

**GHANA ROLL BACK MALARIA CONSULTATIVE MISSION  
(REAPING):  
ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE  
ABUJA TARGETS**

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## 1. EXECUTIVE SUMMARY

The Roll Back Malaria Board, representing the global RBM partners, requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries would require to support the attainment of the Abuja Targets. The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

There were 4 main objectives for the Ghana mission which were to:

1. Assess the full range of developments of RBM in Ghana over the last 5 years
2. Review and update the Ghana Desk Review and Update the Ghana RBM desk Review Report prepared in July-August 2003
3. Complete the needs based planning exercise started in 2003
4. Review and update the Ghana CCM malaria proposal to GFATM

The mission was conducted through document review, meetings and workshops with stakeholders and partners, and culminated in a partners' consensus meeting.

The findings confirmed Ghana's status as a category 1 country, which is pursuing RBM implementation in three areas of intervention namely; ITN use, IPT for pregnant women and improved case management.

A policy on ITMs has been successfully introduced and is being implemented and a policy on IPT has just been introduced and initial health worker training has begun. Preparatory work for the introduction of a new malaria treatment policy incorporating ACTs has been concluded and the policy will hopefully be implemented by early 2005.

Through demonstration projects, various strategies have been tried and tested with good results and experience gained, however, coverage levels for the interventions remain very low. In the light of this, a number of actions deemed essential have been identified for implementation in order to realize the Abuja targets. Aspects of planning and management are already receiving attention, but require further strengthening. RBM interventions need to be expanded to all 110 districts in the country in order to achieve the Abuja targets.

Essential actions (in addition to ongoing activities)

- 1) Review Districts Plans to capture national objectives and Essential Actions.
  - Build and Orient team of Facilitators for Regional based reviews
  - Conduct Needs-based Plans Review workshops in all Regions for DHMTs.
  - Collate Reviewed Plans into Regional and National needs based plans.
  - Present Plans as proposal or integral part of GHS action plan to Partners for Resources.
- 2) Change Policy (IPT, Malaria Treatment)
  - Promulgate Policy Change
  - Contract out Review and printing of Relevant Guidelines and Documents
  - Contract out nationwide Orientation and Training of health workers and other implementers (inc. private and informal)
- 3) Review Implementation/Management arrangements for GHS-SWAPs planning and efficiency
  - MOH/GHS/Health Partners meeting as follow up to REAPING mission to review/affirm SWAPs/Budgetary Arrangements
  - ?Sign an MOU on new ways to do business

- 4) Improve Capacity and Efficiency to Steer and Co-ordinate RBM Partnership and Actions
  - Management Orientation for NMCP
  - Review TOR of NMCP
  - Contract or Hire a CPA
- 5) Monitoring Implementations and Evaluation of Abuja Targets
  - 13. Access and Review Monitoring component of Regional and National Needs-based plans
  - 14. Prepare TOR and Contract out Evaluation for end of 2005
  - 15. RBM Partners to prepare own team to participate in evaluation
  - 16. Conduct evaluation
- 6) Develop Supply and Distribution Plan for 3.672 million ITNs (LLINs) and Insecticides for previously distributed
  - 17. Identify and Assign Identify entity with proven procurement capacity
  - 18. Assign entity to procure ITNs through competitive bidding process and procedures
  - 19. Warehousing of delivered ITNs
  - 20. Contract out distribution of ITNs to community level “sales points”
  - 21. Monitor/verify ITN delivery at all levels in country (port, warehouses, community destination points)
  - 22. Establish functional re-treatment Points/Days
- 7) Finalise COMBI Plan for Ghana
  - 23. Assess and Disseminate information on communication outcome/Impact so far in Ghana on ITNs and Malaria control (transmission, prevention, treatment seeking behaviour and practices)
  - 24. Prepare strategy and activities plan
  - 25. Conduct orientation for agencies involved in communication on ITNs and malaria for harmonisation (of messages), complementarily and effectiveness
  - 26. Contract out COMBI activities to new agencies with proven capability in COMBI.
  - Procurement of ACTs
  - 27. Plan/forecast ACTs needs (MAC)
  - 28. Identify/contract appropriate entity (Malaria Division, WHO/HQ?) to procure ACTs through process of international competitive bidding

The total costs of the required support package has been estimated at US\$ 138,975,000

Given the sound foundations laid and the current good spirit of commitment and attitude to business on the part of the Ministry, Ghana Health Service and RBM Partners, it is possible for Ghana to achieve the Abuja targets if the required resources to implement the essential actions identified by the REAPING mission are made available in a timely manner.

It should be emphasised that the gaps, resource requirements and essential actions identified are additional and complementary to those currently planned and budgeted for within existing resources in the country, including Global Fund monies.

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### 3. ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
ADR	Adverse Drug Reactions
AFRO	Africa Regional Office (WHO)
ANC	Ante Natal Clinic
CCM	Country Co-ordinating Committee
CHPS	Community Health Planning and Services
COMBI	
CPA	Country Partnership Advisor
DA	District Assembly
DALY	Disability Adjusted Life Years
DfID	Department for International Development
DHA	District Health Administration
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EDL	Essential Drugs List
EPI	Expanded Programme on Immunisation
FDB	Food and Drugs Board
FM	Frequency Modulation
GES	Ghana Education Service
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GNDP	Ghana National Drugs Programme
HIPC	Heavily-Indebted Poor Countries
IGF	Internally Generated Funds
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ITM	Insecticide Treated Materials
ITN	Insecticide Treated Net
JHPIEGO	Johns Hopkins
LLIN	Long Lasting Insecticidal Net
MAC	Malaria Action Coalition
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
NMCP	National Malaria Control Programme
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
REAPING	Roll Back Malaria Essential Actions Products, Investment, Gaps
RHMT	Regional Health Management Team
SHEP	School Health Programme
SP	Sulphadoxine-Pyrimethamine
SWAPs	Sector Wide Approach
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WARN	West Africa RBM Network
WHO	World Health Organization
WHOPES	WHO Pesticide Evaluation Scheme

#### 4. INTRODUCTION

The Roll Back Malaria Board representing the global RBM partners requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries<sup>1</sup> would require to support the attainment of the Abuja Targets. The RBM Partnership Secretariat requested the Eastern Africa RBM Network – which represents partners in the sub-region – to participate in these country consultative missions.

The purpose of the country consultative missions is to:

- Re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The expected outcomes of the missions are:

- Determine the status of RBM implementation in relation to the Abuja plan and targets and the milestones set for the remaining two years of the Abuja plan period
- Identification of the essential actions (beyond those already planned) that need to be implemented during 2004 and 2005 to maximise country action to achieve the Abuja Targets
- A Country Support Package that details the additional investments required to carry out these essential actions

The Ghana mission had the following specific objectives:

1. To discuss the full range of RBM developments in Ghana over the last 5 years with respect to:
  - Achievements to date; status of policy development for the various interventions, including those that are under development, those that have been adopted, issues on which agreement has been reached and remaining actions.
  - Strategies to implement policies, including those that are under development, those that have been adopted, issues on which agreement has been reached and remaining actions.
  - Trends and practices as determined through surveys.
2. To review and update the Ghana RBM Desk Review Report prepared in July-August 2003
3. To complete the needs based planning exercise in the Ghana Health Service started in May 2003 aimed at scaling up priority interventions including RBM
4. To review and modify the third round GFATM proposal for re-submission to the fourth round call for proposals.

#### 5. METHODOLOGY

The methodology employed included

1. Workshop at which the country RBM partners, GHS and MOH staff and the external mission team members participated.
2. Interviews with major country RBM partners in both public and private sectors, foreign health partner organizations, UN agencies, NGOs, and civil society organisations (Annex 1).
3. Document review (Annex 3)

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<sup>1</sup> The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions. Ghana is classed as a Category One country

4. Consensus meeting with RBM partners (Annex 2) to obtain partners' agreement on the mission findings and their commitment to support the essential follow up actions identified (the next steps) and the support package required to meet the Abuja targets by June 2005.

The team comprised local and external members drawn from the Ministry of Health, Ghana Health Service (including the NMCP and IMCI), WARN, MAC (MSH, JHPEIGO), AWARE-RH/USAID/WARP, WHO (AFRO/ICP/MAL), RBM Partnership Secretariat - Geneva, NGOs, Malaria Consortium, UNICEF, World Bank, AED/NetMark. Also participating was the COMBI mission team from WHO/HQ (Tunis Office) and WHO/AFRO. The full list of team members is attached as annex.

## 6. SUMMARY SITUATION ANALYSIS

### 6.1. Malaria Transmission and Burden

Malaria is hyper endemic in Ghana with perennial transmission afflicting and affecting people of all ages throughout the country.

The geo-epidemiological transmission of malaria in Ghana is classified as:

Tropical rainforest (middle belt), coastal lagoons/mangrove swamps (south-western part of the country), coastal and northern savannah urban development-related mean geometric malaria parasite density by age and season.

The principal vector transmitting malaria is the female *Anopheles gambiae* complex and *Anopheles funestus*. *Anopheles melas* is predominantly in the swampy south-west and *Anopheles arabiensis* in the northern part of the country.

*Plasmodium falciparum* is the predominant malaria parasite in Ghana accounting for about 90% of all cases while *Plasmodium malariae* accounts for 9% and *P. ovale* is responsible for the remaining 1%.

Malaria is amongst the leading causes of morbidity and mortality and accounts for a significant proportion of the burden of disease in Ghana. It accounts for about 45% of all outpatient clinic attendances in health institutions and is ranked third in terms of cause of death (6.9%) and Disability Adjusted Life Years (DALY) lost (6.8%), with only HIV/AIDS (13.7% mortality and 12.5% DALYS lost) and all cause peri-natal deaths (8.3% mortality and 9.5% DALYS lost) responsible for more deaths. (The figures quoted here were obtained from the NMCP and were stated to have originated from a study carried out by an individual for USAID. These figures should be verified through cross-checking with other data sources or studies).

### 6.2. Policy and Strategy Environment and Partnerships

The government and people of Ghana recognise Malaria as a major health problem afflicting the majority of the population at any given time and having significant negative effects on the socio-economic development of the nation and its citizens. The Government of Ghana acknowledges the importance of malaria and the Head of State participated in the 2000 Abuja summit on Malaria and Ghana is a signatory to the Abuja Declaration.

Ghana has also launched the report on the Commission for Macro Economics and Health and intends to implement certain actions planned following the launch of the report designed to position health at the centre of the socio-economic development agenda and related national programmes.

The Ghana Poverty Reduction Strategy Document, which is one of the principal socio-economic development policy documents of the government was reviewed to harmonise the country's development targets with those of NEPAD and the MDGs. The PRSP document gives prominence to effective malaria control as one of the means to achieving good health status of Ghanaians, which in turn is predicted to promote productivity and micro-economic stability and growth.

Malaria control is classified amongst seven other disease programmes as a key priority of the Ministry of Health and the Ghana Health Service. These priority diseases and Programmes are:

- HIV/AIDS Prevention and Control
- Tuberculosis Control
- Malaria Control
- Expanded Programme on Immunization (EPI)
- Guinea-worm Disease Eradication
- Maternal and Child Health, including Reproductive Health (RH)
- Integrated Management of Childhood Illnesses (IMCI).

Within the health and financial sector policy of the government of Ghana, malaria control activities are budgeted for in the Mid-Term Expenditure Framework (MTEF) and is included in the Sector-Wide Approach (SWAP) arrangements of government and its development partners.

A government Legislative Instrument directs that 1% of central government's development budgetary allocations to the District Assemblies be spent on malaria control activities in the 110 administrative districts of the country. Other sources of funding for malaria control within the provisions of government policy include the Heavily-Indebted Poor Countries (HIPC) debt relief funds, which are disbursed to District Assemblies by central government.

Ghana has a vibrant and functional RBM partnership, membership of which includes UN agencies, bilateral and multilateral development organisations, research and educational institutions, NGOs, Civil Society Organisations, and government MDAs (Ministries, Departments and Agencies) that are actively involved in processes aimed at rolling back malaria in Ghana.

The country RBM partnership has developed a 10-year Strategic Plan to give direction and guidance to malaria control activities in Ghana. At a consensus building meeting held in January 2001, all the major country partners pledged their commitment to provide financial and other resource support for the implementation of the activities contained in the strategic plan and signed a Memorandum of Understanding (MOU) to this effect.

To support the implementation of the strategic plan, several health sector policy documents have been developed or are currently being reviewed. Policy documents include ITMs, Anti-malarial Drugs Management and Use, ITNs and IPT for pregnant women, school health and the facilitation of financial access to malaria prevention and treatment for the poor and other specific categories within the population.

Four main strategies have been adopted and being pursued to control malaria in conformity with those recommended and promoted by the WHO and the RBM partnership. These are:

1. *Improved Malaria Case Management*; ensuring prompt and correct treatment of malaria illness at household, community and health facility levels.

2. *Multiple Prevention*; especially but not exclusively promote use of treated nets, prophylaxis for pregnant women, environmental management
3. *Improved Partnership*; at all levels of society
4. *Focused Research*; for evidence-based decision making for efficient and effective implementation of malaria control.

The strategies highlighted above have been translated into the following areas of intervention

#### ***ITNs and other Vector Control Measures***

The main vector control measure being pursued is the promotion and use of ITNs on the basis of this approach being the most cost-effective preventive measure given the circumstance of Ghana, however, this does not preclude the use of other measures, including environmental management, larviciding and indoor-residual spraying, where appropriate. Screening of houses is also encouraged as a complementary measure.

#### ***Milestones – Policy Development***

Ghana has achieved important successes and reached some critical milestones in various aspects of RBM implementation, including in the area of ITMs. An ITM policy has been developed to guide activities relating to ITM promotion, procurement, distribution, use and monitoring including research on insecticide efficacy and resistance, and the environmental impact of insecticides and net use.

It is now a policy for ITN use to be coupled with IPT for malaria prevention in pregnancy, and a series of training sessions for health workers and other stakeholders have been initiated in order to orient health workers and subsequently the public on the new policy and its implementation.

Government policy of creating an enabling and facilitating environment for private sector led socio-economic development and growth in the country would no doubt further enhance private sector participation in malaria control. There is a remarkably strong public-private partnership for ITNs promotion, availability and use. However this partnership is yet to make the much desired impact with regards to ITNs supply in Ghana.

In demonstrating practical support towards realising the targets contained in the Abuja Declaration, the Government of Ghana through a parliamentary (legislative) process waived customs and excise duties on ITNs. VAT remains the only tax paid on ITNs. Additionally some district assemblies (local government authorities) are committing budgetary allocations to ITN procurement and distribution and environmental management measures in some instances. It is anticipated that with improved dialogue and partnership developing between the District Assemblies and District Health Management Teams at the district level, more funding could be accessed and made available from the HIPC funds and the Common Fund allocated to the District Assemblies by central government.

#### ***Milestones – Strategy Development***

DfID and USAID are jointly supporting actions by the Ghana Health Service to pilot a voucher system for ITN distribution in the Volta Region. Lessons learnt will provide further direction for taking this intervention to scale to cover the rest of the country.

ITN distribution projects carried out in districts in Upper East Region have demonstrated considerable success using a voucher system to distribute ITNs to pregnant women and children under 5 years of age. Vouchers are given to pregnant women and children attending ANC and child welfare and vaccination services. These vouchers are then exchanged for an

ITN through community volunteers. An alternative approach involved the distribution of ITNs by EPI staff and community volunteers during a mass measles vaccination campaign in Lawra district in the Upper West Region. ITNs have also been distributed through DHMTs using a graded subsidy mechanism which specifically targets the poor within the general beneficiary population of pregnant women and children under 5 years of age. DHMTs have also purchased ITNs directly from commercial dealers and resold these at cost or marginal profit to members of the population. Some District Assemblies are providing financial support to their DHMTs for the purchase and distribution of ITNs. A mass re-treatment exercise in parts of the Upper East region of the country was undertaken with success. All these experiences have provided outcomes and useful lessons for scaling up ITNs.

#### *Implementation to Date*

RBM partners in the country have provided support by way of ITN donations (WHO 100,000 and UNICEF 20,000 over a two-year period). These ITNs were received by the NMCP and passed on to the DHMTs for distribution through graded subsidised sales to members of the public, particularly pregnant women and children under 5 years of age.

In addition to the donation cited above, UNICEF has distributed about 350,000 ITNs in its demonstration project areas within economically deprived areas in the Upper East and Northern Regions of Ghana. Some NGOs such as Plan-Ghana have also distributed ITNs in their project areas. However, the activities of partners are not always co-ordinated effectively by the NMCP.

An ITM treatment and management manual has been developed and some copies printed by the NMCP with WHO support, and a limited number of school teachers, Red Cross Volunteers and Disease Control officers of the Ghana health Service have been trained in ITM treatment, with the aim of scaling up this activity to cover communities across the country.

Two major communication activities to support ITN implementation in Ghana have been undertaken and a third has been planned;

- 1) the GSMF ITN communication project which employed electronic media (mainly Television), print materials and other promotional materials
- 2) the JHU/CCP led “he-ha-ho” which is an electronic media (largely radio) communication using drama to educate the public on ITN use and malaria control in general as well as IMCI and family planning. It is broadcast weekly in English and five major Ghanaian languages. Audio and video tapes on “he-ha-ho” are being produced for distribution for community based communication activities.
- 3) 1600 community-based agents to be trained in ITN communication and re-treatment with funding from the GFATM and USAID/DfID

Table 1 depicts the progress made on ITN access and use. Given the preparations made and the experiences acquired over the last 2 ½ years it is envisaged that with the injection of the right amounts of resources ITN coverage and use will increase significantly over the next 18 months.

*Table 1: Trends in ITN Utilisation*

Region (in Ghana)	2000(NMCP)		2003(DHS)	
	U5 (%)	Pregnant (%)	U5 (%)	Women of reproductive age (15-49 yrs)
Western	0	0	1	1.1
Central	0	0	0.7	1.4
Greater Accra	0	0	3.1	1.1

Volta	0	0	2.2	1.9
Eastern	0	0	0.3	0
Ashanti	0	0	1.2	0.8
Brong Ahafo	0	0.8	2.1	1.5
Northern	N/A	N/A	7.2	5.3
Upper East	N/A	N/A	20.7	15.1
Upper West	N/A	N/A	1.9	1.9
National Average			3.5	2.2

*Source: NMCP/GSS –DHS 2003*

Private sector businesses have also sold ITNs to members of the public, especially in the urban centres in the south of the country, but data on this specific contribution is not yet available. The level of activity of the private sector has been lower than expected. It is hoped that this will pick up soon, especially with the recent WHOPEs approval for a second LLIN brand (*Permanet 2.0*). *Olyset*, the other brand of LLIN, which achieved WHOPEs approval earlier is not yet available on the market in Ghana.

### ***Assumptions for Abuja Targets***

If the required resources for implementing the essential actions identified by the REAPING mission are made available in a timely fashion, it is expected that Ghana would be able to scale-up ITN interventions to achieve coverage levels of 35% in 2004 and exceed the Abuja target of 60% by June 2005.

### **6.3. Access to Effective Treatment**

The NMCP has implemented several actions to improve case management in communities, homes and health institutions towards meeting the Abuja target of 60% prompt access to treatment within 24 hours of onset of illness.

#### *Milestones – Policy Development*

The national authorities and RBM partners have begun and are indeed close to concluding the process for updating the anti-malarial treatment policy from Chloroquine to ACTs. The decision to change policy was informed by chloroquine efficacy studies carried out between 1998 and 2001, which revealed 25% treatment failure rates for chloroquine, previously the first-line drug for malaria treatment in Ghana. The process is expected to be complete by February 2005 when ACTs will be introduced for case management, providing that the Ministry is able to access adequate levels of funding to implement the process and procure and distribute the ACTs. There are various government legislative instruments and statutory bodies such as the Ghana Food and Drugs Board and the Ghana Standards Board in existence to ensure the quality, safety and efficacy of various medications (drugs) and foods.

Government policy of enhancing public private partnerships and contracting out services to the private sector is designed to mitigate the human resource constraints and other challenges, while continuing efforts are being made to improve conditions of service of health workers and their work environment.

#### *Milestones –Strategies Development*

These include (re)training of health workers (in both private and public) and community based agents/care-givers in case management. The training has been based on revised and updated WHO AFRO Regional Training Manuals for Malaria and IMCI, and for community and school based caregivers and drug shop attendants new training manuals were developed.

These training manuals serve as resource documents and are supported and complemented by the National Treatment Guidelines and Essential Drugs List. Training activities are

complemented with communication on appropriate actions for treatment of malaria provided through TV and radio broadcasts, posters and person to person interaction.

The National Drugs Programme and the Procurement Unit of the Ministry of Health working with the Food and Drugs Board have ensured the quality and good availability of anti-malarial drugs in all public health facilities. Drug supply and availability is remarkably good in both public and private sectors with no stock-out of anti-malarial drugs in nearly all health institutions. A well motivated private sector ensures availability of drugs in most communities. A fairly well resourced Food and Drugs Board (FDB) operating with a sound policy backed by legislative provisions and a credible work plan ensures that the quality and safety of the drugs meets WHO standards.

#### *Implementation Level to Date*

Review and adaptation, and development of new training manuals for case management have been undertaken. A cascade training programme was initiated and is ongoing as a continuing activity to improve case management capabilities of the clinicians and caregivers.

Chemical/drug shop attendants, community based agents and school health workers are also being trained in malaria prevention and the treatment of uncomplicated malaria.

Most anti-malaria drugs including pre-packed chloroquine (the current first-line drug for malaria treatment) and sulphadoxine-pyrimethamine (SP), are also manufactured in Ghana by local pharmaceutical firms. However chloroquine will soon cease to be the first-line drug in view of the significant resistance level recorded in Ghana and actions being taken by the national authorities to change the malaria treatment policy to the use of ACTs. It is planned that by February 2005, Artemisinin-Based Combination drugs will be in use as the first-line anti-malarial drug in the country.

Sentinel monitoring of anti-malarial drug efficacy has been institutionalized in the Ghana Health Service and requires continued support to function effectively. Sentinel sites for anti-malarial drugs efficacy monitoring have been established but activities at these sites are currently low. It is expected that with the provision of the appropriate resources and funding the sites will be expanded in terms of activity level (functionality) and numbers.

Various herbal preparations are also sold by the private and informal sectors for malaria treatment. The efficacy and effectiveness claims bestowed on these preparations by manufacturers provide a real challenge to the Food and Drugs Board and the Ghana Standards Board as the majority of these products are not submitted to the relevant statutory authority for evaluation and approval before being put up for sale to the public.

The Ghana Country Coordinating Mechanism (CCM) is reviewing the third round GFATM proposal, which in the light of Technical Review Panel comments, will be re-submitted to round four. Additionally, the country RBM partners will pursue the option of sourcing (pooling) funding both locally and internationally outside of the global fund to implement the new drug policy, which has been endorsed as a fundamental action towards effective malaria treatment in Ghana.

#### *Trends in Utilization*

Less than half (just about 30%) of all malaria cases in the country are treated in public health institutions. Health facility access (geographic coverage) is estimated at 60% (8km radius and about 1 hour travel/walking time) and a per capita Out Patient Department coverage of 0.4%. Community based treatment through services provided by chemical shop attendants, self

medication and traditional medical treatment seems to be a significant source of case management. The government and Ghana Health Service pro-poor policy and agenda for the health sector is expected to improve these indicators

#### *Assumptions for Abuja Targets*

That government of Ghana, the Ministry of Health and the Ghana Health Service will change the anti-malarial treatment policy to the use of ACTs as first-line drug for treatment. Resources required to implement the essential actions identified will be provided by government, the Global Fund and RBM Partners. Also that the proposed interventions outlined in policy and programme implementation documents will improve the access and uptake of services by the poor.

The major challenge to case management in Ghana is the significantly high level of chloroquine treatment failure and the principal and most appropriate action required immediately is the completion of the process to change the anti malaria treatment policy for the introduction of ACTs otherwise any actions taken to further improve a system for the continued use of an ineffective first-line drug, Chloroquine, will contribute to the realization of the Abuja targets and the RBM goals.

#### **Specific Assumptions**

- New drug policy adopts ACT (Artesunate-Amodiaquine)
- Subsidised cost of drugs to patients
- April 2004 – submission of GFATM fourth round
- June 2004 – approval of GFATM proposal
- Dec 2004 - release of funds
- Drugs in country 1st quarter 2005

#### **6.4. Malaria in Pregnancy**

The national authorities in Ghana recognise malaria in pregnancy as contributing significantly to maternal anaemia, abortion, intra-uterine growth retardation resulting in low birth weight new-borns, predisposition to peri-natal death and maternal death. A national maternal health policy is in place with a view to preventing malaria and anaemia in pregnancy.

Previously, the policy on malaria prevention in pregnancy was chloroquine chemoprophylaxis. A pregnant woman visiting an ANC clinic for the first time was given a full course chloroquine treatment followed by a weekly dose of 300mg chloroquine phosphate (two tablets) until six weeks after delivery.

#### *Milestone – Policy Development*

Malaria prevention in pregnancy has formed part of the process to review the anti-malarial drug treatment policy in Ghana, and a new policy has been introduced. The new policy states that IPT with SP should be coupled with ITN distribution for effective prevention of malaria in pregnancy. It is envisaged that compliance with the new drug regimen will be higher than with chloroquine prophylaxis, as IPT with SP is only performed a maximum of three times per pregnancy.

#### *Milestones – Strategy Development*

Progress in implementing the new IPT policy include consensus building on the policy among all key stakeholders and the adoption of the new policy by the ministry of health. Training manuals have been developed and printed and health worker training of trainers on implementation of the new policy is underway. A Malaria Action Coalition (MAC) partner

RPM-plus has also assessed the SP drug management and procurement system and has provided support for SP needs forecasting.

ANC attendance cards for pregnant women have been revised to reflect the requirements for IPT implementation and documentation. Design of aspects of the communication component of the IPT implementation strategy has been contracted out to a partner (JHPIEGO). However there is a need to involve other stakeholders in the design of the communication component.

#### *Implementation to Date*

IPT implementation has not yet begun and coverage is presumed to be near zero. The only aspect of the policy being implemented is the training of trainers workshops for regional resource persons, and the adaptation and printing of a limited number of training manuals.

#### *Trends in Utilisation*

Utilisation coverage of IPT for malaria prevention in Ghana is almost zero. The systems for delivering the previous regime of weekly chloroquine chemoprophylaxis to pregnant women through ANC already exist, but the chemoprophylaxis coverage for pregnant women has remained low (about 11.6%) despite a high proportion of women attending ANC (about 80%). Various reasons have been given for the low chemoprophylaxis coverage including poor compliance due to the long duration of administration of the drug. In effect pregnant women are not currently effectively protected against malaria as ITN use was not promoted in the previous policy.

#### *Assumptions for Abuja Targets*

The key assumptions for reaching the Abuja targets include the availability of the required resources to implement the essential actions and the continued functioning of the ANC system. Currently approximately 80% of pregnant women make at least one ANC visit and so prospects for improving effective malaria prevention exist. Partner support for the new IPT policy is good and there is evidence of enthusiastic collaboration among the NMCP, RH Unit and the GNDP and other key implementers, and it should be possible to introduce IPT in all antenatal clinics by the end of 2004. IPT can be expected to reach at least 60% of pregnant women receiving at least two doses of SP by June 2005. The major challenge is the availability of adequate levels of funding to expand IPT/ITNs implementation beyond the 40 out of the 110 districts planned.

## **6.5. Supportive Strategies**

#### *Monitoring and evaluation*

Monitoring has been limited to routine reporting and occasional, but inconsistent, quarterly supervisory visits by the NMCP leadership to the RBM-focus districts. RHMTs have also been supported by the NMCP on occasion to undertake monitoring visits to the implementing levels in the districts.

Five sentinel sites for anti-malarial drug efficacy surveillance have been set up in various locations in the country, with partner support. The GHS/NMCP intends to turn these into composite surveillance sites for monitoring drug and insecticide efficacy, morbidity and mortality. The total number of sites will hopefully also increase and the plan is to divide them into two sets to run in alternate cycles of 2-3 years. No specific evaluation has been carried out since the RBM baseline survey situation analysis in 2001. A DHS was conducted in 2003, and this included a malaria module for the first time. The FDB is a statutory government agency under the MOH with responsibility for drug safety and quality assurance and product registration. NMCP has a comprehensive integrated monitoring and evaluation plan with other

health programmes and national institutions concerned with health and demographic and socio-economic data collection and management. Generally data availability and quality is an area that will likely benefit from continuous improvement.

### *Communication*

Communication activities aim to provide sufficient technical information, conveyed in simple language, to provide a basis on which further communication strategies can be used to encourage behaviours appropriate and effective for malaria control in the context of the RBM initiative. Most of the communication activities in support of all interventions are contracted out to special agencies either directly by donor partners on behalf of the GHS/NMCP or by the NMCP itself.

Communication delivery has been through the channels of electronic mass media (radio and TV), print media, person to person interactions at community durbars, public gatherings, health education by health workers, posters, and limited numbers of billboards.

The first edition of the national malaria bulletin was published during the visit of the consultative (REAPING) mission team.

There has been no comprehensive country wide assessment of the impact of the various communication strategies implemented within the period under review. The perception is that ITN supply has lagged behind the levels of awareness and demand that have been created. It is also perceived that the level of awareness is generally low in rural communities compared to urban ones.

There is an obvious need to expand communication efforts to ensure wider coverage and improve its effectiveness. The NMCP has recently begun entering into contractual arrangements with NGOs and private communication agencies as implementing partners to implement the communication interventions contained in the GFATM proposal for which funds have been received.

## **6.6. Malaria Control and Health Systems**

### *Organisation of Malaria Control*

The RBM partnership and NMCP are under the political and policy directions of the National RBM Coordinating Committee (NCC), constituted by the Minister for Health of Ghana. The major functions of the committee include endorsing, approving and making policy decisions for malaria control by the RBM partnership. Major RBM partners and relevant government and research institutions are represented on this committee, which is chaired by the Director of the Noguchi Memorial Institute of Medical Research.

The NMCP is a programme within the Public Health directorate of the Ghana Health Service and is physically located in an RBM Secretariat housed in a building shared with IMCI, in the spirit of partnership and to foster effective collaboration. The NMCP is headed by a public Health Physician supported by a team of young and energetic officers with the able support of a principal entomologist of the Ghana Health Service. The programme Manager is under the technical direction and supervision of the Director of Public Health. The NMCP runs the RBM Secretariat of Ghana.

Direct technical support for malaria control has been provided by WHO through its Country Office. Other partner organisations, notably the Malaria Consortium, UNICEF, MAC Partners and USAID have provided various forms of technical assistance.

### *Health Systems Development*

Ghana has undertaken a remarkably successful health sector reform, a feature of which is a well decentralised district health system operating on the DHMT (District Health Assembly [DHA]) and sub-districts concept. The DHA is one of the 16 decentralised government ministries, departments and agencies under the District Assembly (Local Government Authority), itself a decentralised structure of government within the Ministry of Local Government. The DHMT head is an ex-officio member of the district assembly and has a functional relationship to the District Chief Executive (the political head of the district assembly and head of government business). The DHMTs have a legal responsibility to be accountable to the DAs and the DAs in turn have the responsibility of planning for the needs of the DHMTs and making appropriate budgetary support to the DHMTs within the mandate governing the disbursement of the district development budgetary provisions from central government, called the “District Assembly Common Fund” and from additional funding sources available to the district assemblies. Often these allocations have to be negotiated by DHMTs even where central government directives are unambiguous on the release of funds.

The DHMT, as the complete functional unit for comprehensive health services planning and implementation is under the technical supervision of the RHMTs headed by a Regional Director. The regions (RHMTs) report to the Director-General of the Health Service at the national level (headquarters). At HQ level there are seven technical directorates who provide direct technical guidance and support to the RHMTs.

The Ministry of Health in Ghana is principally responsible for policy formulation and sourcing funding for GHS to implement work plans based on policy and existing specific health priorities. Priority diseases are managed through programmes, such as the NMCP for Malaria, headed by Managers invariably all under the public health directorate except “Non-communicable Diseases and Disaster Management” but the services implementation and delivery are through an integrated approach within the district health system.

Planning and budget management are based on MTEF (5 year programme of work), SWAPs and direct budgetary support (ear-marked funding). A Budget Management Centre (BMC) is the basic operational planning and budget management unit in the Ghana Health Service. Monitoring and evaluation is done through routine systems and periodic performance review (hearing) processes.

Recent policy direction of government on health service delivery is in favour of enhancing private-public partnership, contracting out of services, franchising and promotion of the establishment of a National Health Insurance mechanism to improve opportunities for health care financing. Ghana does not as yet have a national health account described and documented. As of now patients pay upfront for services they receive. However, there is an exemption policy for childhood immunization services and routine scheduled antenatal care and treatment of diseases such as mental illness, epilepsy and TB. Treatment of meningitis and cholera during epidemic outbreaks is also covered under the exemption policy.

Human resource management regarding recruitment, training (except in-service training to some extent) and career development and progression is centralised at headquarters level.

*Human resources*

The Ghana health Service is facing fairly serious human resource constraints with available levels of skilled health workers being far below that required for effective service delivery. The NMCP has similarly suffered and until a couple of months ago the programme had been managed by a team of two people. Inadequate numbers of health workers especially at the district and sub-district levels has impacted negatively on the implementation of planned RBM activities and the quality of services provided. Contracting out of activities and improving private-public engagements seem to be the probable way out of this difficulty in the interim.

*Logistics*

Logistics levels for programme management and for implementation of control activities have been very low for most of the last 3 years. This has no doubt hindered effective implementation of the programme activities. However with the approval of the GFATM some basic office logistics have been procured, though this remains inadequate. It is recognised that logistics management is weak at all levels in the supply chain, a factor that no doubt hindered effective implementation of programme activities. However with the processes leading to accessing, and the availability of the Global Fund, logistics management has received attention for strengthening as logistics will play a major role in programme management and implementation.

*Financial Resources*

Sources of funding for health service delivery are:

1. Direct Government of Ghana budgetary allocations contained in annual budget statement approved by parliament of the Republic of Ghana. Actual cash flow is dependent on realisation and availability of projected government revenue for the period.
2. Health Partners through SWAPs arrangement and also direct programme (earmarked) funding support.
3. Internally Generated Funds (IGF) - Fees paid by patients/clients to whom services have been rendered.

Though the amounts of financial resources available for RBM activities in and outside of the SWAPs arrangements have been very low, the rate of utilization and the efficiency may also have been inadequate. Logistics and human resource constraints and poor schedules of funds release and availability for implementing activities may have contributed to the low utilisation rate of financial resources.

**7. ABUJA TARGETS – WILL THEY BE MET?**

The Ghana RBM National Strategy and Abuja 2005 targets are:

- 60% of under-fives and pregnant women sleeping under ITNs by 2005.
- 60% of pregnant women receiving IPT1 and IPT2 by 2005.
- 60% of under-fives with fever receiving effective treatment within 24 hours by 2005.

Lack of empirical data and models make it difficult to quote concise coverage figures. The estimates given below should be interpreted as broad indications but as close to reality as possible. They are based on assumptions that:

- The current level of co-operation and commitment of partners will be maintained and even enhanced
- Government commitment and political will will be maintained and raised

- The funds being sourced for through this review and discussions with partners would be available to the RBM programme management and on time
- The NMCP in Ghana implements the essential actions identified through innovative management strategies outlined and those that would be identified.

### 7.1. ITN coverage among under-fives

It is estimated that by the middle of 2005, 60% of children under-five years of age will be sleeping under an insecticide-treated mosquito net if the following occur:

- ITNs are available in adequate quantities
- The cost of the ITNs are reasonably affordable
- The ITNs are available in all communities of the country
- There is an effective set of communication activities to support the supply of ITNs

#### *Insecticide Treated Nets*

Abuja Target: at least 60% of those at risk of malaria, particularly children under five years of age and pregnant women, and benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering by 2005.

A SWOT analysis has revealed the following:

#### **Strength**

- Political commitment
- Tax reduction
- ITN policy available
- Policy of subsidised nets for vulnerable groups
- High awareness created about ITNs

#### **Weakness**

- Weak distribution systems
- Private nets very expensive

#### **Opportunities**

- Private sector participation
- Health partners support (financial)
- Global Fund as a financial instrument
- DACF and HIPC fund
- Political commitment

#### **Threats**

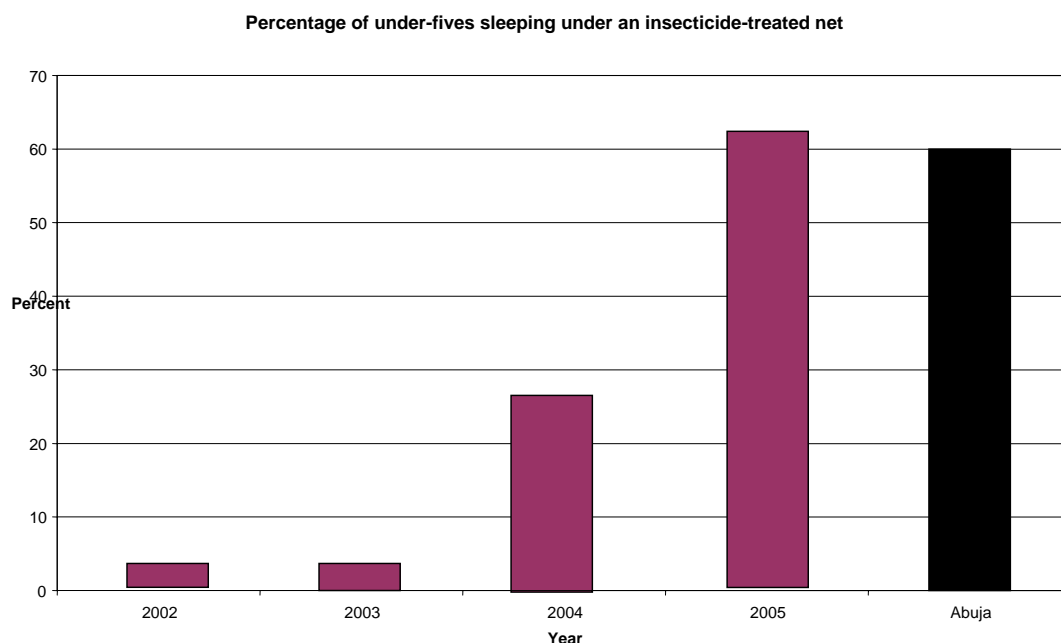
- Sleeping under nets not a popular behaviour with some people
- Poverty levels in the country
- High cost of nets
- Lack of local manufacturers of insecticides
- Priorities of members of the public

Proposed coverage for 2003, 2004, 2005

	2003	2004	2005
Use of ITNs	3.5%, 2.2%(DHS)	25%	60%

Table 2: Outline assumptions and actions for achieving proposed coverage

Year	Assumptions and actions
2003	2003 Coverage at 3.5% and 2.2%
2004	<ul style="list-style-type: none"> <li>• Access Global Fund</li> <li>• Country Partners support (fund) ITNs procurement</li> <li>• All ITN programmes sustained and expanded</li> <li>• ITNs supply adequate to meet demand</li> <li>• Awareness campaign increased</li> <li>• Scaling up continues</li> <li>• Annual review meeting initiated</li> <li>• Targeted subsidy implemented</li> <li>• Re-treatment programme initiated</li> <li>• Promotion of re-treatment of nets increased</li> <li>• Treatment centres set up</li> <li>• Management of ITNs partnership</li> <li>• Improved planning for and commemoration of African Malaria Day</li> <li>• Intensive networking among ITN partners and stakeholders</li> <li>• Operational research on ITNS use continued</li> <li>• Coverage increases to 25%.....</li>   <li>• Coverage increases to 25%...(for children under five years).</li> <li>• Coverage increases to 25% (for pregnant women)</li> </ul>
2005	<ul style="list-style-type: none"> <li>• Access Global Fund</li> <li>• Country Partners Fund ITNs procurement</li> <li>• All ITN programmes maintained</li> <li>• ITNs supply adequate to meet demand</li> <li>• Government and all partners giving final push (support) to reach Abuja targets</li> <li>• Awareness campaign increased</li> <li>• Expansion to new states</li> <li>• Annual review meeting initiated</li> <li>• Increased provision of reward ITN</li> <li>• Targeted subsidy initiated</li> <li>• Festival promotions by partners</li> <li>• Re-treatment programme initiated</li> <li>• Promotion of treatment of other nets increased</li> <li>• Integration of “small scale ITN providers” into partnership</li> <li>• Improved planning for and commemoration of African Malaria Day</li> <li>• Intensive networking among ITN partners and stakeholders</li> <li>• Programme monitoring and evaluation</li> <li>• Coverage increases to 60%.....</li>   <li>• Coverage increases to 60% (for children under five years).</li> <li>• Coverage increases to 60% (for pregnant women)</li> </ul>



## 7.2. IPT coverage among Pregnant Women

It is estimated that by the middle of 2005, 60% of pregnant women will be receiving at least two doses of IPT (IPT1 and IPT2) if the following occurs:

- Implementation Covers entire country by the end of 2004
- Full complete of drugs for 2004 and 2005 purchased by June 2004
- Training of health staff covers the whole country by June 2004
- RBM Partners fund the intervention
- Global fund provides additional funding in 2004
- Coverage at end of 2004 - 20%
- Coverage by mid 2005 - 60%

### *Intermittent Preventive Treatment*

Abuja Target: at least 60% of all pregnant women who are at risk of malaria especially those being pregnant for the first time, have access to chemoprophylaxis or presumptive intermittent treatment by 2005.

### SWOT analysis

#### **Strengths**

- Political commitment (policy adopted for implementation)
- Partners Commitment and resource support
- Guidelines already developed
- Training manuals also developed
- High ANC coverage
- Well-established community structures to support IPT
- Availability of SP at all levels
- Research capability support (monitoring efficacy)

#### **Weakness**

- Not much experience with SP in pregnancy

#### **Opportunities**

- Integration into other RH services

- GFATM approved
- Experience from other researches undertaken and other country experiences.

### Threats

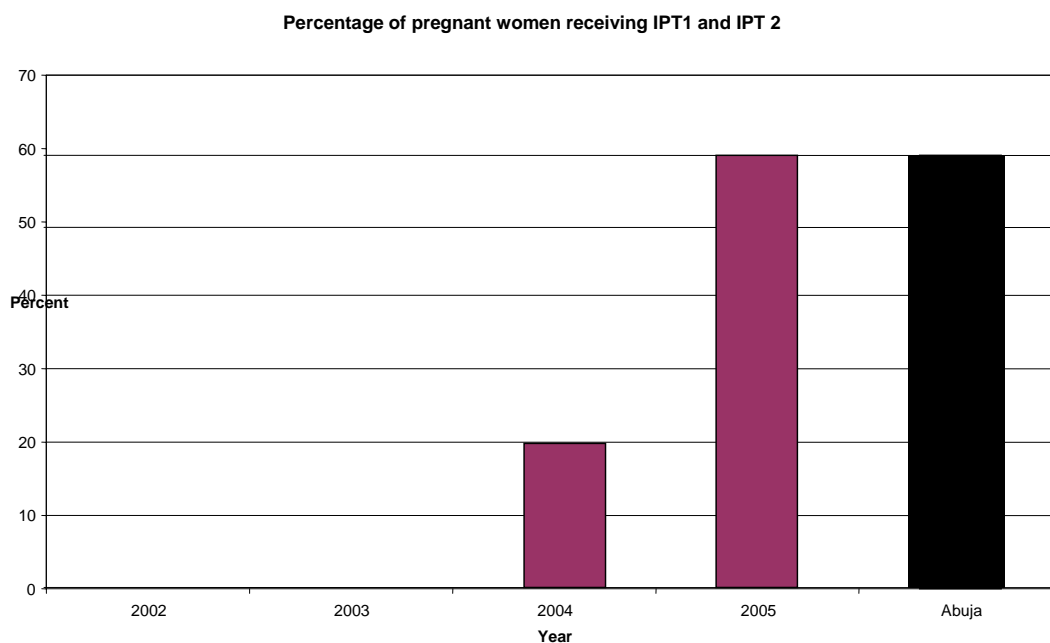
- Non-availability of funding to initiate to scale to cover whole country
- Negative media propaganda
- Adverse Drug Reactions

Proposed coverage:

	2003	2004	2005
IPT	5%	20%	60%

*Table 3: Outline assumptions and actions for achieving proposed coverage*

Year	Assumptions and actions
2003	<ul style="list-style-type: none"> <li>• Coverage was estimated based on available data</li> <li>• Coverage is 5%</li> </ul>
2004	<ul style="list-style-type: none"> <li>• Guidelines developed</li> <li>• Guidelines finalised and adopted</li> <li>• Guidelines disseminated</li> <li>• MIP/IPT focal person identified in the NMCP (at least functionally)</li> <li>• Local Production and pre-packaging of SP</li> <li>• Consensus built within health professional bodies and practitioners on IPT done</li> <li>• Pharmaco-vigilance establish and operating country-wide to community level</li> <li>• ADR management arrangements made</li> <li>• Communication activities strengthened and expanded</li> <li>• Partners able to fund implementation</li> <li>• GFATM available to fund implementation</li> <li>• GHS financing mechanism through needs-based planning (financial sustainability plan if funded initially by GFATM)</li> <li>• Coverage increases: 20%</li> </ul>
2005	<ul style="list-style-type: none"> <li>• Funding Available</li> <li>• Implementation schedule maintained</li> <li>• Good public opinion on IPT</li> <li>• Coverage increases to 60%</li> </ul>



### 7.3. Access to effective treatment for under-fives

It is estimated that by the end of 2005, 60% of under-fives with fever will be receiving effective treatment within 24 hours if the following occurs:

- New drug policy adopts ACT (Artesunate-Amodiaquine)
- Subsidised cost of drugs to patients
- April 2004 – submission to GFATM fourth round
- June 2004 – approval of GFATM proposal
- Release of funds by Dec 2004
- Drugs in country by first quarter 2005
- 1st quarter of 2005 distribution arrangements reviewed and ready

Key issues:

1.1. Implementation dependent on availability of financial resources on time

1.2. If Health insurance in place then drugs will be free to patient and paid by health insurance

SWOT analysis

#### Strengths

- Partnerships with community members, chemical/pharmacy attendants
- Availability of treatment guidelines at all levels
- Political commitment
- Well established drug distribution system
- In country availability of technical expertise
- Well trained human resources
- Wide network of health facilities in the health system – geographical access 60% of population within 8km of health facility
- Experience in scaling up interventions with other programmes
- New willingness by the GHS to contract out to partners in effort to address human resource issues, including Contracting out to private sector

- Use of mass media etc
- Experience in use of pre-packaged drugs
- Drug efficacy monitoring system,
- Technical/Task team in place
- Sentinel sites established
- Functional Food and Drugs Board
- Influenced policy on implementation of CHPS
- Nursing schools increased intake of students
- Increased number of CHPS zones
- Collaboration with SHEP programme of GHS
- IMCI case management training can be modified to facilitate speed of scale up

#### **Weaknesses**

- Low Human Resource levels in Ghana Health Service
- Poor record keeping and data management
- Inadequate laboratory support.
- Weak referral systems
- Poor treatment seeking behaviour
- Introduction of new drug in the middle of implementation period.
- Insufficient human resource capacity at implementation level of Ghana Health Service
- Pharmaco-vigilance system not fully developed
- Poorly functioning Performance/Clinical audit system
- IMCI Case management training is long, laborious, relatively too expensive

#### **Opportunities**

- Availability of volunteers at the community level
- Possibility of integration into school health programmes
- Networks with other countries and of Partners
- Local manufacturers willingness to manufacture and pre-package anti-malarial drugs
- Prospects of the access to Global Fund Resources
- Many FM radio stations to support Communication
- National Health Insurance – when operational would improve financial access to malaria treatment
- Global Fund as a financing mechanism
- Flexibility to allow ring-fencing of SWAPs funds
- Process of institutionalising needs-based planning

#### **Threats**

- Poor health seeking behaviour
- Traditional practices and beliefs delay or preclude appropriate treatment
- Poor prescription habits and practices of some clinicians/health workers
- Poor patient compliance to prescriptions and irrational use of drugs
- Weak national economy to support newer and more effective drugs (ACTs)
- Proliferation of sub-standard and fake drugs
- High cost of new drugs
- Non-availability of drugs
- Possibility for drug resistance development
- Under resourced and poor functioning of FBD

Propose coverage for 2004, 2005

2003

2004

2005

1%

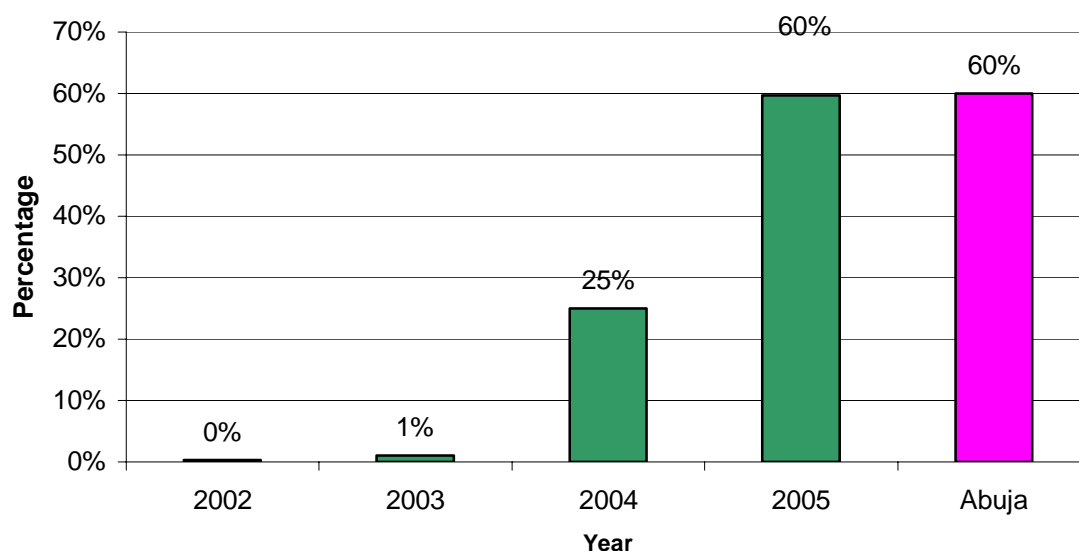
35%

60%

Table 4: Outline assumptions and actions for achieving proposed coverage

Year	Assumptions and actions
2003	2003 Coverage is estimated at 1%
2004	2004 <ul style="list-style-type: none"> <li>• Partners willingness and funding of the new treatment policy implementation</li> <li>• Access to Global fund</li> <li>• Review of Guidelines</li> <li>• Needs based planning taking place</li> <li>• Improved access to and efficient utilization of SWAPs resources</li> <li>• Orientation and Training of health staff and private sector players</li> <li>• Subsidy on drugs (ACTs) to the to the patient</li> <li>• Increased collaboration and integration, between components of the RBM</li> <li>• More sentinel sites established to monitor drugs efficacy</li> <li>• ACTs treatment coverage 35% of patients seeking care</li> </ul>
2005	2005 <ul style="list-style-type: none"> <li>• Partners willingness and availability funding of the policy implementation</li> <li>• Access to Global fund</li> <li>• NHIS operational and covering ACTs treatment</li> <li>• Sustained revitalised partners cooperation</li> <li>• Needs based planning and improved efficiency of SWAPs resource management</li> <li>• Scales-up of activities continues at national level</li> </ul> <ul style="list-style-type: none"> <li>• Coverage increases to 60%</li> </ul>

Percentage of population accessing ACTs for Malria Treatment



NB. Assumption is that about 1% of the population may be using ACTs already through the private sector

## 8. THE ESSENTIAL ACTIONS

The essential actions given below are those deemed necessary by the RBM Country partnership, WARN and RBM Secretariat to accelerate implementation and reach the coverage rates given in the previous section.

It should be emphasised that these essential actions only include those that are not currently planned and budgeted for within existing resources in the country, including Global Fund monies.

### 8.1. Access to Prompt treatment

Gaps	Description of gaps	Essential actions to be taken	Support package needed
Non availability of drugs (ACTs) Lack of information Human Resource constraints (low numbers, poor motivation. Weak laboratory support Drug availability	Health care unaffordable Late reporting to hospital Some traditional beliefs Presence of substandard and fake drugs Poorly trained laboratory personnel and inadequate equipment and supplies level	Procurement of drugs (ACTs) To institute health insurance Exemption for children under 5 and pregnant women IEC Training for prescribers, lab. Personnel Establishing a well defined drug supply system	Funding for dugs and Capacity building including training, provision of logistics Communication T/A

### 8.2. ITNs

GAPS	Description of gaps	Essential actions to be taken	Support package
Supply- Demand Behaviour change	Not enough nets to meet population demand Sleeping under nets not popular	Procure and distribute ITNs Encourage local manufacturing of nets and insecticide Behavioural change communication	Tax waiver private partnership Mass media support Training on retreatment Re-treatment centres mechanism set up

### 8.3. IPT

Gaps	Description of gaps	Essential actions to taken	Support package
ANC attendance Poverty Drug resistance	Irregular and late attendance SP expensive Potential of SP to develop resistance	Encourage ANC attendance Free or subsidization of drugs Continuous drug efficacy monitoring	Training for health workers IEC support Funds Develop guidelines Research capability and research support

### 8.4. Training and Capacity Improvement

- Train health workers and chemical shop operators on new first-line anti-malarial (Artesunate-Amodiaquine) use and SP for IPT
- Train community members on ITN re-treatment and the use of first-line anti-malarial drug for home based care
- Provide technical orientation and resource support to FDB and Pharmaco-vigilance centre on new drugs/products introduced for malaria control

- Contract out some activities likely to compete with NMCP and health worker time (training, monitoring, operational research, products distribution, communication etc) private sector organizations and individuals with the expertise and capacity.
- Establish ITNs treatment centres and re-treatment days in communities.

➤ ..... (c. USD .....)

### **8.5. Monitoring and Operational Research**

- Institute and run integrated regular periodic (quarterly) technical visits and reporting on the use SP for IPT, Artesunate-Amodiaquine for case management and ITN supply, distribution, use and treatment
- Provide technical orientation and funding resources to teams/individuals to undertake operational research on social acceptability issues on IPT, New anti-malarial drugs, quality of health care (malarial management), ITN distribution and use.
- Provide technical guidance and resources support for data generation, collection, management and sharing in a network fashion on drug efficacy, insecticide efficacy, morbidity and mortality at composite (harmonised) sentinel sites.
- Institute and provide guidance for a system of tracking expenditure rates and reporting/feedback
- Provide information and resource support to FDB to improve on anti-malarial drugs registration process and to track quality and supply sources of anti-malarial drugs in both public and private domain.

➤ ..... (c. USD .....)

### **8.6. Drugs, Products and Logistics Supply**

- Supply planning and forecast best estimate of required quantities of SP, ITNs, Insecticides and related supplies
- Purchase commodities by international bidding/tendering processes using recognised procurement identities
- Assess distribution networks (GHS, Private sector and other agencies) in order to reach the optimal solutions.
- Forecast (estimate) quantities, of SP, Artesunate-Amodiaquine, ITNs and other logistics needed
- Develop and communicate/circulate concise guidelines on distribution and use of drugs/products to distributors and delivery points.
- Support FDB to monitor quality of products along distribution chain.
- Renting of premises for safe/secured ware-housing and storage.
- Determine the packaging and presentation of drugs and ITNs and present this manufacturers/suppliers

➤ ..... (c. USD .....)

### **8.7. IPT Implementation**

- Orientate health workers and the public especially pregnant women on the possible side/adverse affects of SP
- Print and hold Adverse Drug Reaction (ADR) reporting forms in clinics and hospitals for completion and forwarding when ADRs occur

- Establish ADR management Mechanism - Negotiate for ADRs to be managed and the cost absorbed by exemption package for pregnant women (this could be budgeted for in needs-based planning or in financial sustainability plan for IPT)
- Print more IPT implementation documents - ANC cards, registers, posters, ADR reporting forms
- Negotiate with government and health partners for SP to be a programme drug as replacement for chloroquine for free hand out to pregnant women and the cost catered for in a financial sustainability plan in a needs-based planning process to facilitate future procurement.

➤ ..... (c. USD .....)

### **8.8. Management of Policy Change and Implementation of New policy (IPT and First-line Drug)**

- Review and revise communication strategies, activities and materials
- Withdraw communication materials or terminate activities that conflict with new policy
- Develop and print adequate numbers of training and communication (IEC) materials
- Phase-out the use or radical withdrawal of obsolete product/drug concurrently with new product/drugs introduction.
- Contract out PR activities/needs to a competent firm or person(s) to handle the public and media misconceptions, misunderstandings, deliberate twists and interference, and genuine misgivings based on incidents of inappropriate management of change process.
- Brief A-G's department adequately and provide regular information on progress of change process.

➤ .....(c. USD .....)

### **8.9. Programme and Partnerships Management**

- Institutionalise regular (monthly) programme management meeting for NMCP secretariat staff and quarterly meeting with implementing partners
- Secure budgetary allocation for logistics, utility services, vehicle running and maintenance costs
- Institutionalise preventive maintenance for office equipment, building and vehicles
- Draw up a plan for partnership development and management and implement it at national, regional and district levels
- Lobby at national level to give high profile to RBM for resources and other support
- Support mainstreaming of needs-based planning into MTEF /SWAPs planning process

➤ ..... (c. USD .....)

### **8.10. Communication (IEC) and Advocacy**

- Contract out development of communication activities and materials on case management, IPT, ITNs and environmental management
- Public advocacy and orientation by PM of NMCP and resource persons identified by PM through the mass media on regular and consistent basis
- Development and erection of bill boards on essential malaria information in the regions/districts throughout the country

➤ ..... (c. USD .....)



## 9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED - GHANA

No	Essential actions (in addition to ongoing activities)	Products	Investments needed							Meeting the Gap
			Human resources	Commodities	Equipment	Cost 2003	Cost 2004 US\$	Cost 2005 US\$	Cost 2006 US\$	
1.	<p><i>Review District Plans to capture national objectives and Essential Actions.</i></p> <ul style="list-style-type: none"> <li>➤ Build and Orientate team of Facilitators for Regional based reviews</li> <li>➤ Conduct Needs-based Plans Review workshops in all Regions for DHMTs.</li> <li>➤ Collate Reviewed Plans into Regional and National needs based plans.</li> <li>➤ Present Plans as proposal or integral part of GHS action plan to Partners for Resources.</li> </ul>	<i>A National needs-based RBM plan</i>	TA	Guidelines			60,000	20,000		
2	<p><i>Change Policy (IPT, Malaria Treatment)</i></p> <ul style="list-style-type: none"> <li>➤ Promulgate Policy Change</li> <li>➤ Contract out Review and printing of Relevant Guidelines and Documents</li> <li>➤ Contract out nationwide Orientation and Training of health workers and other implementers (inc. private and informal)</li> </ul>	<p>- <i>New Policy on IPT and first-line Treatment with ACTs</i></p> <p>- <i>New Guidelines and Resource Documents on IPT and New Treatment with ACTs</i></p> <p>- <i>Trained/Re-orientated health workers and stakeholders in both public and private sectors</i></p>	TA	SP (prepacked)  Coratem (prepacked)	3 laptop computers with LCD projectors		370,000	250,000		
3	<i>Review Implementation/Management Arrangements for GHS-SWAPs</i>		TA							

	<i>Planning and Efficiency</i> <ul style="list-style-type: none"> <li>➤ MOH/GHS/Health Partners meeting as follow up to REAPING mission to review/affirm SWAPs/Budgetary Arrangements</li> <li>➤ ?Sign an MOU on new ways to do business</li> </ul>									
4	<i>Improve Capacity and Efficiency to Steer and Coordinate RBM Partnership and Actions</i> <ul style="list-style-type: none"> <li>➤ Management Orientation for NMCP</li> <li>➤ Review TOR of NMCP</li> <li>➤ Contract or Hire a CPA</li> </ul>	TA			Office logistics, vehicle for CPA		60,000	30,000		
5	<i>Monitoring Implementations and Evaluation of Abuja Targets</i> <ul style="list-style-type: none"> <li>➤ Access and Review Monitoring component of Regional and National Needs-based plans</li> <li>➤ Prepare TOR and Contract out Evaluation for end of 2005</li> <li>➤ RBM Partners to prepare own team to participate in evaluation</li> <li>➤ Conduct evaluation</li> </ul>	TA					20,000	50,000		



	➤ Contract out COMBI activities to new agencies with proven capability in COMBI.									
8	Procurement of ACTs ➤ Plan/forecast ACTs needs (MAC) ➤ Identify/contract appropriate entity (Mal Dept, WHO/HQ) to procure ACTs thro' process of international competitive bidding		TA					40,000,000	80,000,000	
9							<b>TOTAL</b>	<b>49,820,000</b>	<b>89,145,00</b>	

**Grand Total: 138,975,000**

## 10. FOLLOW UP ACTIONS

The following actions were agreed on at the Partners' consensus meeting held on Friday 30 January 2004 as next steps/follow up actions:

1. Strengthening District Plans to capture national objectives and essential actions, harmonising planning cycles of NMCP, GHS-MTEF and Partners. RBM Partners and NMCP to participate effectively in next April planning meeting and conduct business with the REAPING Mission Report - *PPME/GHS, NMCP*
2. Change policy (Malaria Treatment) – *action NMCP, GHS, MOH*
3. Management/Implementation arrangements for the common pot (SWAPs basket) to be resolved to reflect and emphasise how to access and use funds and not merely concentrate on how much funding would be available – improve efficiency. - *action GHS,MOH, NMCP, Partners*
4. Improve management capacity. The NMCP Manager needs to network with the DHMTs / District and Regional Managers and act more in an advocacy capacity and provide technical direction rather than be involved directly in implementation. This requires enhanced capacity including the recruitment/contracting of a Country Partnership Advisor. Map Partners, their activities and locations – *action NMCP, GHS*
5. Prepare an evaluation plan for Abuja: HMIS present but need to collect data at end of period to evaluate implementation. Options include, MICS (if done in Ghana). If no major survey like MICS or DHS at the time then need to conduct special survey employing RBM tools or Malaria component of DHS. - *action NMCP/RBM Partners*
6. Integration of NMCP-RBM plans into MOH/GHS-Health Partners planning cycle. Next meeting in April involving External and Internal Partners. NMCP/RBM should have strong representation and presence at this meeting. Results/report from reaping meeting to be used. RBM to participate efficiently in Partners meetings. – *action NMCP, RBM Secretariat, RBM Partners, PHD/GHS*
7. Develop supply and distribution plan for the required number of ITNs – *action NMCP*
8. Finalise COMBI plan for Ghana – *action COMBI Team Participated Reaping Mission*
9. Develop a business plan which incorporates all the essential actions **above** with cost and timelines – *action immediate by Consultant and External Team*

**11. ANNEX 1: LIST OF ORGANISATIONS CONSULTED**

1. World Bank
2. World health organization
3. European Union
4. DfID
5. UNICEF
6. Ghana Malaria Centre (Gates Funded), University of Ghana
7. Project Concern International
8. DANIDA
9. USAID

## 12. ANNEX 2: AGENDA CONSENSUS MEETING (30 JANUARY 2004)

### MINISTRY OF HEALTH CONFERENCE ROOM, ACCRA ,GHANA.

- 1) Call to Order/Welcome – Chair, Dr. Sam Adjei, Deputy Director-General, Ghana Health Service
- 2) Round of Self Introduction –People Present for the Meeting
- 3) Short Address – Mission Team Leader, Dr Adama Kone
- 4) Presentation of Highlights of REAPING Mission Report and Work Plan on Essential Actions and Resources Required to Reach the Abuja Targets – Dr James Banda
- 5) Discussions – Led by Chair
- 6) Adoption of Plan - Partners
- 7) Next Steps - Chair/ Dr Banda/ Dr Amofah
- 8) Closing Remarks – Chairman
- 9) Closing/End of Meeting

#### 12.1. Key Issues raised at Consensus Meeting

The well attended consensus meeting held at the MOH conference was chaired by the Deputy Director General of the Ghana health service and was held in a good spirit of co-operation. There was unanimous agreement on the following issues:

*Planning:* The needs based planning process which began last May is seen and endorsed as the new way to do business for service delivery in the Ghana Health Service/MOH, with the recognition that SWAPs is a process that begins with the assessments leading to needs identification and targets setting and not limited to resources allocation and disbursement, which occurs later in the process. In this respect there is the need for a paradigm shift to ensure harmonisation of budgetary ceiling, indicators and financial reporting systems, and clarity in guidelines to all levels in the GHS, especially the national and district levels. The needs-based planning is seen as having the potential to resolve the inherent planning problems in the GHS/MOH.

It had been observed that different modes of reporting required from the same implementing levels contribute to distraction and underreporting on activities due to fragmentation.

*Efficiency in Utilising SWAPs Funds:* Priority programmes as of now limit their activity plans to earmarked or project funds and do not make deliberate attempt to reach into the financial resources available through the SWAPs (common pot) arrangement to fund priority health activities/interventions which are managed by these programmes. As a result situations arise when funds may be available in the common pot but priority activities lack the required resources because needs have not been reflected in the work plans for SWAP funds. The “swing-funding” (which allows all of the resources allocated for a period to be disbursed within and before the end of the specified period) arrangement which permits the utilisation of all of a partners’ resource component in the SWAPs is a window of opportunity for accessing resources for priority needs once these are reflected in an approved work and budgetary plan. Ring-fencing (flexibly earmarked funds within the common-pot/SWAPs basket) is another mechanism for programmes to access needed funds within the SWAPs arrangement.

*NGOs Role:* The role played by NGOs is well recognised and will continue to be reflected in all future working arrangements.

*Challenges:* Decentralised planning brings in its wake challenges, including the need to ensure that needs-based planning should be practical and feasible, not theoretical.

*Key Planning Issues:*

*Policy Shift and Development:* There is a need for planners and those involved in planning to be very conversant with several important documents including the Medium Term Strategy Framework, the 5-Year Programme of Work and the Common management Arrangement.

*Elements:* recognising the elements of planning and budgeting as it relates to the GHS is important as these are a) Disease Specific and b) cross-cutting.

*Work Plan for reaching Abuja:* The partners meeting commended the Reaping Mission Team for a remarkable work/resource plan presented as an outcome of the mission and the partners endorsed the plan as a working tool to promote to all districts in the country. The plan will be adapted for all levels within the GHS which contribute to its implementation and the realisation of the various targets and objectives. The partners agreed to hold technical working sessions on the plans, following the mission as one of the steps to implement it. This was to be done through dialogue with and technical guidance to the DHMTs and implementing partners

*Mechanism for delivering Planned Activities:* It is important that an effective mechanism for the delivery of activities, e.g. guidelines for working with community groups, is incorporated into plans or guides the planning process.

*Indicators:* It was stressed that sector wide indicators should not be the basis for appraising implementation at the district level. Applying sector-wide indicators to district level performance has the potential to distract and misdirect district energy and resources away from important activities required to meet the objectives of priority interventions.

*Drug/Treatment Policy change:* The meeting was unanimous on the need to implement a new Antimalarial Treatment Policy which requires the use of ACTs as first line drug for malaria treatment. Cost effectiveness analysis supports this decision as well as the decision to use SP for malaria prevention in pregnant women. Due cognisance is given to the role of the private sector in the implementation of the new policies. The need to improve diagnosis especially in the circumstance of using ACTs was stressed. In country funding sources should be explored to fund the implementation of these new policies especially the procurement of SP for IPT which is relatively cheap. The exemption policy of the MOH/GHS provides free preventive service to pregnant women and treatment of children under 5 years of age and when IPT needs reflected in annual/periodic plans, available in-country financial resources could cater for IPT for pregnant women, and eventually this could be taken up into the NHIS service package. It is important to secure SP procurement first before applying exemption policy to IPT.

*ITNs.* Ghana requires about 3.7 million ITNs to be in use in order to reach Abuja within the next 18 months and it should be possible to roll this out to all 110 districts using in-country resources from all partners. The possibility for local production of ITNs should be pursued. An environmental management and vector control project being planned by a partner for selected metropolitan centres in the country is one avenue for support for ITN availability.

*Clarity of Purpose:* Operational Research activities which are policy formulation issues should be distinguished from disease control (intervention) ones so not to misdirect resources and time for control activities on policy issues at this critical time of reaching Abuja targets within the next 18 months.

*Chairman's Remarks*

The Chairman expressed gratitude to the mission team, and gave assurances that the issues and the plan will be adapted to make them relevant to all levels and provide technical guidance for adoption and implementation. Opportunities to work with the country partners to access funding and other resources to implement the plan to meet the Abuja targets will be explored.

*Products of the Mission:*

- Items/actions in the RBM plan essential to achieve Abuja targets shared with partners.
- Consensus reached on all issues, essential actions and resources required.
- Implementation Plan as presented at meeting attached to this report as annex .
- GFATM third round proposal reviewed for submission to fourth round call for proposal.
- Mission Report

**12.2. Participants at Partners' Consensus Meeting, Friday 30 January 2004**

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### **13. ANNEX 3: DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION**

1. Ministry of Health 5 Year programme of Work 2003-2007
2. Ministry of Health Medium Term Strategy Framework
3. MOH/ Health Partners Common Management Arrangement for 5 Year Programme of Work
4. Ghana RBM National Strategic Plan 2001-210
5. Ghana ITMs Policy Document
6. RBM Business Plan 2003
7. Ghana Poverty Reduction Strategy 2003-2005. An Agenda for Growth and Prosperity
8. Abuja Declaration and Implementation Plan
9. Desk Review for RBM Essential Actions Progress ...Investment Gaps Document , Ghana, July-August 2003
10. Ghana GFATM Round 3 Proposal – Malaria Component
11. GFATM TRP Comment on GFATM Round 3 Ghana Malaria-Component
12. Ghana IPT Policy and IPT Implementation Guideline
13. Ghana Anti-malaria Drug Efficacy Study Report
14. Ghana's Health System- Vision, Strategies, Obstacles and Financing. A Briefing Paper
15. Mobilizing for Action: Communication-for-Behaviour-Impact (COMBI). WHO/SMT/CPE/CDS Publication 2002
16. AIDE MEMOIRE Joint Ministry of Health –Health partners Summit 2-4 December 2003
17. Standard Treatment Guidelines, MOH, Ghana
18. Essential Drug List (EDL), MOH, Ghana
19. Ghana MOH Private Sector Policy
20. Uncomplicated Malaria Management Training Manuals, GHS/NMCP
21. RBM Secretariat Draft Report June 2003. Accelerating Progress In Ghana To Roll Back Malaria at District Level. Preliminary Findings and Recommendations of a Joint RBM Partners Mission Examining Constraints to Scaling Up.

**14. ANNEX 4: LIST OF EXTERNAL REAPING MISSION TEAM MEMBERS**

- |                      |                                |
|----------------------|--------------------------------|
| 1. Dr James Banda    | RBM Secretariat, Geneva        |
| 2. Dr Kamawe Kamanga | WHO/AFRO                       |
| 3. Dr Jackson Sillah | WHO/ICP-MAL, Lome              |
| 4. Dr Suprotik Basu  | World Bank, Washington DC      |
| 5. Dr Rolf Bohlin    | UNICEF, Supply HQ, Copenhagen  |
| 6. Dr John Chimumbwa | AED/Netmark, Johannesburg      |
| 7. Dr Gladys Tetteh  | Malaria Action Coalition (MAC) |
| 8. Dr Mark Amexo     | Consultant, Malaria Consortium |

**15. ANNEX 5: CASE MANAGEMENT**

Objective: TO IMPLEMENT THE NEW ANTI-MALARIAL DRUG POLICY IN ALL 110 DISTRICTS (Drug Cost was based on Coartem)								
Broad activities (Essential Actions)	Process/Output		Baseline	Targets		Responsible/ Implementing agency or agencies	Costs	
	Indicators			Year 1	Year 2		2004	2005
			2002	2004	2005			
Sensitisation on new Anti-malaria Drug policy	No. of health personnel sensitised		0	45	0	GHS Task Force	50,000	<b>50,000</b>
Train relevant health staff on AMDP	No. (%) of health staff trained		0	2020 (30%)	2640 (40%)	GHS Task Force	110,000	<b>110,000</b>
Implement IMCI in 110 districts	No. (%) of health facilities implementing IMCI activities	20		2004 80	2005 110			
Adapt training manuals and approach to shorten duration	Guidelines and manuals available in use for new drug policy implementation	0		2004 100%	2005 100%		50,000	-
Quantification of chloroquine in the system	Quantities of chloroquine in the system estimated	No		Yes	Yes		15,000	10,000
Procure and distribute drugs	Number (%) of health facilities with adequate stock of new first line drug (n=1000)	0		200 (20%)	300 (30%)	Private sector SSDM	924,000	1,540,000
Collaboration with manufacturers and retailers to ensure switch over from Chloroquine to new drugs (ACTs)	Consensus reached with manufacturers and retailers	No		Yes	Yes		5,000	2,000
Monitor use and side effects	Availability of monitoring reports	No		Yes	Yes	FDB GHS NGOs	<b>150,000</b>	<b>50,000</b>
Maintain sentinel sites for AMD resistance monitoring	Number of functioning sentinel sites	6		10	10	Noguchi GHS	60,000	<b>30,000</b>
IEC on new policy	Number of new educational materials produced	0		20000 posters 20000 leaflets	0	Task Force Private sector	100,000 30,000	80,000 30,000
Accredit and contract private sector (Refer to ARV scheme)	Proportion of private facilities accredited	0		2004 50%	2005 90%			
Develop a sustainability plan	By Govt. and Partnership (based on EPI model)	No		Yes	Yes		-	-

Undertake operations research	Availability of research reports	No	Yes	Yes	Research Institutions	20,000	30,000
Monitoring and Supervision of process	Availability of monitoring reports	No	Yes	Yes	GHS Implementing partners CCM		
Preparatory processes to ensure speedy release of funds	Mechanism for timely release of funds in place	No	Yes			-	-
Review district plans to ensure that case management is adequately planned for	Regular review of district plans	No	yes	Yes		20,000	6,500
TOTAL						1,536,000	2,240,500

**16. ANNEX 6: ITNS**

Objective:		To increase the usage of Insecticide Treated Nets in children under five years and in pregnancy (from 9.1% to 60%) and for Pregnant women (from 7.8% to 60%) by year 2007						
Broad activities	Process/Output indicators (indicate one per activity) (Refer to Annex II)	Baseline 2002	Targets		Responsible/Implementing agency or agencies	Costs		
			Year 1 2004	Year 2 2005		2004	2005	
Re-Produce ITN IEC materials and Training Manuals	Number of IEC materials produced *Posters Leaflets	0	100,000 2000000	0 0	Commercial Partners/ GHS	50,000	30,000	
Carry out IEC campaigns on ITNs at community level in 90 districts	Number of radio IEC activities on ITN undertaken	0	52 (once week)	52 a (once week)	NGOs, women, men and youth groups, Faith-based groups, other community groups, health staff	370,000	275,000	
Conduct Training for community based agents in treatment techniques	Percent of targeted Community-based health agents trained in techniques of treatment of Nets	<1%	40% (7200)	40% (7200)	NGOs and Ghana Health Service (GHS)	225,000	225,000	
Procure Insecticide-Treated Nets and insecticide kits for re-treatment *****	Percent of Estimated quantities of ITNs procured	0%	15% of 2,000,000 (75,000)	30% of 2,000,000 (150,000)	Health Partners Procurement Unit of GHS	8,500,000	8,200,000	
Store and Distribute nets and insecticides	Percent of communities with distribution centres for ITNs	0%	10% of 2,000 (200)	25% of 2000 (500)	Private sector NGOs, District Assemblies, District Health Management Teams (DHMTs), Chemical Shops, Community Associations	included above	included above	

Monitor and supervise distribution, use, treatment and re-treatment of nets	Number of Planned Supervisions undertaken by supervising level National, Regional, District	4 6 12	4 6 12	NGOs, District Assemblies, District Health Management Teams (DHMTs), Chemical Shops, Community Associations	20,000	30,000	
Undertake Insecticide Resistance Monitoring (IRM)	National Site for IRM established	0	1	1	Research Institutions	70,000	70,000
Monitor environmental impact of insecticides	Availability of reports on env. Impact	No	Yes	Yes	Research Institutions, Environmental protection Agency	20,000	10,000
TOTAL					9,255,000	8,610,000	

**17. ANNEX 7: IPT**

<b>Objective:</b>	<b>To Provide Intermittent Presumptive Treatment (IPT) to 60% of Pregnant Women in Ghana by year 2007</b>
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Broad activities	Process/Output indicators (indicate one per activity) (Refer to Annex II)	Baseline (Specify year) 2002	Targets		Responsible/Implementing agency or agencies	Costs (US\$)	
			Year 1 2004	Year 2 2005		2004	2005
<b>Sensitisation on IPT</b>	No. of health staff sensitised	0	40	All (private/public)	GHS Task Force	20,000	20,000
<b>Training of health staff on IPT</b>	Percent of antenatal clinic staff trained in IPT for pregnant women	0 0%	2020 (30%)	(100%)	GHS Task Force		
<b>Procure Drugs for IPT</b>	Number of targeted ante-natal clinics with adequate stocks of drugs for IPT in pregnant women(n= 1000)	0%	30% of H/f (300)	100% of HF (1000)	GHS/CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)	2,900,000	-
<b>Undertake IE&amp;C activities on IPT</b>	Number of IE&C materials produced	0	100,000 posters 2,000,000 leaflets	0	GHS/CHAG/NGOs/ Community Agents		
<b>Monitor Drug Quality, use/side effects of IPT in pregnant women</b>	Availability of monitoring reports	No	Yes	Yes	GHS/CHAG/FDB COMMUNITY AGENTS	25,000	30,000
<b>Undertake operation research</b>	Availability of research reports	No	Yes	Yes	Research Institutes GHS	10,000	15,000
<b>TOTAL</b>						<b>3,025,000</b>	<b>115,000</b>