The International AIDS Society

Educational Fund meeting: Outcome report
12-13 May 2019
Ghana

Science and Community in the response to HIV in Western Africa
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This report was developed in collaboration with the Planned Parenthood Association of Ghana (PPAG). The views expressed in the report do not necessarily reflect the views of the International AIDS Society.
2. List of abbreviations and acronyms

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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AIDS 2018</td>
<td>22nd International AIDS Conference</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Virus</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<td>CSOs</td>
<td>Civil Society Organizations</td>
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<td>DSD</td>
<td>Differentiated Service Delivery</td>
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<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>GF</td>
<td>Global Fund</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>IAS</td>
<td>International AIDS Society</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NACP</td>
<td>Ghana's National AIDS Control Program</td>
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<td>PEPFAR</td>
<td>The U.S. President's Emergency Plan for AIDS Relief</td>
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<td>PITC</td>
<td>Provider-Initiated Testing and Counselling</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>POC</td>
<td>Point-of-Care</td>
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<td>Point-of-Care-Technologies</td>
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<td>PPAG</td>
<td>Planned Parenthood Association of Ghana</td>
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<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>STIs</td>
<td>Sexually transmitted infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UHC</td>
<td>Universal Health Care</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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3. Introduction

The International AIDS Society (IAS), in collaboration with the Planned Parenthood Association of Ghana (PPAG), convened a meeting in Accra, Ghana on 12-13 May 2019. The meeting, organized as part of the IAS Educational Fund in the form of a workshop, brought together over 65 HIV professionals and community members from Ghana and across selected West African countries such as Niger, Mali, Burkina Faso and Côte d’Ivoire as well as Chad, Uganda and South Africa, to share knowledge on HIV science, policy and programming. The participants were diversely representative of the several stakeholders in the HIV and AIDS community including clinicians, healthcare workers, policy makers, non-governmental organizations, programme implementers, activists and key populations.

This was the first IAS Educational Fund meeting held in Ghana, and the fourth organized in West Africa. The IAS Educational Fund was launched in 2016 and since then, it has been providing healthcare workers, advocates and policymakers access to the latest science and opportunities to use that information and question how it impacts local epidemics. The meeting featured twelve plenary presentations as well as group work all conducted in both French and English.

One of the primary objectives the meeting was to present key scientific and policy content from the 22nd International AIDS Conference (AIDS 2018) and discuss how to effectively translate this into local policy and practice in the Western African context. The meeting provided a platform to discuss key messages and findings from AIDS 2018, held in Amsterdam, the Netherlands. Highlights from the conference included: presentations on rights-based approaches in Eastern Europe to more effectively reach key populations; promising results of potential new vaccines; innovations in diagnostic technologies; and advances in prevention, testing and treatment, featuring a presentation on preliminary findings from the rollout of pre-exposure prophylaxis (PrEP) in key countries.1,2

Special focus was also placed on four priority themes. The first one was on HIV prevention for adolescent girls, young women and their partners. Scientific findings as well as programmatic impact and recommendations regarding this theme were shared. The second and third themes of the workshop included the status of implementation of differentiated service delivery models regarding HIV programming in Ghana, as well as the status of point-of-care technologies in prevention of mother-to-child transmission (PMTCT) programming. The last theme of the workshop was on integration of HIV management and co-infections, including tuberculosis (TB) and hepatitis, and progress updates for Ghana and Burkina Faso in these areas were shared.

The meeting was successful as its primary expected objectives were met, which was, for participants to proffer contextual recommendations and also provoke a coordinated call to action to translate the latest science and research on the four priority areas discussed into policy and programme implementation in Western Africa. The quality of the research presented and the active participation and contribution of key stakeholders that participated in the meeting point towards a future of significant and impactful improvement in the fight against the HIV and AIDS epidemic within the region.

1 AIDS 2018. Conference Report
Group picture of participants – Accra, Ghana – 12 May 2019
4. Background and context

The HIV epidemic in West Africa has been classified as relatively low\(^3\), in comparison to other regions within sub-Saharan Africa. However, the rate of new infections and the general burden of HIV and AIDS still remain high within the region\(^4\), despite the enormous contributions towards tackling the epidemic within the region. It should, however, be noted that significant progress has been made since the epidemic broke out in sub-Saharan Africa and deaths from AIDS-related illness in the region have declined by nearly a quarter since 2010. Areas in which significant progress has been made include the following: the number of AIDS-related deaths which has been reduced by 30% since 2006\(^5\); new infections among children which have been reduced by 33% since 2010; and new infections among adults which have fallen by 8% since 2010 among others.\(^6\)

As of 2017, the West African region accounted for 21% of the world’s new HIV infections and 30% of global deaths from AIDS-related illness. Specifically, Cameroon, Côte d’Ivoire and Nigeria, together accounted for approximately 71% of new HIV infections in the region in 2017. To place that in perspective, of the approximately 1,800,000 new infections globally in 2017\(^7\), around 1,278,000 came from just these three countries, which is staggering. Nigeria alone accounted for more than half of new infections and deaths from AIDS-related illness, in part reflecting its large population size compared to other countries.\(^8\) In Ghana, the number of new infections decreased by 9.5%, between 2010 to 2017, and the number of AIDS-related deaths also decreased significantly by 23.8% between 2010 to 2017.\(^9\) Therefore, in comparison to other countries within the Western and Central Africa region, the HIV epidemic in Ghana is relatively low.

Within the region, HIV and AIDS incidence, as well as prevalence, is mostly predominant amongst key and vulnerable populations, including adolescent girls and young women, sex workers and their partners, people who inject drugs, men who have sex with men, transgender persons and prisoners.\(^10\) The most recent UNAIDS Data Sheet (2018) showed that 24% of new infections within the region affected key populations and another 16% affected their sexual partners and clients, leading to an accumulated rate of 40% for all new infections linked to key populations.\(^11\) Chad ranks first in new infections and AIDS-related deaths, with more than 50% of the total figure in both categories while Ghana ranks fifth for new infections (5%) and AIDS-related deaths (6%), all among key populations.\(^12\) Mali (female sex workers (FSW)–24.2%, and men who have sex with men (MSM)–13.7%), Liberia (FSW-9.8%, and MSM-19.8%) and Togo (FSW-13.2%, and MSM-22%) also have very high prevalence rates among key populations within their respective countries.\(^13\)

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\(^6\) HIV and AIDS in West and Central Africa (2018) (n 4)
\(^7\) UNAIDS Data Sheet 2018 (n 5)
\(^8\) Ibid 8
\(^9\) Ibid 9
\(^11\) Rousseau-Jemwa, E. and Bekker (n 3)
\(^12\) Ibid 10
\(^13\) Quaye, S. Overview of HIV in Western Africa and Ghana. Plenary Presentation. IAS Educational Fund Meeting 2019
Women are disproportionately affected by HIV, accounting for around 57% of adults living with HIV in 2017. HIV prevalence stands at 2.3% among adult women, compared to 1.6% among adult men. Furthermore, adolescent girls and young women (aged 15-24) are disproportionately more likely to acquire HIV than their male counterparts.\(^\text{14}\) The situation is no different in Ghana, where as of 2017, infections among male adult population (15 years and above) was 35% and female adult population was 65%.\(^\text{15}\) As of 2017, the prevalence rate among young women was three times higher than young men and more than two times higher in women in general than in men.\(^\text{16}\) However, in recent years, the focus of the two major donors for HIV programmes in Ghana - The Global Fund (GF) and The United States President's Emergency Plan for AIDS Relief (PEPFAR) – have started to focus primarily on key populations, with little attention given to the general population, of which adolescent girls and young women belong.

The national and sub-national HIV and AIDS estimations and projections show that the disproportionate infection rate will continue even through 2019 and increase by at least 2% in 2022.\(^\text{17}\) The achievement of the ‘90-90-90’ goal currently does not look likely, unless new aggressive strategies are implemented. The current data for the region shows that, of the first cascade, 48% of people living with HIV (PLHIV) know their status; of the second cascade, 40% of PLHIV are receiving treatment; and of the third cascade, 29% of people living with HIV are virally suppressed.\(^\text{18}\) For Ghana, it seems more likely that the second cascade will be achieved, as currently, 77% of people who know their status are on ART.\(^\text{19}\) However, more work needs to be done to achieve the first cascade and there is also a need to improve reporting on the third cascade.

The national response in Ghana has been good, reflecting the significant contributions and donor support from major organizations including the Global Fund and PEPFAR. Their support has resulted in important outcomes in the fight against HIV and AIDS in the country. Incidence-prevalence ratio has decreased substantially from 0.10 in 2002 to 0.06 in 2017; new infections have declined from 30,000 in 2002 to 19,000 in 2017; and AIDS-related deaths have decreased from 20,000 in 2002 to 16,000 in 2017.\(^\text{20}\) However, the funding for HIV programmes has been reduced significantly over the years.\(^\text{21}\) Funding remains at the core of any coordinated response across the world, particularly in low and middle-income countries such as Ghana. In light of recent dwindling funds for the HIV response, countries within the region have been more agile in mobilizing funds internally to sustain efforts and gains made over the years.

It is within this contextual background that the IAS Educational Fund Meeting was held. The regional challenges regarding the response to the HIV and AIDS epidemic created a platform for the organization of a workshop that allowed stakeholders from within the region to come together and share ideas on how to respond to local challenges. The meeting was convened amidst a period of dire challenges, but also of bright opportunities yet to be taken advantage of. The research findings and plenary discussions were curated to allow the regional

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\(^\text{14}\) UNAIDS (2019) ‘AIDSInfo’

\(^\text{15}\) GLOBAL AIDS UPDATE | 2017 (n 6)

\(^\text{16}\) UNAIDS Ghana Fact Sheet


\(^\text{18}\) UNAIDS Data Sheet 2018 (n 5)

\(^\text{19}\) GLOBAL AIDS UPDATE | 2017 (n 6)

\(^\text{20}\) Ibid 20

participants to analyse their own problems and come up with practical, sustainable and contextual solutions to the challenges created by the HIV epidemic.
5. Meeting report

5.1 Executive summary

The IAS Educational Fund workshop focused on four key priority areas, namely: HIV prevention for adolescent girls, young women and their partners; differentiated service delivery (DSD) models; point-of-care technologies in prevention of mother-to-child transmission (PMTCT); and integration of HIV management and co-infections – TB and hepatitis. The workshop adopted the following strategies in addressing the priority areas: plenary presentations, in-depth discussions and group work. The sessions were facilitated by experts in HIV and AIDS from Ghana, Burkina Faso, Niger, Mali, Chad and South Africa.

The meeting revealed gaps in the HIV and AIDS response in the West Africa Region. Although the incidence rate and AIDS-related deaths have decreased significantly over the last decade, the response has been slow in the region. Thus, it is anticipated that it will be extremely challenging to achieve the ‘90-90-90’ goals in 2020, considering the current progress update. These gaps are fuelled by the following factors: lack of political will – this also includes a lack of/non-enforcement of existing policies and/or laws; lack of or inadequate domestic financing; lack of inadequate investment in new technologies and interventions; and lack of representation of target groups during programme design and implementation.

The key recommendations from the meeting were:

- Intensifying advocacy efforts in the West Africa Region to significantly improve state support for HIV and AIDS programming.
- Investing in new technologies and also adopting the latest scientific interventions.
- Point-of-care devices as one of the main technologies that would have to be adopted and implemented on a larger scale in the region.
- Involving target groups and community stakeholders in programme design and implementation.

5.2 HIV prevention for adolescent girls and young women and their partners

Adolescent girls and young women cannot be overlooked in the fight against HIV. This theme was discussed thoroughly by community experts and stakeholders during the meeting. Young women and adolescent girls are disproportionately affected by HIV in West and Central Africa. In 2017, 7,000 adolescent girls and young women aged between 15-24 years became newly infected with HIV every week. In Western and Central Africa, for every three new HIV infections among young men (aged

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22 HIV and AIDS in West and Central Africa (2018) (n 4)
23 UNAIDS Data Sheet 2018 (n 5)
24 UNAIDS (2019). ‘Women and HIV; A spotlight on adolescent girls and young women’.
15-24 years), there were five new infections among young women.\textsuperscript{25}

Some of the reasons that could account for this disproportionate infection rate in Ghana include gender inequalities, which are especially grounded in this part of the world where societal and cultural norms alienate women from openly demanding access to care. In addition, policy deficiencies, where the age for consent for HIV testing is 18 years and above, while the age for consent for sex is 16.\textsuperscript{26} This gap significantly challenges the time when young women discover their HIV status and can start treatment.

Due to the gap in the HIV response for young women and adolescents, the Ghana Health Service has developed a policy and strategy document that would guide the delivery of health services to young people, including on HIV and sexually transmitted infections (STIs).\textsuperscript{27} This document outlines the contextual needs of adolescents in Ghana and proposes strategies that would impact on their health, including reproductive health. It also synthesizes the roles and responsibilities of major youth focused organizations in country and how they can align with the Ghana Health Service to respond to the health needs of adolescents. Finally, this document also emphasizes the focus on HIV and STIs care for young people, and mentions emphatically that HIV services will be provided to adolescents in all service delivery points in Ghana Health Service facilities across the country.

Challenges associated with HIV care and prevention for young women and adolescents also include: stigma and discrimination, ignorance of services available, limited access to adolescent-friendly services, and inept laws and policies. These challenges were mentioned frequently during the meeting.

**Recommendations:**

Key recommendations on how to improve HIV prevention and care for adolescents and young women were discussed during the group work and included:

- **The implementation of Comprehensive Sexuality Education (CSE).** This strategy would rely on providing adolescents and young women with information on sexual and reproductive health that is age-appropriate, culturally relevant, scientifically accurate, realistic and non-judgmental. This could be implemented for both in-school and out-of-school young women.

- **The establishment of youth corners in health facilities.** These would consist of sections in health facilities that are operated by youth-friendly service providers who deliver services in utmost confidentiality and privacy. Young people would be more comfortable going to these corners to access HIV services. This should be linked to capacity building for service providers to be able to offer youth-friendly services, with or without youth corners.

- **The revision of policies and laws in the country regarding age of consent for sex and testing services.** This would enable young people to test as early as possible, avoiding the risk of infection and facilitating early treatment. The current age of consent for testing is 18 years, however, the age of consent for sexual intercourse is 16. This

\textsuperscript{25} Ghana AIDS Commission (2017) (n 18)


means that young people can significantly increase their risk of contracting HIV as early as 16 years old via unprotected sex but cannot voluntarily test for HIV at that age. Early knowledge of their status would contribute significantly to prevent sharing of the infection and improve the prognosis of the treatment.

- **Community engagement, with a focus on men should also be prioritized.** Nationwide Social & Behavior Change Communication campaigns should be implemented to inform men in the country on the challenges that young women and adolescents face and how their involvement could significantly curb some of these challenges.

### 5.3 Package of care

Package of care interventions within the region were discussed in groups during the meeting. In promoting early HIV diagnosis and assessment of Antiretroviral Therapy (ART) eligibility, package of care interventions are necessary. According to ICAP, comprehensive package of care includes core interventions such as:

- HIV testing and counselling (HTC)
- Provider-initiated testing and counselling (PITC)
- Testing for partners and family members
- Linkage to HIV care of those testing positive from all entry points
- Cotrimoxazole prophylaxis for all eligible people living with HIV (PLHIV)
- TB screening for PLHIV
- Assessment of ART eligibility, with prompt ART initiation for all eligible PLHIV
- Prevention of mother-to-child transmission of HIV
- Medication monitoring and management
- Monitoring and supporting retention in HIV care
- Access to laboratory testing for HIV diagnosis
- Determining ART eligibility
- Monitoring treatment response, and diagnosing TB and
- Psychosocial support.  

The above set of services represents the minimum package of interventions that should be provided at all service delivery points for different target groups including PLHIV and key populations. The concept of package of care provides a clear and universal guidance on the minimum set of services that providers should administer in order to promote quality of life (as a factor of good prognosis for PLHIV) and also prevent new infections (particularly among key population, however not excluding PLHIV). In Ghana, PEPFAR is one of the key stakeholders supporting the implementation of comprehensive package of prevention services and this intervention is aimed at providing package of care services for men who have sex with men and female sex workers in the southern part of Ghana.  

Challenges to effective implementation of package of care interventions include; discrimination on health centres against people living with HIV and using antiretrovirals

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(ARVs), scarcity of contraceptives and PrEP for key populations, resistance of healthcare workers to implement DSD models and the insufficient adaptation of facilities.

Recommendations:

- **Increase awareness creation, education and advocacy through various avenues including social media to ensure that persons who are diagnosed early can live productive lives.** Citizens should be encouraged to facilitate action and engage in self-testing. The legal age gap for getting testing should be bridged to encourage all age groups of people to routinely test. Governments should also mobilize resources for centres that undertake testing and enforce Point-of-care (POC) devices. Lastly, novel technological tools should be developed to facilitate interventions.

- **Adolescents should have centres/facilities dedicated to meeting their needs** and in the absence of such, facilities should be made adolescent-friendly with the presence of peer counsellors to encourage attendance. Youth leaders should be empowered and parents should be sensitized, given comprehensive sexuality education, and educated on how to handle situations involving HIV. Extensive awareness should be created to dissociate issues of sexuality with taboos. Criminalization is determined to have a direct link with HIV prevalence among men who have sex with men who should be seen as beneficiaries and not just partners of projects.

- **Recognize the valuable participation of service providers.** It is important to provide proper training with monitoring and supervision, mentorship programmes, franchising sustained availability of services, targeting of “hotspots” for key populations to easily access services, peer education and support.

- **At the community level, service providers are required to deliver quality services based on standards that have been set so it is also necessary for data flow and documentation of information at community points to ensure accountability for these services.** People living with HIV can be engaged in design and implementation of services by getting them on board to extend refills to people receiving treatment, distribute refills and support funding.
5.4 Scaling up integrated, people-centred approaches within the framework of Universal Health Coverage

The World Health Organization (WHO) defines Universal Health Coverage (UHC) as ‘ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship’ 30. Most countries in the world have committed to ensuring UHC in their jurisdictions and Ghana is no exception. The country has committed to ensuring UHC by 2030 by increasing both access to health services and financial protection through targeted health service delivery and financing reforms. 31

Within the agenda of UHC, WHO also recommends the adoption of people-centred and integrated health services. This strategy simply recommends the design of health systems that are contextually appropriate and which take into account the needs of the population the system is supposed to help. WHO has developed a framework to guide the design and implementation of integrated, people-centred approaches. The framework is a call for a fundamental shift in the way health services are funded, managed and delivered. 32 It supports

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countries’ progress towards UHC by shifting away from health systems designed around diseases and health institutions, towards health systems designed for people. This is urgently needed as the life expectancy of populations has increased and the burden of costly long-term chronic conditions and preventable illnesses requiring multiple complex interventions over many years, continues to grow. It is also essential to better prepare for and respond to health emergency crises through integrated services as became evident during the Ebola virus disease outbreak.

The WHO global strategy for people-centred and integrated health services builds on the universal health coverage and primary healthcare movements, as well as action on non-communicable diseases and addressing the social determinants of health, but also more on recent calls to strengthen national health emergency and disaster management, and the resilience of health systems.

**Recommendations:**

Within the Ghanaian context, UHC still has some way to go before the 2030 deadline. The speakers and plenary discussed thoroughly the way forward, to ensure Ghana meets the deadline.

- **Need to enforce political will.** The UHC agenda in Ghana is largely coordinated by the state, and hence it is their willingness that will make the most impact in the UHC agenda. The state will have to follow through and fulfill all commitments they have made towards the UHC agenda. Also, as a show of political will, the state should enact and enforce policies to guide the implementation of UHC in the country.

- **Need to engage the community members in the UHC agenda.** It has become imperative that the end-users and/or beneficiaries be allowed to gain a sense of ownership or belonging in this, which will then contribute to favourable behavioural patterns of community members, leading to them accessing health care voluntarily and serving as peer influencers within the localities to encourage others to also access health care in standard health facilities. The engagement of the community members will also ensure that solutions that are designed will meet the exact needs of the people.

- **Skills’ development of service providers** was also recommended as the UHC agenda is a broad objective, thereby reiterating the unique needs of the various parts of the country. Therefore, there is the need to build capacity of service providers, with the training based largely on the needs of the community they will be serving. This will ensure that they have the necessary skills and resources to tackle the needs of their communities.

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33 Osei-Boateng, R. Scaling up integrated, people-centered approach within the framework of universal health coverage. Plenary Presentation. IAS Educational Meeting 2019.
5.5 Point of Care Technologies in PMTCT Programme

Ghana first began the implementation of prevention of mother-to-child transmission (PMTCT) programmes based on the four-pronged strategy of WHO. Over the years, the country has changed and improved the strategies and guidelines to ensure impactful results. The PMTCT programme in Ghana offers a range of services for women of reproductive age living with or at risk of HIV to maintain their health and stop their infants from acquiring HIV. The services in particular are offered before conception and throughout pregnancy, labour and breastfeeding.

Point of care technologies (POCT) have become one of the priority areas in HIV and AIDS programming in a bid to improve service delivery. This has been particularly emphasized in PMTCT programming in Ghana. POCT are simple to use devices that can be used not only by laboratory staff but also by other health care professionals with basic training. POCT have become useful in the expansion and provision of PMTCT services for HIV, syphilis and other diseases such as malaria and bacterial pneumonia rarely, covered in PMTCT. The criteria for POCT that emphasizes its importance is as follows: diagnostics and devices that are affordable, sensitive, specific, user-friendly, rapid and robust, equipment-free, and deliverable to end-users.

POCT has become very important in early infant diagnosis (EID). Studies have shown that children who are treated early live better and the more the medicines work, the more confident parents become. POCT makes it possible to test infants on-site and to receive the results within hours. HIV-positive infants can then begin ART immediately which reduces the risk of loss to follow-up and significantly improves prognosis.

Recommendations:

Despite the increasing sophistication of novel diagnostic technologies, the impact of POCT will be limited unless the coordinating authorities (the Ghana Health Service (GHS) and the National AIDS Control Programme (NACP)) can successfully accommodate the weaknesses in healthcare systems in resource-constrained settings, which often affect the successful delivery of diagnostics in-country. In lieu of this, the speaker, Prof William Ampofo and the plenary made the following key recommendations.

- **Build the capacity of frontline service providers** to be able to manage the new technologies for point of care diagnostics. This capacity building endeavour should be scaled across the country to improve the impact of the intervention.
- **Implement a comprehensive strategy to deal with potential supply chain problems** and this strategy should be strong enough to ensure availability of commodities and equipment all year round.

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39 Ibid 42
41 Ibid 42 and HIV and AIDS in West and Central Africa (2018) (n 4)
Apply vigorous quality assurance controls and mechanisms to significantly reduce the potential for harm and injury from the diagnostic devices, as well as from the potential damages from errors such as misdiagnosis.

5.6 Integration of HIV management and co-infections – Tuberculosis and Hepatitis

The topic of integration of HIV management and co-infections, with a particular emphasis on tuberculosis (TB) and hepatitis, was discussed during the meeting. The focus of the plenary presentations were on the outcomes of the integration in Ghana and Burkina Faso.

Several studies have shown that there is a very strong link between HIV and TB, as well as HIV and hepatitis. TB is the most common presenting illness and cause of death in people living with HIV, being responsible for one of every three HIV associated deaths. Risk of developing TB is estimated to be between 16-27 times greater in people living with HIV than among those without HIV infection. In 2015, there were an estimated 1.2 million cases of TB disease among people living with HIV, 71% of whom were living in Africa (11% of the 10.2 Million TB cases globally).

The global estimate burden of HIV-hepatitis C (HCV) co-infection is 2.75 million. One of the key links between HIV and HCV is that both infections share common routes of transmission, which is through sharing of sharp objects. HIV infected people are six times more likely to have HCV infection and it is worth noting that the burden of HCV co-infection is greatest in the African and Southeast Asia Regions.

In Ghana, the prevalence of HIV infection in TB patients is about 14.7%, the HIV/hepatitis B (HBV) co-infection prevalence rate is estimated as 13.6% and the HBV/HCV co-infection

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47 UNAIDS (2019) (n 29)
rate among HIV-1 patients is around 18%.51 One significant challenge with the integration agenda is that true prevalence of co-infections is largely underreported, with many going unscreened and undetected52, thereby distorting planning and decision making. Another key problem with the HIV integration in Ghana is challenges with the high cost of HIV/TB integrated services. Again, a hepatitis programme is a novelty in Ghana, hence funding for it is almost non-existent.

In Burkina Faso, as of 2017, there were 5,836 cases of tuberculosis, and of this number, 5,455 were HIV positive, representing a co-infection rate of 93.5%.53 However, nationally, the TB/HIV co-infection stands at 9.4%, and this continues to decrease every year.54 Currently, the number of TB/HIV patients on ARV sums up to over 80%. The country has also taken significant steps towards ensuring the integration of HIV/TB services. Since 2006, Burkina Faso has been implementing a strategic document which was designed to guide the management of TB-HIV co-infections. There has also been active research on the topic, supported by the National Tuberculosis Programme. In the area of service delivery, the state has decentralized HIV care to enhance access to care.

Amidst the significant steps taken in TB/HIV integration, there remain major challenges. Even though HIV care has been decentralized, the number of centres with integrated TB/HIV care is limited and the majority of health facilities only have partial TB/HIV integrated care.

**Recommendations:**

The plenary and speakers discussed thoroughly the outcomes of the integration systems in both Ghana and Burkina Faso.

Key recommendations for both countries were made, including:

- **Calls for the states to provide consistent domestic financing for HIV integration programmes.** Local resource mobilization in both Ghana and Burkina Faso is stagnant and not enough to meet the demand. The states should therefore, take the lead in this regard and prioritize it as well as enact policies and also enforce redundant programmes in the area of HIV integration service delivery.

- **Frontline service providers should be trained on all aspects of HIV/TB integration to facilitate quality service delivery.**

- **Strengthen logistics:** equipment and commodities should be provided at health facilities. Preferably, point of care devices should be deployed at the centres to facilitate faster service delivery.

- **In Ghana in particular, there is a strong need to design a robust programme that focuses on HIV, TB and hepatitis integration** as currently, there is no such comprehensive programme.

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51 WHO (2019) (n 35)
52 Ibid 55
54 PAI (2017) (n 36)
5.7 Differentiated Service Delivery Model

Differentiated Service Delivery (DSD) is defined as a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of groups of people living with HIV, while reducing unnecessary burdens on the health system. Over the years, there has been the need to devise and model new approaches to tackling the HIV epidemic across the world, taking into account the various unique and contextual attributes. This led to the development of the Differentiated Service Delivery (DSD) Model by the World Health Organization, in consultation with other international stakeholders. The universal focus of this model is towards ensuring that the 90-90-90 target is attained.

In Ghana, the adoption and implementation of the concept of DSD Models within the HIV and AIDS context has been spearheaded by the National AIDS Control Programme since 2017, with support from the United States Agency for International Development (USAID) and PEPFAR. The rationale of the model’s implementation in Ghana is also towards taking significant steps towards achieving the 90-90-90 targets by 2020. Specifically, it is expected that by 2020, twice as many people would know their status, and three times as many clients are initiated on ART compared with the achievements documented in the 2018 NACP service data. The model has been designed to improve adherence to treatment and again, increase the rate of viral suppression for patients on treatment. Furthermore, DSD in Ghana provides an opportunity to adapt health services to the needs of clients while reducing the burden on health care workers.

Since the implementation of DSD started in Ghana, there have been remarkable results:

- There was an increase of 40% to the provision of initiated testing and counselling (PITC).
- Within DSD oriented facilities, the linkage to care for all positive clients rose from 20% to 50%.
- About 60% of health facilities provide six-month clinic visit appointments.
- There is a renewed interest in community-based care. (30% of facilities now provide such service).
- The number of health facilities implementing the Multi Month Scripting and Dispensing Programme (MMSD) has increased from 20% to 60%.

The MMSD is a programme implemented by EQUIP and supported by USAID and PEPFAR with the objective of addressing the challenge of retention and adherence support. The programme addresses this challenge by using contextual solutions to increase treatment initiation, patient retention and disease suppression.

Even though the DSD model has set off amidst good results, there are a number of challenges encountered including a lack of funding to scale the model into more facilities across the country. As of today, only the Centers for Disease Control and Prevention (CDC) and the

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55 WHO (2016). Consultation on HIV differentiated service delivery models for specific populations and settings: Pregnant and breastfeeding women, children, adolescents and key populations
57 Osei-Boateng, R. (n 38)
58 Ibid 61
60 Maiga, A.A., Amadou, M., Karimou. (n 39)
Global Fund have supported trainings and implementation of the model. Another challenge is the unavailability of commodities – test kits and ARVs – which have made the implementation of the model non-effective in some sites. There is also a lack of a robust system to help track lost-to-follow-up clients. Finally, one last key challenge is the lack of monitoring and evaluation tools embedded in the national operational strategy.

Recommendations:

Key recommendations provided through the presentation and panel discussion included:

- Scaling up capacity building activities for service providers who will implement the DSD model.
- Intensifying structural supportive supervision.
- Using peer educators and laymen for refills and also as psychosocial counsellors.
- Extending refills for clients who are adherent to treatment to serve as a reward and foster adherence even further.
- Adopting a social franchising model to take services closer to the clients. This will involve collaborating with private facilities within areas that are difficult to access or do not have government facilities and capacitating them to be able to provide service to people living with HIV.

Panel discussion, Ghana, 13 May 2019
5.8 Stigma and Discrimination

In West African countries, HIV stigma and discrimination rates are highest in Ghana (67.7%), followed by Burkina Faso (57.5%) Sierra Leone (53.4%), Senegal (53.2%), Liberia (52.7%), Mali and Togo (45.8%). A study conducted in sub-Saharan Africa found that the cultural structure of HIV and AIDS built on beliefs about infection, sexuality and religion, plays a vital role and influences hostility reactions and discrimination in society. AIDS-related stigma is problematic for all in the society, in the sense that it imposes severe hardships on people living with HIV and it ultimately restricts treatment and prevention of HIV infection. Emphasis on the obliteration of AIDS-related stigma would facilitate the creation of a conducive social climate that employs a coherent, operational and compassionate response to this epidemic.

Reducing the stigma and discrimination towards people living with HIV is only possible by taking a multifaceted approach. All stakeholders have key parts to play in the reduction and eradication of stigma and discrimination concerning HIV. This subject was discussed thoroughly during the meeting.

Recommendations:

- Governance systems need to critically review policies and directives to ensure that they are inclusive for people living with HIV (PLHIV) and give no leeway for the stigmatization of PLHIV. Health centres should also be mandated to carry out the integrated service delivery and best-practice relevant for HIV prevention and treatment. It is necessary that there are sustainable resources and ready partners who can facilitate the care of PLHIV and centres providing quality services.

- Legal systems should also be accommodating of key and vulnerable populations and laws that negatively affect them should be decriminalized, like those related to sex work and men who have sex with men communities, for example. When PLHIV or people with better understanding of HIV are in key positions of influence, they are better able to push this agenda, hence they must be encouraged.

- Investment should be channelled into testing the viral load to enable eradication and training of professional community health service providers to cater to the needs of PLHIV in a safe environment; free of judgement and stigma. Specialized clinics for certain key groups like adolescents are necessary to create a safe atmosphere for them to receive quality HIV services.

- The general population also has a role to play in accepting PLHIV as members of the society and extending to them the respect, privileges and responsibilities that are accorded to all other citizens. There should be massive awareness creation and education on HIV as well as services available. Key players in the healthcare delivery system like Civil Society Organizations (CSOs) and PLHIV groups can be

identified to play a hands-on role in the education and sensitization of the general population. In a highly religious continent like Africa, religious groups have substantial clout to make impact on the general population, hence they must be actively engaged to reduce stigma towards PLHIV and embrace them as members of the society. Cultural acceptance should also be gained with chiefs and traditional leaders at the forefront.

- **PLHIV need a chance to be economically stable where they can choose and afford preferred services.** This can be achieved with an enabling environment where people living with HIV can empower themselves to be self-sufficient and increase their quality of life. As a form of equity, PLHIV should be given a quota of employment opportunities for example. PLHIV also need to be sensitized, empowered and educated to help eliminate the stigma surrounding them.
6. Conclusion

The IAS Educational Fund meeting was truly educative and inspiring. The participation of several key stakeholders within the HIV community throughout the workshop spoke volumes of the desire to ensure that the epidemic is brought under control within the region. During the meeting, ideas were exchanged and partnerships and collaborations were initiated, through the group work, panel and plenary sessions discussions, and again this demonstrates the need to be optimistic about the future of the national and regional response.

The workshop was successful in meeting its objectives as detailed and summarized below, followed by key outcomes and next steps that emerged from the discussions.

Objective 1: To present key scientific and policy content from the AIDS 2018 conference and discuss how to effectively translate this into local policy and practice in the Western African Region context

The workshop successfully provided a platform for key stakeholders to deliberate on the research findings from AIDS 2018 and to analyse how these findings could translate into policy and practice in Ghana and West Africa as a whole.

The possibility of implementing pre-exposure prophylaxis as one of the HIV prevention interventions was one of the main points of discussions. In Ghana, plans are stagnant on PrEP roll-out as an HIV prevention strategy. The tendency for abuse, as witnessed in the case of emergency contraceptive pills complicates plans. Laws and policies are weak and not enforced, making key actors in the HIV community pessimistic about the management and use of PrEP. In the West Africa region as a whole, plans are also not far advanced to streamline PrEP. As a consequence, the pace of reduction for new infections might not slow down, as new technologies and interventions are not taken advantage of. Moreover, breakthrough research findings presented at AIDS 2018 would take a few more years before they can be translated into mainstream policy and practice.

Key recommendations:

- Intensifying advocacy efforts in the West Africa Region to significantly improve state support for HIV and AIDS programming.
- Investing in new technologies and also adopting the latest scientific interventions.
- Point-of-care devices as one of the main technologies that would have to be adopted and implemented on a larger scale in the region.
- Involving target groups and community stakeholders in programme design and implementation.

Objective 2: Present and discuss research results and regional updates on HIV prevention for adolescent girls, young women and their partners

This objective was met through keynote presentations and a panel discussion.

The current plight of young women and adolescent girls regarding HIV infections has put them in contention with the key population for special focus and targeted interventions. This was mentioned several times by key actors during the meeting and there was a general consensus among participants from across West Africa on the need to re-categorize young women and
adolescent girls, setting them apart and underscoring it with the necessary factors for a global response. There is no question that the prevalence and incidence rate among key populations is high, but it is equally dire among young women and adolescents girls, and emphasis should be placed on them as well. This bodes well for the regional response, as the consensus partly indicates unity in purpose.

**Key recommendations:**

- The implementation of Comprehensive Sexuality Education (CSE).
- The establishment of youth corners in health facilities.
- The revision of policies and laws in the country regarding age of consent for sex and testing services.
- Community engagement, with a focus on men should be prioritized.

**Objective 3: Research results and regional updates on implementation of differentiated service delivery models**

The status of differentiated service delivery models (DSD) particularly in the Ghanaian context was discussed. Although this DSD is relatively new in Ghana, the results since the beginning of the implementation have been remarkable. The general consensus on the immense benefit of this model speaks to the need to scaling up as soon as possible.

The national and regional responses have taken a new turn, relying heavily on science and technology to drive progress. The DSD model implies a new phase of productivity and impact, where resources are properly channelled, with little room for misallocation. Therefore, considering the history of inadequate planning and bureaucracy in the West Africa region, the recommendation of comprehensive preparation before DSD deployment into new areas should be taken extremely seriously.

**Key recommendations:**

- Scaling up capacity building activities for service providers who will implement the DSD model.
- Intensifying structural supportive supervision.
- Using peer educators and laymen for refills and also as psychosocial counsellors.
- Extending refills for clients who are adherent to treatment.
- Adopting a social franchising model to take services closer to the clients.

**Objective 4: Research results and regional updates on point of care technologies in prevention of mother-to-child transmission (PMTCT) programming**

The general interest and contribution during the presentations on point of-care technologies (POCT) showed the achievement of this objective. PMTCT has come a long way in Ghana, to its current positive state. This has been underscored by the adoption of modern technologies. However, the broader picture of adoption of POCT in PMTCT in the West Africa region, including Ghana could prove slower than anticipated, as demonstrated during the plenary sessions. The potential of POTC cannot be disputed, as it has proven to be a breakthrough solution in many countries in the world, but the economic, social and even political climates of many of the West African countries could delay the impactful deployment of POTC. This was also emphasized by participants from other West Africa countries.
The proffered contextual solutions to the successful deployment of POCT in obstetric care throws some light on the immense possibilities of this intervention in the region. It is anticipated that the key actors from other West African countries would inculcate it into their national response strategies, thereby implying a positive outlook on the future of POTC regionally.

**Key recommendations:**

- Build the capacity of frontline service providers.
- Implement a comprehensive strategy to deal with potential supply chain problems.
- Apply vigorous quality assurance controls and mechanisms.

**Objective 5: Research results and regional updates on integration of HIV management and co-infections – TB and Hepatitis**

This objective was met as through presentations and group work on this subject within the context of Ghana and Burkina Faso, as well as the West Africa region. HIV/TB and HIV/hepatitis co-infections are high around the world, including West Africa, but the integration of services has not been optimal. Over the years, significant advances have been made in the area of HIV/TB integration in the region. However, it has not advanced enough over the years and significant gaps still remain in HIV integration services, as emphasized during the meeting.

The two key factors that need to be recognized as the core of the issue are funding and infrastructural inadequacies. Research in this field has been done extensively in West Africa and it has been identified that what is required is the funding and the infrastructural make up, including quality human resource and good supply chain management. The regional response to HIV integrated services would therefore, remain inadequate if these two challenges are not significantly tackled.

**Key recommendations:**

- Calls for the states to provide consistent domestic financing for HIV integration programmes.
- Frontline service providers should be trained on all aspects of HIV/TB integration to facilitate quality service delivery.
- Strengthen logistics: equipment and commodities should be provided at health facilities.
- In Ghana in particular, there is a strong need to design a robust programme that focuses on HIV, TB and hepatitis integration.

**6.1 Key Outcomes and Next Steps**

**Political Will and Support**

Throughout the meeting, every deliberation and way forward emphasized the need for state and/or political support. In Africa, as in many parts of the world, the state/government is the most powerful entity, as well as ‘primary caretaker’. Without the backing of the state, in terms of financial support, policy and law, the HIV and AIDS response would be severely deficient. Almost every West African country’s national health programming is primarily supported by the government, followed by private and international donors. Even though the private and
international donor support values higher than that of the state’s, the country’s financial commitment is extremely important and usually the catalyst for external support.

The plenary agreed to intensify advocacy efforts in their respective countries to help significantly improve state support for HIV and AIDS programming. The advocacy will focus on key areas such as getting the state to fulfil financial commitments made locally or internationally towards HIV and AIDS programmes. The second focus will be to get the state to enact new policies and laws to govern the HIV and AIDS sector; and/or set up robust systems to enforce existing policies or laws.

Specifically, in Ghana, the plenary agreed that advocacy efforts will have to be intensified for the age of consent for sex and age, so consent for HIV testing can be made the same and preferably reduced or avoid late detection. This is a matter of policy change and would require a coordinated advocacy attempt.

**Investment in new technologies and interventions**

The key messages from AIDS 2018 set the tone for the discussions on the recent scientific and policy advancements in the response against HIV and AIDS. The HIV and AIDS landscape in sub-Saharan Africa has changed over the years and it keeps changing. This comes down to changes in the population and the accompanying social, cultural and political factors. The interventions that worked in the late 1980s, when the disease was ravaging sub-Saharan Africa, would not get the desired results nowadays because the strategies have been changing ever since.

Some of the key outcomes from the meeting were the need to invest in new technologies and also adopt the latest scientific interventions. Point of care devices is one of the main technologies that would have to be adopted moving forward. This technology would have to be scaled across the region in an aggressive mode. The benefits of using this technology are immense and would go a long way in improving the results in the regional response against HIV and AIDS.

The adoption of DSD models was also a key point in the meeting. Differentiated service delivery models are based on research and analytics, so adopting this methodology would significantly improve results, particularly with respect to client retention and therapeutic adherence. The latter leads to viral suppression and contributes to achieving the second and third cascades on the 90-90-90 goals. Ghana has an operational strategy document for DSD and the other West African countries have prioritized the development of such guidelines.

People-centred approaches, which prioritize designing solutions based on the humane and contextual needs of clients, should also be adopted. This strategy operated under the DSD models would emerge a robust set of interventions that are targeted and efficient.

**Extensive community engagements and inclusion**

Throughout the meeting, the plenary re-echoed the need to involve target groups and community stakeholders in programme design and implementation. In the HIV and AIDS sector, there are several programmes designed for different target groups, including key and vulnerable populations as well as the general population. Within these, there are also variations. This speaks to the need to engage extensively, to the core of the target group at
whom the interventions are targeted. This is to avoid a one size fits all strategy, which is usually not efficient.

Community members have been identified to be the primary drivers of their healthcare services. Such that, when the community members are engaged from the beginning and they acquire a sense of belonging, the programme’s scale within the target group becomes organic. This equally supports the Universal Health Coverage agenda, which the plenary agreed that also depends on the commitment of the target group/community for it to succeed.

Male involvement should also be prioritized as part of the community engagements. Programming should place some focus on behaviour change among men as well, particularly regarding male involvement in supporting access to care for young women and adolescent girls.

**Involvement of Young People**

Discussions pointed to the fact that young people have been left out of the fight against HIV and AIDS for long and there is currently a need for a holistic, adolescent and youth-friendly approach in the fight against HIV and AIDS. The plenary agreed that there is growing evidence that the youth is a population that attention needs to be paid to, judging from the fact that there is a higher rate of new infections among adolescents. One key recommendation therefore, was for young people to be classified as part of a key population group in order to ensure concerted efforts to reduce the rate of new infections among them and also warrant the allocation of more resources for their cause.

Furthermore, young people should be more involved in the provision of services for their peers; this includes engaging young people and giving them a role in the provision of HIV services. Key areas in which adolescents support will be needed are in the provision of counselling and in the operation of support groups that would increase adherence and reduce the stigma around HIV and AIDS.

The integration of HIV services into the lives of adolescents is a critical component that was discussed in the plenary. In order to make services more accessible to young people, changes should be effected in the way they receive ARVs. For instance, ARVs could be integrated into normal school sessions, in effect reducing the reticence of adolescents to visit health centres that may not be receptive to their needs. Adolescents should also have easy access to online platforms where they will be able to access information on HIV services.
7. Acknowledgements

The International AIDS Society (IAS) and the Planned Parenthood Association of Ghana (PPAG) would like to acknowledge all participants and stakeholders in Ghana, as well as representatives from across selected West African countries such as Niger, Mali, Burkina Faso and Côte d’Ivoire as well as Chad, Uganda and South Africa for their contribution towards making the IAS Educational Fund meeting in Accra, Ghana on 12-13 May 2019 a huge success. Special appreciation goes to the Chairs, speakers and panellists for their participation.

The IAS and PPAG also would like to recognize the commitment and participation of the Ghana AIDS Commission and National AIDS Control Programme, who endorsed the meeting. We are grateful for their contribution towards the successful planning and organization of the workshop.

The IAS would also like to extend its appreciation to ViiV Healthcare, the Swiss Agency for Development and Cooperation and Merck for their financial support for the meeting.
8. Appendices

8.1 Programme

12 May 2019

Chair: William Ampofo, Virologist/Public health Specialist, Ghana

08:00-09.00 Registration

09:00-09:30 Official comments and welcome

Abene Acheampong, Executive Director, PPAG, Ghana

09:30-10:30 Key messages from AIDS 2018

Speaker: Elzette Rousseau, Senior Investigator, Desmond Tutu HIV Foundation, South Africa

10:30-10:45 Coffee break

10:45-12:00 Regional overview of HIV in Western Africa

Speakers:

Silas Quaye, CDC/PEPFAR, Ghana

Irène Dabou, Coordinator of the Planning and Monitoring Evaluation Unit (SP/CNLS-IST), Burkina Faso

Mariam Sylla, Center of excellence for pediatric care, Hospital Gabriel TOURE, Mali

Alhousseini Aboubacar, President of the Niger Network of People Living with HIV, Niger

Abbas Moustapha, Deputy National Executive Secretary of the National AIDS Council, Chad

12:00-13:00 Lunch

13:00-14:30 Presentation and Panel discussion: HIV prevention for adolescent girls and young women and their partners

Keynote speaker: Dorcas Obiri-Yeboah, University of Cape Coast, Ghana

Panel moderator: Ishmael Kwasi Selassie, PPAG, Ghana

Panelists: Grace Afful, University of Cape Coast, Ghana (Youth voice)

Ernest Kenu, University of Ghana (Clinician voice)

Fred Nana Poku, Ghana AIDS Commission, Ghana (Policy maker voice)
Caroline Yonaba, Department of Pediatrics, CHU Yalgado Ouédraogo, Burkina Faso (Clinician voice)

14:30-15:50 Group work

Lead Group moderator: Ishmael Kwasi Selassie, PPAG, Ghana

Topics:

Package of Care according to HIV stage

Group moderators:

Raphael Sackitey, Ghana AIDS Commission, Ghana
Christian Yonli, Sector Program Coordinator, HIV and STIs Health, Burkina Faso

Innovative recommendations for HIV prevention for AGYW

Group moderators:

Lawrence Achiam, PPAG, Ghana
Mariam Koné, Association Kénédougou Solidarité, Mali

15:50-16:00 Closing remarks & evaluation

13 May 2019

Chair: Angela Trenton-Mbonde, UNAIDS Country Director, Ghana

08:30-09.00 Registration

09:00-09:25 Opening comments and overview of the day

09:25-10:20 Presentation and Panel discussion: Scaling up integrated, people centered approaches within the framework of Universal health coverage

Keynote speaker: Major Richard Osei-Boateng, Military Hospital, Ghana

Panel moderator: Panel Moderator: Kusi Poku Berko, Korle-Bu Teaching Hospital, Ghana

Panelists: Daniel Ankrah, Korle-Bu Teaching Hospital, Ghana (Clinician voice)
Oumaima Mahamat Djarma, Ministry of Public Health, Chad (Policy maker voice)
Christian Yonli, Sector Program Coordinator, HIV and STIs Health, Burkina Faso (Clinician voice)

10:20-10:50 Point of Care Technologies in PMTCT Programme. How impactful?

Speaker: William Ampofo, Virologist/Public health Specialist, Ghana
Coffee break

Integration of HIV management and co-infections - TB and Hepatitis

Speakers:
Kafui Senya, WHO, Ghana
Armel Poda, University and Teaching Hospital of Bobo Dioulasso, Burkina Faso

Lunch

Presentation and Panel discussion: Differentiated Service Delivery Models. How could they be implemented?

Keynote speaker: Akosua Badoo, NACP, Ghana
Panel moderator: Stephen Ayisi Ado, NACP, Ghana
Panelists: Alex Kofi Donkor, LGBT Rights, Ghana (Key populations voice)
Henry Nagai, JSI, Ghana (Key populations voice)
Anna Grimsrud, IAS, South Africa (Scientific voice)
Ismael Cissé, Association Vision Plurielle, Burkina Faso (Key populations voice)
Rebecca Carl-Spencer, Sexual and reproductive health and rights, IPPF, Uganda (Programmes advisor voice)

Group work

Lead Group moderator: Ishmael Kwasi Selassie, PPAG, Ghana

Topics:
Integration of HIV management and co-infections - TB and Hepatitis

Group moderators:
Divine Atupra PPAG, Ghana
Karim Issa, NGO BALLAL, Niger

Impact of stigma on HIV prevention and treatment

Group moderator:
Kusi Poku Berko, Korle-Bu Teaching Hospital, Ghana

DSD models

Group moderators:
Emmanuel Larbi, Ghana AIDS Commission, Ghana
Marou Amadou, NGO Mieux Vivre Avec le Sida, Niger

Evaluation, next steps & closing remarks