level of poverty and vulnerability of households to fall below the poverty line.

The economics of interventions are determined by the dynamics of the epidemic. Ghana has a somewhat stable epidemic over the past ten year, leveling off around the 3% infection rate. Neighboring countries show a similar pattern of leveling off, be it at higher prevalence levels. Most importantly for prevention efforts, specific geographical areas and specific societal groups are far more affected than others. Therefore, and also because impact per sector cannot be shown, it is inefficient to develop sector-wide interventions, e.g. the entire private sector or the entire cocoa or agricultural sector. Since youth less than 24 years old are hardly infected, even education-based interventions should be undertaken with some caution, as the link prevention of new infections is unclear. Infections in Ghana occur at a much later age and it is unclear if prevention interventions at school age are cost-effective.

There are no data available for Ghana on the costs of averting a new infection per specific target group. However, there is clear evidence in Ghana that the far majority of male infections are related to sex work. From a cost-effectiveness point of view, targeting sex workers and their clients on a national scale and with sufficient intensity to achieve relatively quick results is the highest priority. Experience from Senegal and Southern Cote d'Ivoire has shown that these interventions can be effective at a cost of perhaps $20-$30 per sex worker. Given that sex workers are a relatively small part of the population (estimates range from 30,000 to 100,000), these interventions have the highest efficiency in averting new HIV cases, e.g. when compared to youth or formal sector workers, numbering several million and requiring $5 - $ 10 per person for prevention interventions.

Two other groups in Ghana might have high priority in mitigating new infections: prisoners, as initial studies have shown infection levels of over 50% within some prison populations; and MSM, some of whom show extremely high risk behaviors as have show to spread HIV rapidly in Europe and the US. Efficiency of preventive interventions among those groups might be high in Ghana.

A new preventive intervention that might have a high efficiency of averting new infections is by not concentrating on specific groups but on specific places, where individual go to meet partners, do drugs, etc. The method is promising as it can reach people who do not belong to a specific subgroup (MSM, CSW) but who do exhibit high-risk behaviors. This method (called PLACE) is in an experimental stage in Ghana.

The efficiency of treatment activities for preventing new infections is extremely low and possibly non-existent, especially because ARVs are provided in the later stages of the disease, when sexual activity would have been low. There is therefore little doubt that prevention activities should be the bulk on the response within the specific dynamic of the epidemic in Ghana.

2. Financial Analysis

The total gap in resources for HIV/AIDS between estimated costs and current and planned contributions from all sources is expected to rise from $37 million in 2005 to $58 million in 2010. An analysis of the gaps in the financing and programmatic coverage of existing and planned programs shows that lack of funds for the purchase of antiretroviral drugs (ARVs), exacerbated by procurement and disbursement delays, remains the single most important rate-limiting factor affecting the speed of scaling up HIV/AIDS services in Ghana, especially antiretroviral treatment (HAART). This funding gap stems from the high cost of ARVs relative to other medicines, and the unwillingness of donors, other than the Global Fund, to finance the purchase of ARVs. Ghana's National Health Insurance Scheme (NHIS) launched in 2004 will cover the cost of some HIV/AIDS drugs to treat OIs but will not be able to cover the cost of ARVs due to their high cost. This funding gap, not expected to change any time soon, directly affects the number of people living with HIV/AIDS who can be treated and the rate at which new HAART sites can be opened.

In 5 years time, with continued economic growth, currently averaging 5% in the past 10 years, and if the rate of HIV prevalence can be maintained below 4%, the government believes that it can sustain the program after the initial investment has been made. One percent (1%) of the government health budget ($5.6 million) currently goes to districts for services. The National Health Insurance Scheme (NHIS) launched in 2004, which will cover the cost of many OI drugs, is expected to grow and may be able to offer partial coverage for ARVs after a 5-year period. Cost recovery programs already in place, including patient co-payments for ARVs and monitoring, backed by other internally generated funds (IGF) will also contribute towards the costs of sustaining services. The National Health Insurance Levy is projected to provide $147.2 million (26%) of the national health budget in 2005[20]. Internally Generated Funds (IGF) are projected to contribute $46 million (8%), and expected HIPC inflows another $23 million (4%). The Health Fund stands at $66.7 million in 2005, evidence of the government's good relations with development partners. In addition, the cost of ARVs, other HIV/AIDS drugs and commodities is expected to decline in the next 5 years as buyers groups are formed and economies of scale are realized.

[20] Ministry of Health. The Ghana Health Sector 2005 Program of Work January 2005 (in press).

ANNEX 10: PROJECT PROCESSING SCHEDULE AND SUPERVISION STRATEGY

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

Project Schedule	Planned	Actual
Time taken to prepare the project (months)		7
First Bank mission (pre-appraisal of repeater)		02/21/2005
Appraisal mission departure	05/08/05	09/26/2005
Negotiations	10/03/05	10/10/2005
Planned Date of Effectiveness	December 31, 2005	

Prepared by:
Government of Ghana: Ghana AIDS Commission, Development Partners

Preparation Assistance:
BB Funds; Simplification Funds

Bank staff who worked on the project included:

Name	Speciality
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Laura Rose	Task Team Leader, AFTH2 (starting at appraisal) Senior Health Economist, AFTH2
Evelyn Awittor	Health Specialist, AFTH2
Albertus Voetberg	Lead Health Specialist, AFTHV
Michael Diliberti	Sr. Country Officer, AFC10
Beatrix Allah-Mensah	Social Development Specialist, AFTS4
Frederick Yankey	Sr. Financial Management Specialist, AFTFM
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Tsri Apronti	Procurement Specialist, AFTPC
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Gregoria Dawson-Amoah	Program Assistant, AFC10
Paul Geli	Consultant

Quality Assurance team:
Jonathan C. Brown (GHAP); Kristan Schultz (UNAIDS Kenya);

Additional support was provided by:

Institution	Staff	Speciality
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	Matilda Owusu-Ansah	HIV/AIDS Advisor
	William Guest	Deputy Program Manager
	Ruby Bentsi	Economic Advisor
DANIDA	Jakob Jakobson	TTL
	Sanne Wennes	Consultant
GTZ	Holger Till	Medical Officer
UNAIDS	Warren Naamara	TTL, Technical Co-Lead
	Lord Lartey	Social Mobilizing Officer
	Taavi Erkkola	M & E Advisor
UNFPA	Esi Awotwe	Nat. Program Officer on HIV/AIDS
UNICEF	Andrew Osei	HIV/AIDS Officer
USAID	Peter Wondergem	M & E Lead
WHO	Melville George	Country Representative
	Morkor Newman	National Professional Officer on HIV/AIDS
	Napoleon Graham	HIV/AIDS Technical Advisor
	Rosalina Hernandez	HIV Treatment (3x5 Officer)
	Selasie D'Almeida	Health Economist

ANNEX 11: DFID STATEMENT

DFID HIV/AIDS Strategy and the Ghana Multi Sectoral HIV/AIDS Project (MSHAP)

Introduction

DFID's country policy is to support countries with a sound and nationally driven Poverty Reduction Strategy by transferring resources directly through the Government's budget. This is accompanied by support for capacity building within Government, civil society organizations, private sector development, and for the strengthening of institutions inside and outside Government which promote accountability. DFID pursues this approach in close partnership with other Development Partners with the overarching aim of contributing towards the achievement of the MDGs in Ghana.

Framework for DFID Assistance

At the core of DFID's support is the implementation of the GPRS, ensuring that the GPRS is well integrated into government planning and budgeting processes (the MTEF); that there is mainstreaming of action to address the needs of vulnerable and excluded groups; and that there is effective, participatory monitoring and evaluation of the GPRS to promote the accountability of government to its citizens. Currently DFID supports Ghana by providing budgetary support through government systems and also by working through multi-donor mechanisms.

Areas of DFID support in Human Development

- Support for health and education through existing programs focusing on reducing inequalities and improving basic education and primary health care;
- Facilitating greater donor coordination/harmonization in health, education and HIV/AIDS. · TA support to the Ministry of Health and Education on planning, budgeting, management, monitoring and evaluation;
- Support to the Ghana Aids Commission for the national response program to the threat of HIV/AIDS;
- Advocate mainstreaming HIV/AIDS through programs; particularly with the Ministry of Health and Education.

The Ghana Aids Partnership Program (GAPP)

DFID's current £20 million five-year HIV/AIDS program - the Ghana AIDS Partnership Program (GAPP) is due to end during 2006. GAPP was designed as an "umbrella program" to support a range of interventions broadly aligned with Ghana's 2000-2005 National Strategic Framework for HIV/AIDS. Funds were programmed by DFID directly as the program

progressed. Specifically GAPP supported the MOH to Strengthen HIV/AIDS Surveillance systems and also to scale up antiretroviral therapy in the country. The Ministry of Education has been supported to provide HIV/AIDS educational materials and training to teachers in all Public and Private Basic Secondary Schools. Prevention and behavior change activities included capacity building for vulnerable and high risk groups as well as the social marketing of condoms.

GAPP's main achievements have been to: help GoG to build a robust national HIV/AIDS surveillance system; ensure an adequate and reliable supply of condoms in the public sector and through social marketing; strengthen the analytical and co-ordination capacity of the Ghana AIDS Commission (GAC) Secretariat; support HIV/AIDS teacher training and curriculum development in all public schools; and fund the first provision of anti-retroviral treatment in the public and mission hospitals, including making available ARVs for infants.

DFID Support to MSHAP

The Multi Sectoral approach to HIV/AIDS promotes an effective multi-sectoral response in Ghana covering prevention, care and impact mitigation. The program has been designed in collaboration with all partners and is recognized as consistent with the priorities and needs identified in the GPRS and the National Strategic Framework 2006-2010. DFID's support is aimed at strengthening the GAC's ability to implement a multisectoral approach within the broader policy environment and enabling Government sectors like health, education and local government as well as civil society and the private sector to become more effective.

DFID will support the 2006-2010 National Strategic Framework through the MSHAP funding arrangements by making both earmarked and pooled contributions to the program. DFID intends to support the NSF II for through out the period but will make commitment on an annual basis based on annual priorities as identified in the POW. In 2006 DFID will transfer to GAC management of on-going HIV/AIDS programs with the Ministry of Health, Ministry of Education and a number of civil society organizations, amounting to around $6million in total. The extent of these activities will be reflected in the MSHAP budget. These programs are part of DFID's £20 million HIV/AIDS Partnership Program, agreed with the Government of Ghana for 2002-2006. By transferring management of on-going activities DFID hopes to assist GAC in strengthening its co-ordination and engagement with key partners in the national response. Subject to the successful operation of the mechanism in its first two years, DFID will un-earmark its funds progressively

The main risks facing the DFID program relate to the nature of the epidemic,
Institutional capacity and performance of GAC and value for money from DFID funds.

ANNEX 12: DOCUMENTS IN THE PROJECT FILE

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

Project Implementation Plan
Five Year Program of Work: 2006-2010. GAC, September, 2005.
Monitoring and Evaluation (M&E) Framework 2006-2010, October, 2005.
Annual Program of Work for CY 2006
GAC Administrative and Accounting Manual
GAC Procurement Manual
GAC Operational Manual
Medical Waste Management Plan. MOH, May 2005
2003 Sentinel Survey for HIV/AIDS
2003 Ghana Demographic and Household Survey results

Bank Staff Assessments

Policy documents and Program description
The Joint Review of Ghana's National HIV/AIDS Response. GAC, June 2004.
2006-2010 HIV/AIDS National Strategic Framework.
2004 National HIV/AIDS Policy
2004 National HIV/AIDS Workplace Policy
Draft Orphans and Vulnerable Children's Policy
Memorandum of Understanding between the funding partners

ANNEX 13: STATEMENT OF LOANS AND CREDITS

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

			Original Amount in US$ Millions						Difference between expected and actual disbursements	
Project ID	FY	Purpose	IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P056256	2005	GH-Urban Water (FY05)	0.00	103.00	0.00	0.00	0.00	104.13	0.00	0.00
P081482	2005	H: Community Based Rural Development	0.00	60.00	0.00	0.00	0.00	60.23	2.17	0.00
P084015	2005	Small Towns Water Supply & Sanitation	0.00	26.00	0.00	0.00	0.00	26.23	0.00	0.00
P082373	2004	GH-Urban Env Sanitation 2 (BD FY04)	0.00	62.00	0.00	0.00	0.00	61.26	0.33	0.00
P071157	2004	GH Land Administration	0.00	20.51	0.00	0.00	0.00	20.80	3.04	0.00
P050620	2004	GH-Edu Sector SIL (FY04)	0.00	78.00	0.00	0.00	0.00	74.17	-3.12	0.00
P071399	2003	Partnerships w/ Traditional Authorities	0.00	0.00	0.00	0.00	0.00	3.60	1.70	0.00
P073649	2003	2nd Health Sect. Prog. Support	0.00	57.30	0.00	0.00	0.00	53.90	-8.72	0.00
P050623	2002	GH ROAD SECTOR DEVELOPMENT PROGRAM	0.00	220.00	0.00	0.00	0.00	178.06	55.32	0.00
P067685	2002	Ghana: GEF- Northern Savanna	0.00	0.00	0.00	7.90	0.00	5.91	2.84	0.00
P071617	2001	AIDS Response Proj. (GARFUND)	0.00	25.00	0.00	0.00	0.00	8.12	-19.78	0.00
P000968	2001	GH-Agricultural Services APL (FY01)	0.00	67.00	0.00	0.00	0.00	46.46	60.16	0.00
P050616	2000	COMMUNITY WATER II	0.00	25.00	0.00	0.00	0.00	4.90	6.41	1.34
P069465	2000	Ghana: RURAL FINANCIAL SERVICES PROJECT	0.00	5.13	0.00	0.00	0.00	3.60	20.61	0.00
P040659	1999	Community-based Pov. Red.	0.00	5.00	0.00	0.00	0.00	1.46	1.12	0.72
P000974	1999	Nat. Func. Lit. Program	0.00	32.00	0.00	0.00	0.00	18.98	14.09	10.69
P000970	1999	TRADE GATEWAY & INV.	0.00	50.50	0.00	0.00	0.00	23.26	21.49	0.00
P000926	1995	GH Thermal (Power VII)	0.00	175.60	0.00	0.00	0.00	18.06	20.37	26.62
		Total:	0.00	1,012.04	0.00	7.90	0.00	713.13	178.03	39.37

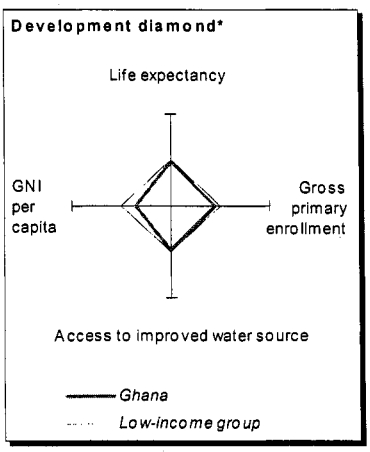
GHANA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
1990/91/96	AAIL	0.00	0.00	3.26	0.00	0.00	0.00	3.26	0.00
1993	AEF Afariwaa	0.16	0.00	0.00	0.00	0.16	0.00	0.00	0.00
1995	AEF Antelope Co.	0.40	0.00	0.00	0.00	0.40	0.00	0.00	0.00
2001	AEF GPPI	1.17	0.00	0.00	0.00	1.17	0.00	0.00	0.00
1998	AEF NCS	0.00	0.00	0.53	0.00	0.00	0.00	0.53	0.00
1997	AEF PTS	0.00	0.00	0.31	0.00	0.00	0.00	0.31	0.00
1999	AEF PharmaCare	0.05	0.00	0.00	0.00	0.05	0.00	0.00	0.00
1994	AEF Shangri-la	0.93	0.00	0.00	0.00	0.93	0.00	0.00	0.00
1996	AEF Tacks Farms	0.43	0.00	0.00	0.00	0.43	0.00	0.00	0.00
1989	Cont Acceptances	0.00	0.88	0.00	0.00	0.00	0.88	0.00	0.00
2001	Diamond Cement	4.25	1.00	0.00	0.00	4.25	1.00	0.00	0.00
2000	ELAC	0.00	0.10	0.00	0.00	0.00	0.10	0.00	0.00
1991	GHANAL	0.00	0.44	0.00	0.00	0.00	0.44	0.00	0.00
2001	MFI SSLC	0.00	0.49	0.00	0.00	0.00	0.49	0.00	0.00
	Total portfolio:	7.39	2.91	4.10	0.00	7.39	2.91	4.10	0.00

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
2004	BP Ghana	0.00	0.00	0.00	0.00
2004	Japan Motors	0.00	0.00	0.00	0.00
2004	Takoradi II	0.06	0.00	0.00	0.00
	Total pending commitment:	0.06	0.00	0.00	0.00

ANNEX 14: COUNTRY AT A GLANCE
GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

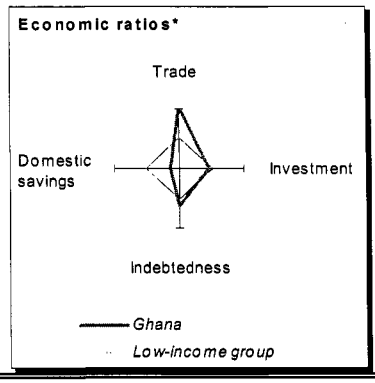
POVERTY and SOCIAL	Ghana	Sub-Saharan Africa	Low-income
2003			
Population, mid-year *(millions)*	20.4	703	2,310
GNI per capita *(Atlas method, US$)*	320	490	450
GNI *(Atlas method, US$ billions)*	6.5	347	1,038
Average annual growth, 1997-03			
Population *(%)*	2.6	2.3	1.9
Labor force *(%)*	2.2	2.4	2.3
Most recent estimate (latest year available, 1997-03)			
Poverty *(% of population below national poverty line)*	40	..	..
Urban population *(% of total population)*	45	36	30
Life expectancy at birth *(years)*	55	46	58
Infant mortality *(per 1,000 live births)*	60	103	82
Child malnutrition *(% of children under 5)*	25	..	44
Access to an improved water source *(% of population)*	73	58	75
Illiteracy *(% of population age 15+)*	26	35	39
Gross primary enrollment *(% of school-age population)*	81	87	92
Male	85	94	99
Female	78	80	85



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

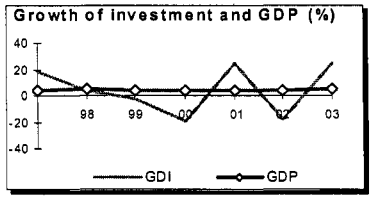
	1983	1993	2002	2003
GDP *(US$ billions)*	4.1	6.0	6.2	7.7
Gross domestic investment/GDP	3.7	22.2	22.3	19.4
Exports of goods and services/GDP	5.6	20.3	42.5	37.2
Gross domestic savings/GDP	3.3	6.0	10.3	5.6
Gross national savings/GDP	2.4	12.8	22.8	18.9
Current account balance/GDP	-6.1	-9.4	0.5	-0.5
Interest payments/GDP	1.1	1.4	1.2	1.4
Total debt/GDP	41.1	81.0	119.1	103.5
Total debt service/exports	30.4	24.6	7.3	23.1
Present value of debt/GDP	..	..	63.4	..
Present value of debt/exports	..	..	147.5	..

	1983-93	1993-03	2002	2003	2003-07
(average annual growth)					
GDP	5.0	4.3	4.5	5.2	4.9
GDP per capita	2.0	2.3	1.9	2.5	2.6

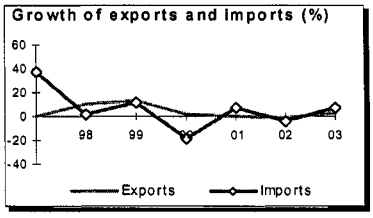


STRUCTURE of the ECONOMY

	1983	1993	2002	2003
(% of GDP)				
Agriculture	59.7	36.9	36.0	35.2
Industry	6.6	24.8	24.3	24.8
Manufacturing	3.9	9.4	9.0	8.4
Services	33.6	38.3	39.7	40.1
Private consumption	90.8	79.5	78.3	82.9
General government consumption	5.9	14.4	11.4	11.5
Imports of goods and services	6.0	36.4	54.5	50.9

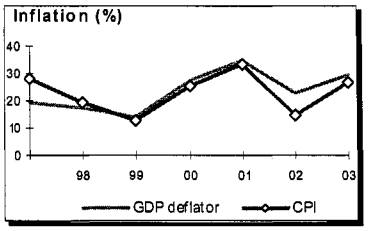


	1983-93	1993-03	2002	2003
(average annual growth)				
Agriculture	2.3	4.0	4.1	4.6
Industry	6.6	4.6	6.3	0.7
Manufacturing	3.9	4.0	0.0	-1.4
Services	7.8	4.5	4.4	6.9
Private consumption	4.4	4.6	9.1	4.3
General government consumption	5.9	3.9	-4.4	7.2
Gross domestic investment	6.2	2.0	-17.6	24.1
Imports of goods and services	8.5	7.1	-4.4	7.7



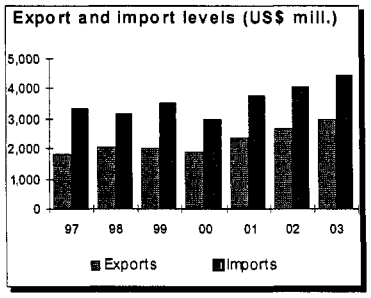
PRICES and GOVERNMENT FINANCE

	1983	1993	2002	2003
Domestic prices				
(% change)				
Consumer prices	122.9	25.0	14.8	26.9
Implicit GDP deflator	123.1	31.8	22.8	29.3
Government finance				
(% of GDP, includes current grants)				
Current revenue	5.5	23.5	20.2	24.3
Current budget balance	-1.9	5.5	0.2	4.1
Overall surplus/deficit	..	-5.6	-5.9	-4.5



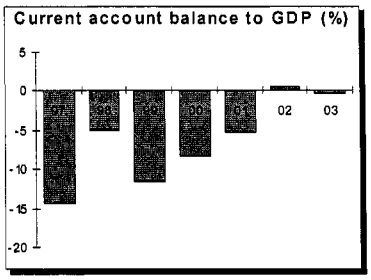
TRADE

	1983	1993	2002	2003
(US$ millions)				
Total exports (fob)	..	1,084	2,681	3,015
Cocoa	..	286	463	772
Timber	..	147	182	176
Manufactures	..	..	..	..
Total imports (cif)	..	1,888	4,099	4,469
Food	..	..	..	..
Fuel and energy	..	158	275	295
Capital goods	..	..	..	..
Export price index *(1995=100)*	94	76	81	88
Import price index *(1995=100)*	102	96	96	97
Terms of trade *(1995=100)*	92	79	85	90



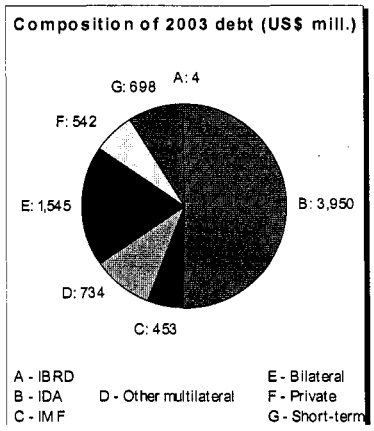
BALANCE of PAYMENTS

	1983	1993	2002	2003
(US$ millions)				
Exports of goods and services	477	1,208	2,613	2,856
Imports of goods and services	634	2,172	3,355	3,910
Resource balance	-157	-964	-742	-1,054
Net income	-90	-112	-129	-158
Net current transfers	-2	517	901	1,177
Current account balance	-248	-559	30	-35
Financing items (net)	-7	600	127	413
Changes in net reserves	256	-41	-157	-378
Memo:				
Reserves including gold *(US$ millions)*	..	..	631	811
Conversion rate *(DEC, local/US$)*	45.4	649.1	7,932.7	8,677.4



EXTERNAL DEBT and RESOURCE FLOWS

	1983	1993	2002	2003
(US$ millions)				
Total debt outstanding and disbursed	1,666	4,834	7,339	7,926
IBRD	128	77	5	4
IDA	141	1,838	3,471	3,950
Total debt service	145	303	193	670
IBRD	20	20	2	2
IDA	2	17	30	29
Composition of net resource flows				
Official grants	46	222	328	..
Official creditors	61	302	175	187
Private creditors	26	25	-23	-294
Foreign direct investment	2	125	50	..
Portfolio equity	0	0	0	..
World Bank program				
Commitments	72	269	0	166
Disbursements	23	205	99	198
Principal repayments	10	17	12	10



ANNEX 15: MAP OF GHANA (IBRD 33411)

GHANA: MULTI-SECTORAL HIV/AIDS PROJECT

IBRD 33411

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SEPTEMBER 2004

IBRD 33411

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SEPTEMBER 2004