GHANA

NATIONAL AIDS SPENDING ASSESSMENT 2007

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES TO CONFRONT HIV AND AIDS

By

Felix Ankomah Asante, PhD

Ama Pokua Fenny, MSc

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KEY PROJECT PARTNERS

Ghana AIDS Commission;
Ministry of Finance and Economic Planning;
Ministry of Health/Ghana Health Service/National AIDS Control Programme;
Specialised departments of relevant line Ministries and Agencies;
Regional/Districts administration;
Development partners;
UNAIDS providing technical and financial assistance.

GHANA NASA TEAM

Dr. Felix A. Asante (Team Leader)
Ama Pokuaa Fenny
Anantiele Mills
Bright Yeboah
Kate Ako
Leo Laryea
Hayford M. Ayerakwa
Ben Johnson

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Executive Summary

Considerable progress has been made in creating an enviable environment for increased partnerships and a stronger coordination of stakeholder activities for more effective response to the HIV and AIDS epidemic. Yet the funding of these activities remains a challenge for many implementers such as the NGOs and CBOs. A second round of the NASA was deemed necessary primarily to assess the level and trend of expenditures on the various HIV and AIDS programmatic areas.

The NASA results show that the total expenditure on HIV and AIDS related activities in Ghana for 2007 was US$52,445,091.00, an increase of 61% from 2006. There has been a systematic increase in funding for HIV and AIDS related programmes over the past three years, 2005 to 2007. Total funding increased from US$28.4 million in 2005 to US$32.6 million in 2006 and to US$52.5 million in 2007. As has been the case in the previous years, the largest proportion of the funds was sourced from international organisations. In 2007, funds from international organizations formed 78.3 percent of total spending on HIV and AIDS.

The spending patterns in terms of expenditure on the key priority areas show that in 2007, most of the funds were spent on Treatment and Care (40 percent); Programme Management and Administrative Strengthening (35 percent) and Prevention Programmes (12 percent). In value terms, US$21,026,047.00 was spent on treatment and care which was very close to the US$21,567,300.00 budgeted for this category in the 2007 POW. The total amount spent on prevention was US$6,339,069.00, which fell short by almost $3 million of the total budget for that category in the 2007 POW budget.

There has been a decline in the total expenditure on prevention programmes, from 39 percent of total spending in 2005 to 23 percent in 2006 and 12 percent in 2007. This is a worrying trend given that expenditure on treatment and care has increased from 17 percent of total spending in 2005 to 22 percent in 2006 and to 40 percent of the total in 2007. In value terms, there was a 200 percent increase in the expenditure on treatment and care from 2006 to 2007. Although the increase in budget allocation for treatment and care for 2007 is in line with the Three by Five Initiative and the Global Fund to Fight AIDS, TB and Malaria (GFATM) which focuses on

treatment, more support is needed for prevention programmes as it remains the cornerstone of the national strategy to overcome the epidemic.

Analysis by beneficiary group shows that most of the programmes are targeted towards the general population. This is reflected in results from the various NASA studies in 2005, 2006 and 2007. In 2007, the general population group accounted for about 76 percent of the total expenditure on HIV and AIDS activities whilst people living with HIV (PLHIV) benefitted from 16 percent of total funding. In 2007, the Most at Risk Population (MARP) benefitted from 2 percent of total funding which is woefully inadequate although there has been a marginal improvement from 2005 and 2006 where the share of the MARP in both years was 1 percent of the total.

As in previous years, the results of the qualitative study show that adequate funding remains the key challenge for implementers. The stringent reporting requirements by DPs coupled with inadequate staffing at NGO level results in delays of financial reports which further delays the disbursement of funds. This situation is also worsened by cumbersome procurement rules. There is also a high competition for available funds which results in funds being spread very far and wide leading to overall inadequacy of funds and thus a low impact in the end.

1. Introduction

1.1 Context for the Assessment

There is a global recognition that the current pace of scale-up of HIV and AIDS related activities world-wide may not help in the achievement of the MDG6 goal of halting and hopefully reversing the HIV epidemic by 2015. Ghana, through increased partnerships and a stronger coordination of HIV and AIDS related activities has made strides towards a more effective response to the epidemic. However, there are a number of challenges associated with these efforts; particularly, the challenge of funding for key activities for HIV and AIDS from year to year.

To overcome this difficulty with funding, it is important to track and collate all expenditures in HIV and AIDS related activities to ensure that funding is being channelled to areas where they are most needed. In order to be able to this effectively, another run of the National AIDS Spending Assessment (NASA) was conducted to collect information on HIV and AIDS expenditure in Ghana. The overall objective of the assessment was to track transactions of total public, private and foreign spending on HIV and AIDS across different sectors.

Despite, the marked increases in financing for the HIV response globally and in Ghana, it is important that the funds are used efficiently to limit the number of new infections that are recorded each year. The scaling up of antiretroviral therapy and prevention programmes presents a new challenge both in finances and human capacity. In that regard, exhaustively tracking expenditures in HIV and AIDS is important both for funding agencies and service providers.

1.2 Objectives and Purpose

The specific study objectives are to:

- Analyse the structure of HIV and AIDS-related services and organizations in Ghana in the public and private sector, including bi- and multilateral organizations active in Ghana;
- Develop a data collection plan for the national level and selection of districts.
- Validate, enter and analyse financial data for national and regional/district level data; and
- Document and share the NASA process and findings with stakeholders.

1.3 Scope of the Assessment

The study focused on the national and selected districts. Data collection covered the domestic spending on HIV and AIDS, the external aid for HIV and AIDS (including those funds channeled through the government) and contributions made by firms in the business sector in 2007. However, there was no capture of household out-of-pocket expenditure. Six sentinel sites in six (6) districts were selected for case studies. Site selection was done in consultation with the key project partners using the following criteria: (i) high/low prevalence sites (districts); and (ii) urban or rural district.

The major sources of data/information include (see Table 1 for a more comprehensive list of sources):

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

2. The National Response to HIV and AIDS in Ghana

2.1 HIV and AIDS Situation

Ghana seems to have a prevalence rate much lower than other countries in the Sub Saharan African region. After an increase in median HIV prevalence in 2006, there has been a decline in 2007 slightly lower than the level in 2005. The 2007 HIV Sentinel Survey Report indicated that the median HIV prevalence rate declined from 3.2 percent in 2006 to 2.6 percent in 2007. Since 2000, the median HIV prevalence rate increased from 2.3 percent to 3.6 percent in 2003, declined to 2.7 percent in 2005, rose to 3.2 percent in 2006 before falling to 2.6 percent in 2007. The cyclical movement is worrying and even in spite of these low prevalence rate, the rate of new infections each year seems to frustrate efforts to lower the prevalence rate even further. Nevertheless, the positive results are a reflection of an increase in funding for HIV and AIDS related activities in the country and the government's efforts to establish a comprehensive response to the HIV epidemic.

It is also worth pointing out that in the last 3 years, HIV prevalence among ages 15-24 has been consistently increasing. According to the 2007 HIV Sentinel Survey Report, the 15-19 year group for the first time since 2005 was not the group with the lowest prevalence. There are a number of possible reasons which may account for this; notable among them is the lack of preventive programmes focused towards the youth (especially youth out of school) and perhaps fears of stigmatization. There are also regional variations as has been the case in previous years. Some regions recorded an increase in prevalence from 2006 while others saw a decline. The Eastern region continues to be the region with the highest prevalence rate. Overall, HIV prevalence in urban areas was higher than in rural areas (HSS, 2008).

2.2 National Response to HIV and AIDS in Ghana

Since the onset of the HIV and AIDS epidemic, there have been several international meetings which aimed to create a number of principles that can be adopted in various countries to foster effective and efficient implementation of HIV and AIDS related activities. One of which is the "Three Ones" principles endorsed in April 2004, at the Consultation on Harmonization of International AIDS Funding. The principles involve the following:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and
- One agreed country-level monitoring and evaluation system.

Ghana's national HIV response is currently based on these principles. In 2005, the Ghana AIDS Commission in agreement with partners and representatives of key stakeholders agreed on a National Strategic Framework 2006-2010 in addition to a Five-year Programme of Work (POW). Both documents essentially provide the framework for the national response from 2006 – 2010. The GAC has the mandate to oversee all the activities outlined in the POW and also ensure a broad participation in the development, review and periodic updating of the National AIDS action framework.

The response to date has seen significant progress in prevention, treatment, care and support in all the regions. There has also been improvement in the coordination and management of HIV related activities by GAC. As part of encouraging broad participation, GAC has been instrumental in the setting up of the National Business Coalition for HIV, primarily to coordinate, monitor and enhance business sector participation in the national response.

Research, Surveillance, Monitoring and Evaluation are tools which can help in assessing not only the epidemic but also the response to help national AIDS authorities to allocate their limited resources to best advantage and to respond to emerging trends in timely manner. Fortunately, in Ghana this area has received some attention from the GAC with the conduction of the first NASA in 2007 with the support of UNAIDS.

2.3 Financing the Annual Programme of Work (APOW)

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

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

3. NASA Methodology

3.1 Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic. This accounting must be **exhaustive**, covering entities, services and expenditures; **periodic**, as a result of a continuing recording, integration and

analyses, to produce, ideally, annual estimates; **systematic**, as the structure of the categories and records/reports must be consistent over time and comparable across countries[1].

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

3.2 Sources of Data

Most of the key sources of data (detailed expenditure records) for 2007 were obtained from primary sources. For the purposes of this study a financial year was from 1st January to 31st December. Only a few data sources were either obtained from secondary sources (e.g. expenditure of small NGOs were captured from GAC's and other donor reports), or were estimated using the best available data and most suitable assumptions. Table 3.1 shows the list of institutions visited for the HIV and AIDS expenditure and the status of data collected. The institutions were grouped into the following categories; Public, External, NGOs and Businesses. This year's study allowed us ample time to visit many more institutions, hence we were able to double the number of NGOs/CSOs visited last year.

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

Table 1: List of Institutions and Status of Data Collected on HIV and AIDS Spending, 2007

INSTITUTION	2007[2]		2007[3]
PUBLIC		**EXTERNAL**	
Ghana AIDS Commission	✓	USAID (International & Ghana)	✓
National AIDS Control Program (NACP)	✓	GLOBAL FUND	✓
TB Control Program		DANIDA	✓
MoH – Health Research Unit	✓	UNICEF	✓
MoH – Health Fund		UNFPA	✓
MoH - Central Medical Stores	✓	UNAIDS	✓
GHS– Salaries		World Bank	✓
MLGRDE	✓	WHO	✓
MoESS	✓	UNHCR	✓
MOWAC	✓	UNESCO	✓
Dept. of Social Welfare	✓	WFP	✓
Inst. of Local Government (ILGS)	✓	ILO	✓
District Assembly Common Fund (DACF)	✓	JICA	✓
Noguchi Mem. Inst for Med. Research	✓	GTZ	✓
		SHARP	✓
EXTERNAL		**NGOs**	
DFID	✓	World Vision – Ghana	✓
Royal Netherlands Embassy	✓	Reach the Children - GH	✓
WAPCAS	✓	Health Watch Resources	✓
OICI (Int. & Ghana)	✓	PPAG	✓
PLAN (Int. & Ghana)	✓	All MSHAP transfers to NGOs/CBOs (via GAC)	✓
Futures Group	✓	ISODEC	✓
Family Health Int. (& Ghana)	✓	Research International	✓
		Sam Woode Consult	✓
NGOs		Maple Consult	✓
CARE	✓	GSMF	✓
CRS	✓	Action Aid Int. & Ghana	✓
NAP +	✓	CUSO	✓
GHANET	✓		

[2] Key for the symbols can be found below the Table.

[3] Key for the symbols can be found below the Table.

ARHR	✓	**BUSINESS**	
AWARE	✓	Ghana Business Coalition against AIDS	✓
GSCP	✓	Ghana Employers Association	✓

Data was not available
✓ Data was available and captured in NASA RTS

3.3. Key Assumptions and Estimations

- A few development partners had different financial year periods from that used by the Government of Ghana (1st January to 31st December). Thus, effort was made to capture the actual expenditure within each fiscal year, January to December. In this case we relied mainly on monthly or quarterly expenditures from the development partners to make the necessary adjustments.
- Where funds are pooled, the expenditure contribution of donor to the activities was assumed to be equal in equal proportions as the contribution to the total fund. The same rationale was also applied to any under spending. Also where detailed expenditure records of providers were not available, we assumed equal split of funds between the key activities, unless instructed otherwise.
- The annual exchange rate of the US dollar to the cedi was used in this study. For 2007, the rate was 0.9704 US$ to GH¢1 (SGER, 2008)[4]. There was a redenomination exercise in the middle of 2007 which saw the cancellation of four zeros from the old currency. Hence 10,000 of the old cedi was equivalent to 1 of the new Ghana cedi.

3.4 Limitations of the Assessment

- The study could not include private expenditure such as private insurance, businesses outside the GCBA, traditional healers, and household out-of-pocket payment expenditures.
- Data on salaries of health and non-health personnel working in HIV and AIDS related activities from MOH, GHS and other MDAs were not available and thus not included.

[4] SGER (2008). The State of the Ghanaian Economy in 2007. Published by the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana, Legon.

- The overheads of many institutions were not captured due to the fact that many of them were engaged in other activities besides HIV and AIDS programmes, thus making it difficult to estimate the proportion of their overheads used for HIV and AIDS related activities.
- Some of the data on beneficiaries were disaggregated but most were not and as such the bulk of it was assumed to be targeted to the general population.

The study also excluded the following expenditure which was difficult to collect:

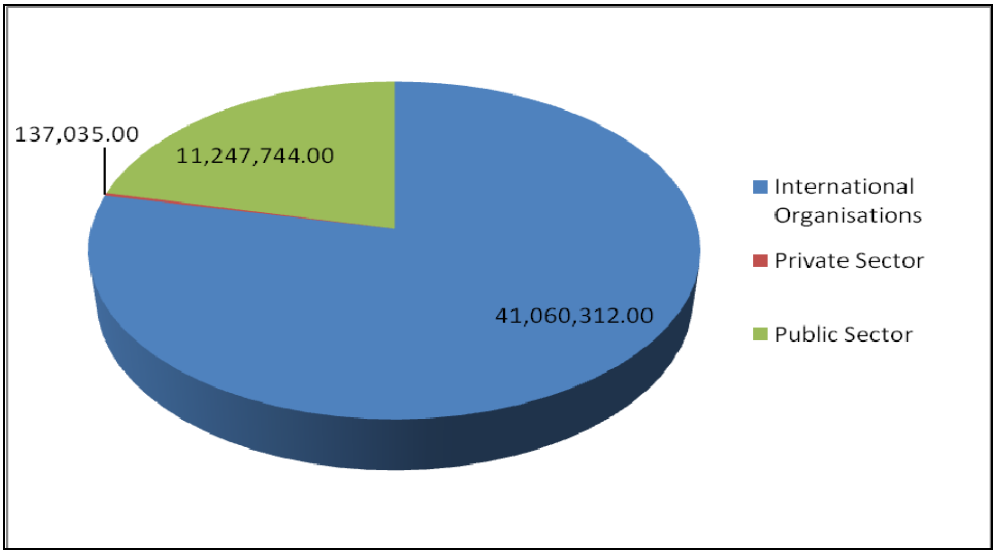
1. Sexual reproductive health spending share that might be related to HIV and AIDS;
2. The proportion of TB treatment that was related to HIV and AIDS.

4. Findings - NASA Estimates for 2007

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

The total expenditure on HIV and AIDS activities in Ghana captured in the NASA RTS for 2007 was US$52,445,091.00. Figure 1 shows that in 2007 the largest proportion of the funds was sourced from international organisations. Funds from international organizations formed 78.3 percent of total spending on HIV and AIDS; public funds formed 21.4 percent of the total expenditure whilst private sources of funding constituted 0.3 percent. The study did not collect all private (businesses and household or individual out-of-pocket) spending on HIV and AIDS related activities, hence this total from the private sector does not represent their contribution to the total spending on HIV and AIDS in 2007. Specifically, what is recorded here is the total private spending from Ghana Business Coalition against AIDS and Ghana Employers Association. Comparing the total expenditure on HIV and AIDS in 2007 and what was budgeted in the National Response for 2007 of US$43,425,663.00, there was an over spend of US$9,019,428.00.

Figure 1: Sources of Funds for HIV and AIDS Expenditure, 2007



A key finding was that out of the total funding by international organisations only 23 percent was sent to the pooled or earmarked fund overseen by the GAC. The majority, 77 percent was sent directly to implementing agencies which defeats one of the aims of the Paris Declaration of pooling funds to avoid duplication of efforts and a more effective response to the epidemic.

4.2 Composition of HIV and AIDS Spending

Table 2 shows the total spending on the key priority areas of HIV and AIDS in 2007. Most of the funds were spent on Treatment and Care (40 percent); Programme Management and Administrative Strengthening (35 percent) and Prevention Programmes (12 percent). The remaining 13 percent of the total funds was shared amongst the remaining 5 priority areas.

Table 2: Total Spending on Key Priorities or Intervention Areas, 2007

Key areas of Expenditure	(US$)	(%)
Prevention	**6,339,069.00**	**12.09**
Treatment and Care	**21,026,047.00**	**40.09**
Orphans and Vulnerable Children (OVC)	**153,233.00**	**0.29**
Programme Management and Administrative Strengthening	**18,566,509.00**	**35.40**
Incentives for Recruitment and Retention of Human Resources	**2,788,821.00**	**5.32**
Social Protection and Social Services(Excluding OVC)	**1,256,559.00**	**2.40**
Enabling Environment and Community Development	**902,332.00**	**1.72**
HIV- and AIDS-Related Research (Excluding Operations Research)	**1,412,512.00**	**2.69**
Grand Total	**52,445,091.00**	**100.00**

4.3 Key Spending Priorities by Funding Agents[5]

In 2007, 40 percent of funds from International Organisations was spent on programme management and administrative strengthening; whilst another 40 percent went into Treatment and Care component and 9 percent on Prevention programmes. For Public Sector funds, 43 percent was spent on treatment and care; 23 percent on prevention; 15 percent on programme management and administrative strengthening; and 9 percent on research. Although there is no public spending on OVCs, the government has since July 2008 made provision for OVCs through the implementation of the Livelihood Empowerment Against Poverty (LEAP) programme which provides cash transfers or social grants to targeted, extremely poor and vulnerable households. On the part of the private sector, 73 percent of the total funding was spent on programme management and administrative strengthening; 24 percent to provide incentives for recruitment and retention of human resources whilst 2 percent was spent on prevention programmes (Table 3).

Table 3: Spending Priorities by Agents, 2007 (US$)

Key Priority Areas	Public sector	Private sector	International Organizations	Grand Total
Prevention Programmes	2,639,964.00	2,749.00	3,696,356.00	**6,339,069.00**
Treatment and care components	4,786,506.00	-	16,239,541.00	**21,026,047.00**
Orphans and Vulnerable Children (OVC)	-	-	153,233.00	**153,233.00**
Programme Management & Administrative Strengthening	1,746,556.00	100,851.00	16,719,102.00	**18,566,509.00**
Incentives for Recruitment & Retention of Human Resources	205,175.00	33,435.00	2,550,211.00	**2,788,821.00**
Social Protection and Social Services(excluding OVC)	160.00	-	1,256,399.00	**1,256,559.00**
Enabling Environment and Community Development	825,991.00	-	76,341.00	**902,322.00**
HIV- and AIDS-Related Research (excluding operations research)	1,043,392.00	-	369,129.00	**1,412,521.00**
Grand Total	11,247,744.00	137,035.00	41,060,312.00	**52,445,091.00**

[5] The agents are international organisations, the private sector and the public sector.

4.4 Prevention Programmes Spending Activities

Prevention remains the cornerstone of the national strategy to overcome the epidemic. The total amount spent on prevention was $6,339,069.00, which fell short by almost $3 million of the total budget for that category in the 2007 POW budget. Table 4 shows which prevention programme areas received funding in 2007. One of the priority activities in the 2007 POW was to procure male and female condoms for the vulnerable in a more decentralised manner to ensure that they reached the targeted groups. From the data collected, 18 percent of the total spending on prevention programmes was spent on procuring female condoms, whilst 0.03 percent was spent on condom social marketing. The scaling up of VCT in the various districts and designated private centers may not have been achieved since about US$340,000.00 was spent in that category in 2007 well below the original budget of US$1,742,675.00 meant to allow at least 60,000 clients to be reached with VCT/PMTCT services.

Table 4: Prevention Spending Activities, 2007

Key Areas of Expenditure	2007 (US$)	Percent (%)
Communication for social and behavioural change	631,692.00	9.97
Communication for social and behavioural change not desegregated	1,113,501.00	17.57
Community mobilization	6,065.00	0.10
Voluntary counselling and testing	339,329.00	5.35
BCC/IEC as part of programmes for vulnerable and special populations[6]	1,734,582.00	27.36
Programmatic interventions for sex workers and their clients	444,290.00	7.01
Programmatic interventions for men who have sex with men (MSM)	132,680.00	2.09
Prevention programmes in the workplace	746,734.00	11.78
Condom social marketing	19,214.00	0.30
Public and commercial sector condom provision	582.00	0.01
Female condom	1,170,400.00	18.46
Total	**6,339,069.00**	**100.00**

[6] These are interventions aimed to promote risk reduction measures including peer outreach among other vulnerable groups not captured else where.

4.5 Treatment and Care Spending Activities

Table 5 shows the key areas of expenditures in 2007 on Treatment and Care categories. Almost all the funding for this component was spent on Anti Retroviral Therapy (ARV). The results show that about 77 percent of the total expenditure on the Treatment and Care component was from International Organisations and 23 percent from the Public Sector. The increase in budget allocation for treatment and care for 2007 was in line with the Three by Five Initiative which focused primarily on treatment and also to the Global Fund to Fight AIDS, TB and Malaria (GFATM) proposal which also focused on mostly on treatment. Total expenditure on home-based care both non-medical and non-health care was very small, US$836.00 in 2007. There is the need to encourage more funding in this area and also encourage the NGOs and CBOs to be more active in home based care since they are closer to the PLHIV in the communities.

Table 5: Treatment and Care Spending Activities, 2007

Key Areas of Expenditure	2007 (US$)	Percent (%)
Provider initiated testing and counseling[7]	3,255.00	0.02
Adult antiretroviral therapy	14,903,297.00	70.88
Pediatric antiretroviral therapy	6,118,659.00	29.10
Home-based non medical /non-health care	836.00	0.00
Total	**21,026,047.00**	**100.00**

4.6 Care and Support Spending Activities

The support for activities designed to reduce the economic impact of HIV and AIDS on infected and affected households especially OVC and other vulnerable groups is a significant objective of the NSF II. NGOs are being supported in various ways to provide and support OVC. Expenditure on OVCs formed 0.29 percent of total spending on HIV and AIDS related activities in 2007. Of the total expenditure on OVCs in 2007, 85 percent was spent on in- kind benefits consisting of mainly food items, 8 percent on education and about 5 percent on OVC home support (Table 6).

[7] This amount may be larger given the cost of the test kits, however information given by the NACP did not give a clear indication of how much was spent in this category making it difficult for the actual amount to be quoted. It is quite likely that this has been embedded in the other line items presented by the NACP

Table 6: Total Spending on OVCs, 2007

OVC Spending Categories	Amount (US$)	Percent (%)
OVC Education	96,346.00	62.88
OVC Family / Home support	53,249.00	34.75
OVC Administrative costs	3,638.00	2.37
Total	**153,233.00**	100.00

Social protection efforts have also been scaled-up to mitigate the socio-economic effects of the epidemic. The finalization of a National Social Protection Strategy (NSPS) will in future encourage government involvement in this process to ensure that the vulnerable are not left in abject poverty. In 2007, almost $1.3 million was spent on offering social protection, 99 percent of which was spent on in-kind benefits (Table 7).

Table 7: Social Protection and Social Services (excluding OVC)

Key Areas of Expenditure	2007 (US$)	Percent (%)
Social protection through monetary benefits	9,151.00	0.73
Social protection through in-kind benefits	1,244,153.00	99.01
Social protection through provision of social services	-	0.00
HIV-specific income generation projects[8]	3,255.00	0.26
Total	**1,256,559.00**	100.00

4.7 Programme Management and Administrative Strengthening

Coordinating and managing the expanded and decentralised response to the HIV and AIDS epidemic involves diverse and complex processes including joint planning, resource mobilization monitoring, among others. In 2007, about US$19 million was spent in managing programmes, 81 percent of which was spent directly on management, 12 percent on transaction cost, about 3 percent on planning and coordination and 2 percent on upgrading and construction of infrastructure (Table 8). Monitoring and Evaluation (M&E) accounted for 1.2 percent of total expenditure on programme management. Monitoring and Evaluation of HIV and AIDS related

[8] The NACP in its 2007 annual report indicates that it received and disbursed a grant of US$1.2 million from the Global Fund to 167 PLHIV Associations to be used for income – generating activities. The expenditure sheet given by the NACP to the NASA team was not disaggregated enough to show this. Therefore although this amount has been captured it has been invariably captioned under a different category.

activities needs to be taken serious and therefore requires the channeling of more resources. Indeed, without a good M&E system, it will be difficult to access the progress and redirect resources to areas that need more attention.

Table 8: Programme Management Spending Activities, 2007

Key Areas of Expenditure	2007 (US$)	Percent (%)
Programme Management	15,137,739.00	81.53
Programme Administration	26,918.00	0.14
Transaction Costs	2,292,112.00	12.35
Planning and Coordination	482,283.00	2.60
Monitoring and Evaluation	224,727.00	1.21
HIV Drug-resistance Surveillance	1,905.00	0.01
Drug Supply Systems	2,135.00	0.01
Upgrading and Construction of Infrastructure	398,690.00	2.15
Total	**18,566,509.00**	**100.00**

4.8 Human Resources and Retention Incentives

The success of any programme depends on an effective and reliable workforce. Several initiatives have been undertaken to recruit more workers and encourage those already in the system to give off their best. In 2007, about US$2.8 million was spent on human resource recruitment and retention incentives, 66 percent of which supported formative education to build-up an HIV workforce, 33 percent on monetary incentives for other staff and 1 percent on monetary incentives for nurses (Table 9). Training was as low as 0.1 percent.

Table 9: Human Resources' Recruitment and Retention Incentives Spending Activities, 2007

Key Areas of Expenditure	2007 (US$)	Percent (%)
Monetary Incentives for Nurses	30,032.00	1.08
Monetary Incentives for Other Staff	917,797.00	32.91
Formative Education to Build-Up an HIV Workforce	1,840,694.00	66.00
Training	298.00	0.01
Total	**2,788,821.00**	**100.00**

4.9 Enabling Environment and Community Development

The 2007 POW identifies strongly the key role of creating an enabling environment which includes the enforcement of laws and non-discriminatory practices in all spheres of the society.

In 2007, about US$902,000 was spent on activities in this area (Table 2). Data collected for the NASA was not disaggregated to get the various sub-components under this priority or intervention area.

4.10 HIV and AIDS Related Research

High quality data from research on HIV and AIDS related issues aids the process of fine-tuning programmes and also serves as a vital tool for monitoring and evaluation. In 2007, the NASA RTS captured a total of US$1.4 million for research which includes biomedical, vaccine-related, clinical and epidemiological research (Table 10). Most of these researches are often multi-disciplinary in nature cutting across some aspects of behavioral, social and economic issues. They also encourage capacity strengthening efforts to ensure the sustainability of ongoing programmes.

Table 10: Spending on HIV and AIDS-Related Research

Key Areas of Expenditure	2007 (US$)	Percent (%)
Biomedical research	372,419.00	26.37
Clinical research	185,153.00	13.11
Epidemiological research	111,557.00	7.90
Vaccine-related research	743,392.00	52.63
Total	**1,412,521.00**	**100.00**

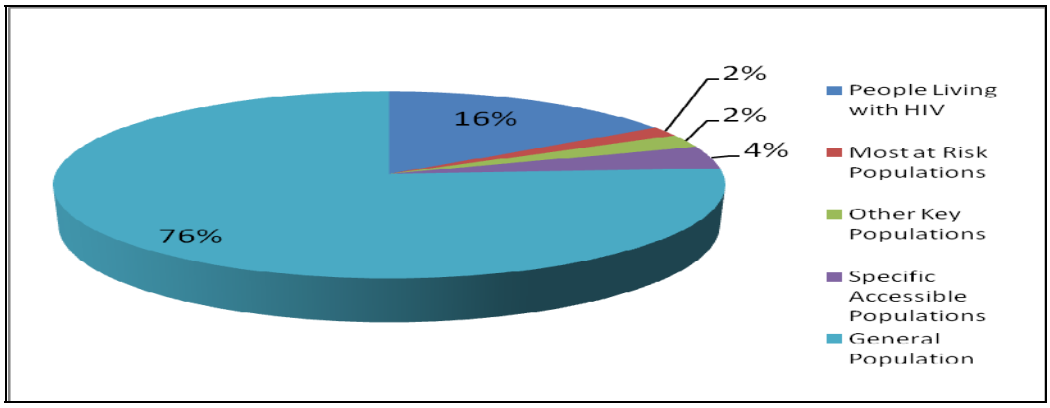
4.11 Beneficiaries of HIV and AIDS Spending

The results show that the general population formed the largest beneficiary group in 2007, accounting for about 76 percent of the total population, whilst people living with HIV (PLHIV) benefited from 16 percent of the total (Figure 2). Other groups who benefited from HIV and AIDS spending included accessible, most at risk and other key population groups. The pattern of spending on HIV and AIDS beneficiaries reemphasizes the fact that interventions are focused more on the general population as Ghana is experiencing a generalized epidemic.

Overall, in 2007, all the age groups benefitted from treatment and care, programme management and prevention programmes. PLHIV benefited most from treatment and care programmes. Other accessible groups such as OVC benefited from social protection services. A note of caution concerning the size of the general population; given the lack of disaggregation of the data by

some providers it may be possible that the general population group may include some of the other beneficiary groups. Some of the specific groups which benefited include commercial workers and their clients (US$534,000.00), men who have sex with men (US$312,000), youth aged between 15 to 24 years[9] (US$509,000) and prisoners (US$11,045).

Figure 2: Spending by Beneficiary Group, 2007



5. Trend Analysis of HIV and AIDS Expenditure, 2005 to 2007

Over the last three years (2005-2007), there has been a systematic increase in funding for HIV and AIDS related programmes, increasing from US$28.4 million in 2005 to US$32.6 million in 2006 and to US$52.5 million in 2007. Funding increased by 11.4 percent between 2005 and 2006 and by about 61 percent from 2006 to 2007 (Figure 3). In all the three years, International Organisations funded most of the activities; accounting for 71 percent of the funding in 2005, 68 percent in 2006 and 78 percent in 2007. The public sector's share was about 28 percent in 2005, 31 percent in 2006 and decreased to about 21 percent in 2007.

[9] Even though they are part of the general population, data collected was disaggregated only for this age group.

Figure 3: Sources of Funds for HIV and AIDS Expenditure, 2005 – 2007

	2005	2006	2007
Public Sector	7,850,376.00	10,174,465.00	11,247,744.00
Private Sector	315,210.00	416,819.00	137,035.00
International Organisations	20,249,118.00	21,984,015.00	41,060,312.00

A further disaggregation of data by the NASA AIDS Spending Categories show that the three key spending priorities between 2005 and 2007 have been mainly on prevention; treatment and care; and programme management and administrative strengthening. There has been a decline in the total expenditure on prevention programmes, from 39 percent of total funding in 2005 to 23 percent in 2006 and 12 percent in 2007 (Table 11 and Figure 4). On the other hand, expenditure on treatment and care increased from 17 percent of total spending in 2005 to 22 percent in 2006 and to 40 percent of the total in 2007.

A key intervention area where spending has increased over the years is incentive for recruitment and retention of human resources. Total spending in this category was about US$130,000.00 in both 2005 and 2006 (0.5 percent of the total in both years) increasing significantly to US$2.8 million in 2007 (5 percent of the total spending). Total spending on Orphans and Vulnerable Children (OVC) remain very low at 1.25 percent, 1.08 percent and 0.29 percent of the total spending, respectively in 2005, 2006 and 2007.

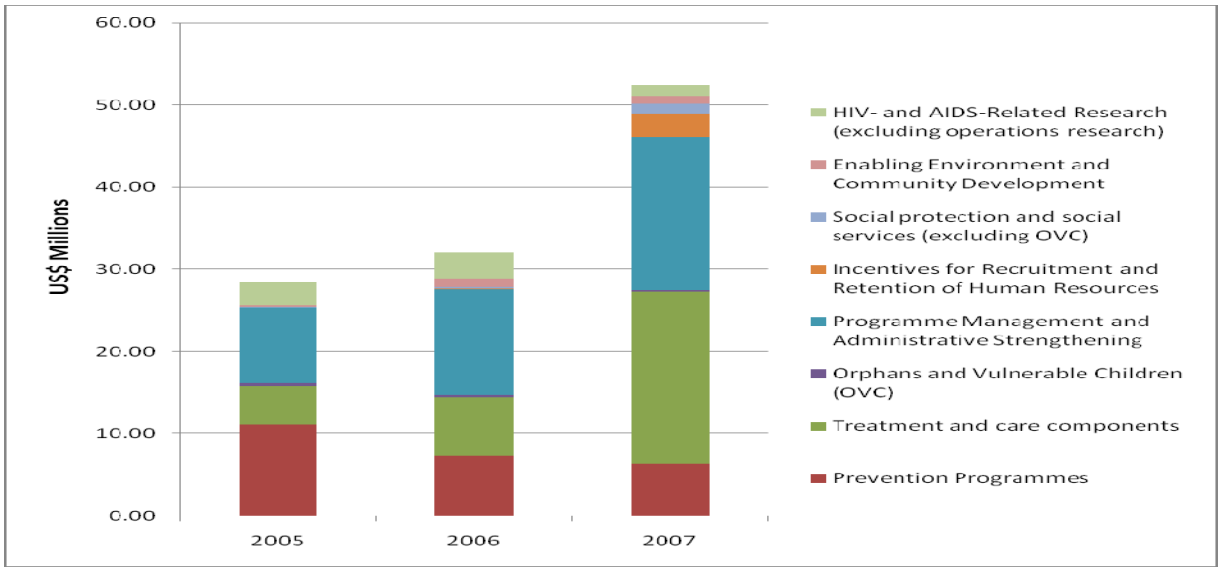
A worrying feature is the overall decline in expenditure on prevention programmes as a share of total expenditure in 2005, 2006 and 2007. This needs more attention given the importance of prevention programmes in changing people's attitude regarding practises that leave them vulnerable to being infected. Although the NSF II recognizes treatment, care and support to

PLHIV as a critical investment to complement prevention programmes, it seems that funding for treatment and care increased at a higher pace than on prevention programmes. Spending on ART for both adults and children took up the bulk of this expenditure. Expenditure on support services such as home based care and the giving of nutritional support for those on ART therapy has been minimal. Total expenditure on HIV and AIDS related research increased from US$2.7m in 2005 (9.5 percent of the total) to US$3.2 million (10 percent of the total) declining to US$1.4 million in 2007 (2.7 percent of the total).

Table 11: Total Spending on Key Priorities, 2005 – 2007

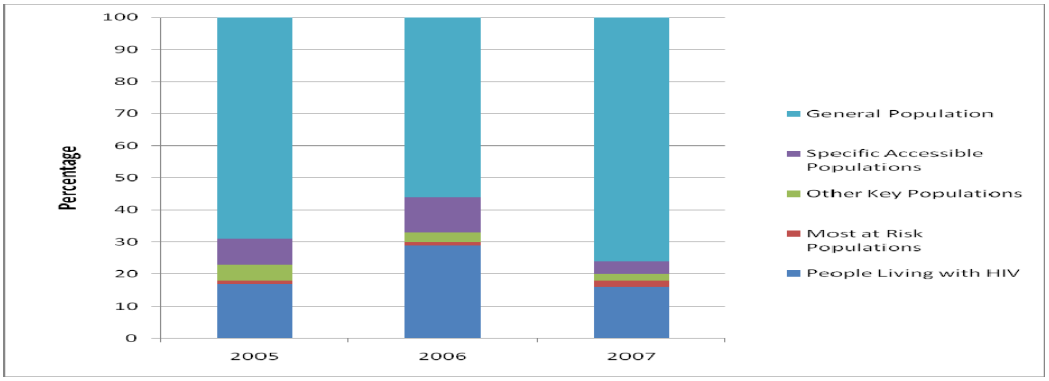
Key Areas of Expenditure	**2005 (US$)**		**2006 (US$)**		**2007 (US$)**	
Prevention Programmes	11,157,054.00	**39.27**	7,352,150.00	**22.93**	6,339,069.00	**12.09**
Treatment and care components	4,682,149.00	**16.48**	7,050,088.00	**21.99**	21,026,047.00	**40.09**
Orphans and Vulnerable Children (OVC)	354,865.00	**1.25**	344,997.00	**1.08**	153,233.00	**0.29**
Programme Management & Administrative Strengthening	9,133,721.00	**32.14**	12,820,701.00	**39.98**	18,566,509.00	**35.40**
Incentives for Recruitment & Retention of Human Resources	130,246.00	**0.46**	130,620.00	**0.41**	2,788,821.00	**5.32**
Social Protection and Social Services(excluding OVC)	46,669.00	**0.16**	164,425.00	**0.51**	1,256,559.00	**2.40**
Enabling Environment and Community Development	214,902.00	**0.76**	995,591.00	**3.10**	902,332.00	**1.72**
HIV- and AIDS-Related Research (excluding operations research)	2,695,102.00	**9.48**	3,209,063.00	**10.01**	1,412,521.00	**2.69**
Grand Total	**28,414,708.00**	**100.00**	**32,676,350.00**	**100.00**	**52,445,091.00**	**100.00**

Figure 4: Total Spending on Key Priorities, 2005 - 2007



Between 2005 and 2007, HIV and AIDS related programmes were targeted to the general population (Figure 5). In 2005, the general population benefitted from 69 percent of total funding decreasing to 56 percent in 2006 and increasing sharply to 76 percent of the total expenditure in 2007. People living with HIV (PLHIV) accounted for 17 percent of the total in 2005, to 29 percent in 2006 and 16 percent in 2007. In value terms however, funding targeted at programmes for PLHIV has seen a significant increase over the years, increasing from $5 million in 2005 to $9.5 million in 2006 to $8.5 million in 2007. Most At Risk Population (MARP) benefitted from 2 percent of total funding in 2007, a marginal improvement from 2005 and 2006 where the share of the MARP in both years was 1 percent of the total (Figure 5).

Figure 5: Spending by Beneficiary Group, 2005 - 2007



6. Findings – Qualitative Section of NASA Questionnaire

The study allowed for the assessment of the funding processes, reporting requirements, bottlenecks and challenges faced by the various stakeholders involved in the national response to the epidemic in Ghana.

6.1 Development Partners (DPs) in Ghana

Generally, DPs stringent reporting formats delays the preparation of financial reports which further delays the disbursement of funds. A major bottle neck reported by the DPs is inadequate staff with competent skills at the implementing level as well as high staff turnover which often delays projects. Cumbersome procurement rules also cause undue delay to projects. DPs also noted that implementers often demand HIV and AIDS support in-kind benefits such as food and other items that will improve the standard of living for PLHIV and OVC. Unfortunately, funding for such provision is often not included in their budgets which explain the low level of funding for home-based care and support.

There is also a high competition for available funds which results in funds being spread very far and wide leading to overall inadequacy of funds and short programmes (1-3 year) that have very little impact. Some of the UN agencies are of the opinion that if the budgets and activities are strategically thought out by implementers, accessing funds and effectively implementing them should not be a challenge. Many NGOs have weak administrative capacity to deliver projects on time.

6.2 Non-Governmental Organisations

Many of the NGOs/CBOs/FBOs interviewed complained of inadequate funding. Most often their budgets were scaled down and funds approved unduly delayed. They also had difficulties with capacity especially in the preparation of proposals for funding. Donors were often reluctant to provide funds for capacity building. Also, some of the procurement requirements encourage the acquisition of cheap equipments which often broke down, making it difficult to complete projects. Global economic downturns with its accompanying inflationary pressures and high cost

of fuel meant that original budgets needed to be revised to allow for these changes. Approval procedures to effect these changes were too slow and involved several layers of procedures.

On a more positive note, many NGOs agreed that some of the reporting systems ensured transparency and accountability. It is recommended that DPs and the government through the GAC, pool funds specifically for building capacity of the NGOs in fund management and financial reporting.

7. Case Studies

As part of the National AIDS Spending Assessment (NASA) study, six sites were selected for case studies on the basis of their peculiar HIV prevalence rates as well as rural and urban biases.

Prevalence

The results of the case studies reveals that areas where the prevalence rate has declined or been maintained over the period (2006 -2007) have experienced an intensified education and awareness of HIV and AIDS and have also benefitted from agencies in their various districts. On the other hand, districts with higher prevalence rates have attributed the cause to some prevailing cultural practices, prostitutions and the engagements of the youth in all forms of promiscuous activities during festivals, funerals and other social gatherings. Cross border activities where commercial sex workers have been known to operate account for the high prevalence rate in some of the districts surveyed. Stigmatization remains a key deterrent for people to test or disclose their status in order to benefit from treatment, counseling and other assistance offered to PLHIV in the communities.

Finances

The biggest challenge facing many district hospitals, NGOs and other organizations involved in HIV and AIDS activities is inadequate funding of programmes from the District Assemblies and GAC. Many of the key informants explained that the funds they received were often smaller than the original budgets. The delays in release of these funds to the appropriate agencies meant that some programmes were disrupted or rushed through yielding very minimal results.

Human Resources

In order for programmes to be effectively implemented there is the need for the engagement of adequately trained personnel. Sadly, many of the districts lacked these and the high staff turnover common in these agencies have contributed immensely to delays in the submission of reports and subsequent release of funds from the various financing agencies.

Activities to Enhance the Livelihood of PLHIV

PLHIV in the districts have been reluctant to seek counseling or join PLHIV associations due to stigmatization from community members. However, in some of the districts a number of them had been registered and adequately provided with ARV drugs in the district hospitals. The introduction of ART means that most of them healthily engage in income generating activities such as petty trading, bee keeping, beads and soap making. This has often been made possible with both financial and technical support from NGOs/CBO and FBOs working in the districts.

Clearly, there is the need to increase HIV and AIDS awareness in all districts especially prevention programmes targeting the youth. Adequate funding and support should also be provided by the GAC and other financing agents to build capacity for HIV and AIDS activities. This would reduce the unnecessary delays in reporting and disbursement of funds. Also, programmes will be effectively and efficiently implemented as waiting time is significantly reduced.

8. Conclusions and Recommendations

8.1 Conclusions

The current NASA results confirm that indeed there has been a global increase in funding for HIV and AIDS. Although Ghana has made some positive strides in stabilizing the epidemic, there are reported cases of new infections each year. Implementers still complain of inadequate funding for their activities and yet there was an overspending by almost $9 million as we compared the total amount spent and that budgeted for 2007. Clearly, there are a number of bottlenecks that need to be addressed in order for funds to be allocated where they are most needed and used in a more efficient manner.

Overall, Ghana continues to make progress in its AIDS response. With the prevalence rate stabilizing and funding for HIV and AIDS related activities increasing, there is hope that eventually there will be fewer cases of new infections and a better control and management of the epidemic. However, the bulk of expenditure is skewed towards the provision of treatment and care services at the expense of prevention programmes and other key priority areas. Prevention programmes have a vital role to play in the fight against HIV and AIDS and care must be taken not to relegate its importance.

8.2 Recommendations

The second round of the NASA yielded much better results than the first because of the increase in coverage size and less reluctance by the key stakeholders to give access to their data. Even though there was improvement in coverage of institutions visited and access to data there were a number of limitations which made it difficult to get disaggregated data. Hence we make the following key recommendations to the following groups: government, development partners and implementers.

I. Government

- GAC should insist that institutions which benefit from their funds, present their financial reports according to the NSF priorities to make assessment of their progress easier.
- The impact of HIV and AIDS programmes go beyond the efficient use of resources; hence the GAC should monitor on regular basis outcomes against intended targets. There is thus a need for an improved M&E system. In 2007, the NASA results showed that M&E expenditure was only 1.2% of the total spending on programme management and administration.
- Institutionalization of NASA – Given that this is the second round of the NASA in Ghana, the key lesson learnt regarding its institutionalization is the need for increasing awareness of the NASA process and usefulness among the key stakeholders through training workshops. This will help in the collection of more accurate and disaggregated data for subsequent NASA activities. GAC should also build capacity and be able to conduct the Ghana NASA future.

- There is also the need to localize the NASA key areas to fit the GAC's NSF categories to enable a clear comparison of what has been budgeted for in each category and what was actually spent. Currently only two of the categories (prevention; and treatment and care) can be accurately compared. Localizing the NASA key areas will also make the NASA an important M&E tool.
- Although the report was limited in its ability to present an accurate picture of public sector spending on HIV and AIDS related spending with regards to salaries and some institutional overheads, it is essential for the government to increase its level of direct spending on HIV and AIDS programmes. The NASA results show that expenditure for these programmes was supported largely by funds from international organisations.

II. Development Partners

- Funding for prevention programmes must be increased using specific criteria (such as areas where the HIV prevalence rates have increased in specific cohorts) to equip more NGOs /CBOs/FBOs with the funds and materials needed for prevention programmes.
- DPs and the government through the GAC pool funds should build capacity of the NGOs in fund management and financial reporting to reduce delays in the submission of project and financial reports.
- Harmonise reporting mechanisms to conform to the Three One Principle of one national M&E framework.
- The study showed that many development partners were keen to fund programmes directly than send their monies to the GAC's pooled and earmarked funds. This current funding process needs to be reversed so that more funds goes into pooled funds for effective and coordinated HIV and AIDS programmes and also avoid duplication of programmes/activities.

III. Implementers

- Agencies and implementers should be clearer on their target population where possible to give a more accurate picture of which groups are truly benefitting from the HIV and AIDS related expenditures.

- There is still more room for implementers to improve on the data quality. This can be achieved through training programmes.
- Private sector involvement in the national response is limited. For instance, the GBCA can be supported to allow it to widen its network and also encourage a fuller participation of the existing members in workplace HIV and AIDS activities.