

**ACCELERATING PROGRESS IN GHANA TO ROLL BACK MALARIA AT DISTRICT LEVEL**

**Preliminary Findings and Recommendations of a Joint RBM Partner Mission Examining Constraints to Scaling-up**

**DRAFT - June 2003**

**Roll Back Malaria Partnership Secretariat**

**World Health Organization**

**The World Bank**

**Malaria Consortium**

## **EXECUTIVE SUMMARY**

### **District commitment to malaria prevention and control**

Districts are committed to malaria prevention and control activities and consider malaria as a key priority disease. The team found that malaria interventions feature prominently in District Health Management Team (DHMT) plans and that districts want to do more and could do more to combat the disease even with existing capacity. Most districts are engaged, in varying degrees of implementation, of key malaria prevention and control interventions in line with the RBM National Strategic Plan, which include:

- Capacity building for case management at facility level.
- Home based management of fevers
- Promotion and distribution of ITNs
- Chemoprophylaxis
- Information, Education and Communication
- Environmental Sanitation

### **Financing of malaria control at district level**

Malaria control activities are primarily financed within the framework of the priority diseases tackled by the districts. The funds to implement the activities come from a variety of sources, primarily:

- Government of Ghana (GOG)
- Donor Pooled Funds (DPF) – Health Fund
- Internally Generated Funds (IGF)
- District Assemblies
- earmarked or project funds

Though the health sector has been generally under-funded, there are significant new resources coming on-line in 2003 and 2004. Within the SWAp arrangement, the Royal Netherlands Embassy and the World Bank are substantially increasing their contribution to the Health Fund. Outside of the SWAp, monies from the Global Fund for AIDS, TB, and Malaria should begin disbursing in 2003 and applications to receive third round GFATM financing have been submitted in May 2003. Included in this third round application is an intention to scale-up the package of priority malaria control activities to all districts in Ghana. The pharmaceutical costs related to the implementation a new anti-malarial policy as well as that for ITNs necessary to implement a strategy to cover vulnerable groups (pregnant women and children under five) have been included in the Global Fund application. In the short term, should the application be unsuccessful, or in the medium term, once the period of GFATM support concludes, there will likely be financial implications that will require attention through the SWAp mechanism.

## Constraints to scaling-up

A number of constraints keeping districts from scaling up priority health activities, including malaria control were ascertained by the mission team, they include:

- Insufficient ambition in planning  
Though district directors were found to have had realistic and capacity-based ideas to scale-up malaria control activities, these were rarely found in annual plans of work. One reason for this is possibly the current arrangement of resource-based planning, which may be a bottleneck for district scale-up and may obscure partners' understandings of what resources are necessary for district to achieve targets
- Insufficient financial resources at district level to allow scale-up  
The resources made available to districts have been insufficient which may be exacerbating the negative impact of resource-based planning on scaling-up
- Late and smaller than expected disbursement of monies from both Government of Ghana and Donor Pooled Funds hinder critically the ability of district to carry out planned activities  
Planned activities targeting priority health concerns are not being implemented as a result of unreliable resource flows. In addition, evidence from previous years has shown that there is a discrepancy between pledged resources and actual disbursements.

## Recommendations

1. Districts would benefit from immediate support to elaborate 2004 workplans based on needs and capacity to absorb/target increased resources and meet national targets for priority health concerns, including but not limited to malaria. This support could be provided within the framework of existing national systems to promote institutionalization of the process and clear ownership at all levels.
2. The Ministry of Health/Ghana Health Service and Partners should take up the issue of focusing on outcomes for priority health concerns for discussion, using malaria and the findings of this mission as an example, at the June Health Summit and include the discussion in the *Aide Memoire*.
3. In the medium to long term, partners must ensure that pledged resources are made available to support the plans developed by the districts in a timely fashion
4. The process started in Ghana has provided valuable lessons for countries implementing RBM activities in the context of health sector-wide approaches, and there is a need to share lessons with RBM Partners active in other SWAp countries. Specifically, the need for partners to be more proactively involved in the planning process of countries, particularly at the district level may be crucial if efforts at scaling up will have any chance of success.

**OUTLINE**

**1.0 BACKGROUND..... 5**

**2.0 MISSION OBJECTIVES ..... 6**

**3.0 METHOD OF WORK ..... 6**

**4.0 MAIN FINDINGS OF MISSION ..... 7**

    4.1 Historical Development of RBM in Ghana..... 7

    4.2 Current district level malaria control activities ..... 7

    4.3 Financing of district level malaria control activities..... 9

    4.4 The Global Fund for Malaria and the Sector-Wide Approach..... 10

    4.5 Constraints to scaling up ..... 11

**5.0 CONCLUSIONS - ENABLING DISTRICTS TO SCALE-UP RBM ACTIVITIES 14**

    5.1 Building on the opportunities to address constraints to scaling-up..... 14

**6.0 RECOMMENDATIONS ..... 17**

**ANNEXES..... 17**

**ANNEX A: Proposed Timing and Method of Work ..... 18**

**ANNEX B: List of Persons Consulted ..... 19**

**ANNEX C: Roll Back Malaria Joint Partner Mission Team ..... 20**

## 1.0 BACKGROUND

Malaria is one of the major public health problems in Ghana. A national response to the problem has been the development of a Strategic Plan to Roll Back Malaria and the Ghana Health Sector Strategy. The broad Health Sector Strategy includes key malaria-specific indicators - a reduction in malaria case fatality rate for children less than 5-years of age to 15%, and an increase in the use of bednets from 10% to 56% - reflecting the relative importance assigned to malaria reduction by the MOH in the 2003-2006 Plan of Work (POW-II). Furthermore, one of the key objectives of the POW-II and Ghana Poverty Reduction Strategy is the reduction of inequalities in health. As a disease, malaria is particularly regressive; recent evidence demonstrates that the consequences of malaria infection are felt greatest by the poor. A reduction in the malaria burden, particularly in the poorest regions (i.e. the Northern Belt), would likely result in considerable progress toward achieving the equity objectives of the Ghana Health Strategy.

There have been notable improvements in financial management and planning capacity at district and sub-district level Budget Management Centers (BMCs), as reflected by an increasing proportion of Sector Wide Approach (SWAp) financing being allocated to district health services. Given the improving district managerial and implementation capacity, a key next challenge is the determination and removal of constraints to the scaling up of district malaria control activities in order to reach the health targets set in the HSSP and PRSP. The successful application of the Ghana Country Co-ordination Mechanism (CCM) to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) demonstrates that stakeholders have already begun the prioritization process for scaling-up malaria-specific activities at district level. However, reaching the targets set in the POW-II, will also require a measured approach to overcome constraints to the scaling-up of priority malaria interventions in districts in line with the overall sectoral strategy.

The upcoming Joint Review/Health Summit and the preparation of a new proposal to the GFATM to support public health priorities mark important opportunities for health sector partners to understand and discuss constraints to scaling-up malaria control activities at district level and encourage complementarity between new GFTAM resources and MOH-partner donor investments.

In the light of the foregoing, the national authorities of Ghana invited the Roll Back Malaria Partnership to assist in an analysis to assess constraints in scaling-up malaria control activities as they both prepare an application to the GFTAM and look toward the Health Summit to discuss ways Health Partners can better support priority malaria activities through the Sector-Wide Approach to achieve short-medium term health targets.

This mission was undertaken by a team comprising staff of RBM Secretariat, World Bank, Malaria Consortium and WHO (AFRO and Country Office), from 3 to 20 May 2003 (List of team members attached in annex).

## **2.0 MISSION OBJECTIVES**

The objectives of the mission were to:

- Examine the current district-level malaria control implementation constraints, including the capacity of the SWAp to provide adequate support to malaria control activities at the BMC (district and sub-district) level, to enable further progress toward the POW-II targets and reduce poor/less-poor inequalities in a manner consistent with the overall Ghana Health Sector Strategy and financing modalities.
- Provide an input (“gap analysis”) into the GFATM proposal process and overall 2003 Health Sector Review process, and specifically to undertake a preliminary assessment of district-level malaria control activities, sources of financing, and constraints to scaling-up and to raise these in discussions with Partners to support district malaria control efforts.
- Guide the Roll Back Malaria Partnership in its effort to determine processes to define country support packages in the context of Sector-Wide Approaches.

## **3.0 METHOD OF WORK**

In the first week of the mission (May 3-8), the RBM Team observed the Ghana Health Service (GHS) Public Health Retreat in Bolgatanga. While in Bolga, the team advised the GHS on the development of a third round proposal for malaria to the Global Fund. In addition, the team held focus group discussions with all Upper East Region Directors of District Health Services (DDHS), who were participating in the Retreat. The team also held in-depth discussions at district level with two District Health Management Teams (DHMT) as well as with the Regional Health Management Team (RHMT) of the Upper East Region.

The second and third weeks (May 9-21), the team engaged in similar district level consultations in the Ashanti, Volta, and Eastern Regions, where the team met with a number of DHMTs, DDHS, and District Chief Executives as well as with a number of Regional officials. As part of the mission, the team participated in the commemoration of the Africa Malaria Day in the Asuogyaman District, where a member of the team delivered a goodwill message. On returning to Accra, consultations regarding the obstacles to scaling-up at district level were held with officials at the national level, as well as with key health partners. The team attended a session called by the Malaria Task Force of the Ghana CCM for the Global Fund, where input was provided into the review process for the submissions from various stakeholders to strengthen the country application to the GFATM. In addition, the team attended the debriefing session organized by the consultants who undertook Health Sector Annual Review for 2002 in order to build synergies between the two efforts. Finally, at the request of the World Health Organization Representative to Ghana, the RBM Team held a debriefing session on the mission and its preliminary findings for a wide range of health partners prior to departure. The list of persons met during the mission is included in the annex, as is a list of the RBM Team members.

## 4.0 MAIN FINDINGS OF MISSION

### 4.1 Historical Development of RBM in Ghana

The Ghana National Malaria Control Program (NMCP) has developed a 5 Year National Strategic Plan (2000-2005) to Roll Back Malaria. Following the development of the Strategic Plan, guidelines for its implementation were sent to districts as an attempt to aid bottom up planning.

Using these guidelines, some districts (e.g. Bawku district), created district level partnership structures, including budgetary responsibilities and multisectoral engagement. They developed ambitious multisectoral plans based on the expectation, at least at national levels, that significant amount of resources will flow from RBM partners through the NMCP. Unfortunately, most of the planned activities were not implemented, as the anticipated earmarked inflow of malaria-specific resources to the districts did not materialize. In addition, the RBM plans were prepared as “project-support” and not only did not necessarily fit into the routine health district plans, but also did not always take into consideration existing activities being implemented by other partners.

The NMCP then selected 10 and later 20 RBM districts (2 per each of the 10 regions) with the expectation that they will receive concentrated partner support for the implementation of the key malaria interventions. All 110 districts, however, receive orientations, guidelines and technical support from the NMCP and RHMTs for the implementation of routine malaria control activities. Some specific activities have a national coverage, such as the Johns Hopkins University Center for Communications Programs – USAID supported public health education program.

In 2002, the MOH/GHS, through the Country Coordinating Mechanism (CCM), successfully applied for funds from the GFATM for malaria control interventions in the 2<sup>nd</sup> round of approvals. The proposal covered support for interventions in 20 districts with the following objectives:

- To institutionalize antimalarial drug policy review process;
- To provide Intermittent Presumptive Treatment (IPT) to 60% of pregnant women;
- To increase usage of ITNs in pregnant women and children under five;
- To increase the proportion of mothers/caretakers who respond appropriately to malaria within 24 hours of the onset of disease.

The five-year project has a budget of US \$ 9.3 million, with a significant proportion of the budget for the first two years (54%) devoted to commodities (ITNs and SP). The grant agreement has recently been signed between the CCM and the GFATM and it is expected that funds will start to be disbursed shortly.

### 4.2 Current district level malaria control activities

In all districts, malaria is perceived as key priority disease if not the greatest priority. In public statements as well as in the district health plans, malaria interventions feature prominently as

DHMTs prioritize the disease based on data obtained from their facilities' records. Most districts are engaged, in varying degrees in implementation of the key malaria prevention and control interventions, which include:

*Capacity building for case management at facility level.* Most districts have trained and/or retrained staff at the facility level (medical officers, medical assistants, nurses, and community health nurses) in the management of uncomplicated malaria cases with support and technical backstopping from the RHMT and the NMCP.

*Home based management of fevers:* In furtherance of the objective of improving access to prompt and effective treatment, some districts have trained chemical sellers, volunteers and guardians to promote home base care. A collaboration has evolved with the Ghana Education Service, and some DHMTs have trained school teachers to treat uncomplicated malaria in pupils while they are at school.

*Promotion and distribution of ITNs:* All districts consulted have accepted ITNs as a key RBM intervention and are using various strategies to make ITNs available to the pregnant women and children under five years. Several mechanisms are in existence:

- Direct procurement by DHMT: Some districts, like Suhum, have used funds from the Donor Pooled Fund (DPF) to purchase ITNs from the private sector (at prices ranging between C 50,000 and C 75,000 – approximately US\$ 6-10) and made this available at cost to the target group. Funds realized from the sales have been put into a sub-account in the DPF and labeled “malaria account” and will be the first source used to finance malaria control activities.
- Allocations from the NMCP: The RBM districts have been allocated some ITNs by the NMCP that they are to sell at subsidized prices to the target group. The bulk of the proceeds of the sales (75%) are returned to the NMCP.
- Procurement from the NMCP: In order to meet the demand from the population, a district not among the 20 RBM districts selected by the NMCP bought ITNs from the NMCP with funds from the District Assembly (DA) for sale to the target group. In all these cases, the mechanism for distribution have been the health facilities – ANC and Child Welfare Clinics (CWC).
- Direct donor support: Unicef is supporting some districts in the north in the provision of ITNs at subsidized prices. The mechanism is through chits (similar to vouchers) given to beneficiaries at ante-natal clinics and community welfare clinics for redemption at Community Agents. Similarly, the American Red Cross is implementing a pilot project involving the distribution of free ITNs linked with immunizations, though none of the districts consulted on this mission are included in this pilot project.
- Direct sales by commercial sector: Some locally produced nets were found in the homes of some communities in Suhum District which were purchased from the market at the cost of C35,000 to C40,000 – approximately US\$ 4-5). These nets are also found in markets in Accra and Kumasi. It has not been possible to ascertain the quantities of these nets from the informal sector. These nets are generally not treated. It is believed that there is a thriving and possibly substantial structured and organized local market with its own distribution system in place (Source: Jo Lines and Jayne Webster – Summary

findings of a Consultancy support to the ITN Partnership in Ghana). Across the country, ITNs are also sold by the commercial sector in markets and retail outlets at prices ranging from C 50,000 to C 70,000.

*Chemoprophylaxis:* Chemoprophylaxis with chloroquine tablets is being implemented as current national policy for the prevention of malaria in pregnancy across districts. This intervention is not being well implemented partly due to the problems surrounding timely and complete reimbursement associated with the exemptions policy, in which regions reimburse districts on a monthly basis for costs incurred against a list of priority activities and target groups.

*Information, Education and Communications:* Public education on the prevention and control of malaria is being carried out by the districts. There is an emphasis on the promotion of the use of ITNs and recognition of symptoms of malaria and appropriate actions to take. Methods used include community durbars, radio programs and health talks at facilities.

*Environmental Sanitation:* Most districts are, mainly for political reasons, engaged in environmental sanitation and community cleaning activities even though the impact on malaria from these activities is questionable at best. There is also the tendency for DAs to select this intervention, which has more general health benefits than the other more cost-effective malaria interventions. In New Juaben District for example, the DA selected and funded larviciding of stagnant water sources and environmental sanitation activities from a list of activities put forward by the DHMT that included purchase of ITNs, training of chemical sellers and public education.

#### 4.3 Financing of district level malaria control activities

Malaria control activities are financed within the framework of the priority diseases tackled by the districts. The funds to implement the activities come from a variety of sources including:

- Government of Ghana (GOG)
- Donor Pooled Funds (DPF)
- Internally Generated Funds (IGF)
- District Assemblies
- earmarked or project funds

The report of the Health Sector Annual Review 2002 showed that the level of resource allocation to the health sector in general has been on the increase over the years, with the percentage of GOG budget for the sector climbing to 11.1% in 2002. This has been matched with similar increases in the support from development partners, which is made available for health sector activities under the tag of DPF. The mission team learned that two partners, the World Bank and the Royal Netherlands Embassy, are bringing in significantly larger contributions to the POW II. On another positive note, the proportion of the total health sector budget that is spent at the district level and below was 42% in 2002.

The potential for increased resources for priority health activities in the district is noted in the form of increased resources that are becoming available to the DAs. Not only are the GOG funds

going to the DAs on the increase, but also resources from the HIPC funds are channeled through the DAs and have been essentially used for the education sector and for capital expenditures in health.

All districts consulted noted that the financial resources made available for health activities. According to the recent Annual Review, the proportion of disbursements relative to budgets for the year 2002 at the district and below level was only 60% of GOG funds and 40% of DPF (note that this analysis only included Quarters 1 and 2 of FY2002).

This problem of inadequacy of resources is exacerbated by the delays in the receipt of the funds at the district level. Most districts receive their allocations late in the year, compromising the efficiency with which these resources are used in the end.

In addition, the Annual Review report alluded to above indicated that the problem of allocative efficiency remains critical in the financing of health services across the country. Whereas real per capita spending on personnel rose by 9% in 2002, spending on non-personnel items fell by 4.5%. In effect many districts are barely able to meet their personnel costs and have little or nothing left to spend to provide services.

#### 4.4 The Global Fund for Malaria and the Sector-Wide Approach

- *A response to unmet expectations for earmarked money*

After earmarked financing to implement the RBM National Strategic Plan did not materialize, the Global Fund was looked to as one of the only viable options to scale-up “RBM financing” by providing additional resources to those available through the SWAp.

- *Attempts were made to use existing financial mechanisms but faced resistance and failed*

The CCM attempted to encourage complementarity with the SWAp by seeking to use the established financial mechanisms used by the Health Partners. In so doing, however, the CCM faced resistance from the Global Fund, which necessitated separate financial channeling and accounting. Though this issue merits further examination, if taken at face value, there appears to be a disconnect between the GFATM on one hand encouraging complementarity with existing country resources, and the regulations tied to the use of GFATM resources. The Team suggests that future negotiations with the GFATM involve integrating the GFATM resources with the existing SWAp financial mechanisms.

- *A desire to improve complementarity in future GFATM rounds*

In principle, the mission team did find any reason why GFATM resources and those from the SWAp could not be complementary. One of the key issues, however, is the need for any additional resources to build on the achievements of the health sector reforms, namely the capacity built in all 110 districts in planning and budgeting. In accordance with this, the Team, when asked to advise the GHS on the development of a third round

proposal to the GFATM for malaria, responded by suggesting that all 110 districts benefit from any new resources to scale-up a package of malaria interventions, rather than pursuing an incremental district-by-district approach.

- *Lack of timely GOG/DPF disbursement a factor in looking to the Global Fund*

The desire to look to the Global Fund was a result of not only the need for additional resources, but in some ways was a direct response to the unreliability in timeliness of GOG and DPF resources. Recent performance with regard to timely disbursement of SWAp resources has further engendered doubts as to whether or not the SWAp mechanism is up to the task of financing time-sensitive health sector activities such as immunization. This further underscores the urgent need for the MOH and Health Partners to improve the reliability of district disbursement.

#### 4.5 Constraints to scaling up

##### *Ambition*

In the consultations with the DHMTs, the mission team noted that most of the DDHS had sufficient information of the national RBM targets. There were also clear in their minds as to what will be required at their levels to contribute to the achievement of these national goals. However, in the annual district health plans, these are not translated into planned activities. There is thus a disconnect between what they know is required to scale up implementation of priority disease control and what is put in the plans.

The mission determined that a number of factors could be responsible for this disconnect. The most obvious reason is that the planning process is historically resource-based. Districts have been obliged to plan with the benefit of the resource flows of the preceding year(s). Even when the initial plans are big in scope, they usually get cut with a new level of prioritization when the budget ceilings are provided by the RHMTs. If the national and global targets are to be met, the district plans need to be more ambitious and be tied more to the “needs” of the population. The plans should be output-based and aim to scale up the implementation of the different strategies.

##### *Financial Resources – insufficiencies and unreliable disbursement*

A second constraint to scaling up has to be the insufficiency of the financial resources, coupled with the problems of resource flows. Districts need more funds to be able to push the scope of coverage of the different interventions. The proportion of health workers trained on case management must be increased significantly to assure effective and appropriate treatment at health facilities. The training of more chemical sellers, volunteers and mothers and other caretakers, can expand home-based management of fevers. More schoolteachers need to be trained as well for the treatment of fevers in school pupils. More ITNs need to be procured and made available to the target groups. All of these will require substantially more resources than has been made available to district to date.

### *Human Resources*

A final constraint to scaling up is the shortage of human resources at district level. Although there is some level of underutilization of existing human resources, we suspect that with better and increased flows of resources, there will be need for increase in the human resources to provide the pertinent services.

#### 4.6 Existing Opportunities

*Recognition of malaria as a district priority and a major contributor to poor pregnancy outcomes*

- All districts consulted report malaria as the disease with the highest burden indicated by out patient department attendances in clinics and hospitals (40-70%)
- Maternal and child health workers have highlighted malaria as the primary cause of low birth weight and maternal death.

*Districts recognize that more could be done with existing capacity for implementation and have declared capacity and desire to scale-up.*

- Malaria-related activities in line with current capacity included in existing district plans of work but implementation is below desired levels due to resource constraints at district level.
- DHMTs often have clear understandings of what it would take to scale-up the package of priority interventions

*Collaboration between District Assemblies and DHMTs is improving in a number of districts*

- District Assemblies have set aside 1% of their Common Fund for malaria-related activities, and some have made these available to DHMTs (One DA has publicly announced to increase the 1% to 2%).
- DHMTs and District Assemblies have begun to collaborate in planning for health activities
- District Assemblies are increasingly recognizing health as a priority area for their engagement while DHMTs are beginning to look beyond the health sector for support

*Acceptability of ITNs perceived to be high as a result of successful promotion, though supplies are inadequate*

- A number of districts have taken the initiative to purchase and distribute ITNs to vulnerable groups
- Demand for ITNs has surpassed supply in both demonstration projects and district-driven initiatives
- Some District Assemblies have supported DHMTs to procure ITNs for distribution.
- Encouraging levels of involvement of other community stakeholders in ITNs promotion and distribution in the districts.

*Progress in district-driven case management training*

- Majority of DHMTs consulted have planned and executed case management training for health workers with solely DHMT (DPF/GOG) budget without program/project financial support from the national level
- Recognition of the need to train and retrain more staff.

*Progress in home/community based management of simple malaria*

- Majority of DHMTs consulted have planned and executed home/community based management training for mothers, school teachers, chemical sellers, and others with DHMT (DPF/GOG) budget without program/project financial support from the national level
- Recognition of the need to train and retrain more in the community

*Implementation of district-driven community IEC activities*

- Undertaken in all districts as integrated Health Education activities with messages on malaria prevention, ITNs use and correct treatment for malaria cases
- Africa Malaria Day celebrations in many districts as a result of national guidance and district planning/financing, sometimes including support from District Assemblies.

## 5.0 CONCLUSIONS - ENABLING DISTRICTS TO SCALE-UP RBM ACTIVITIES

### 5.1 Building on the opportunities to address constraints to scaling-up

#### 5.1.1 *Simplified RBM Guidance to Districts*

There is a need to provide simplified guidance on translating policies and the strategic plan into implementation plans. For example, districts would use a clear package of technically-sound interventions – ITN distribution, Intermittent Presumptive Treatment, Home-based Management to name a few – and tailor them to their district-specific situations. In Bawku district, for instance, the close collaboration with the District Assembly would continue in the implementation of the RBM package of interventions, while in Bolga, the ITN scheme would build on past work using vouchers and community-based agents to facilitate ITN distribution to vulnerable groups.

#### 5.1.2 *Structured Dialogue to Assist Districts in Needs/Capacity-Based Planning*

It is increasingly clear that DHMTs are committed, with the desire and capacity to scale-up, though this is not consistently reflected in district planning and budgeting. Decentralization has encouraged districts themselves to guide the pace of scale-up and priority setting. Targets for priority health concerns, including malaria, are generally set at national (and global) levels. As they stand, the current targets set by districts are not ambitious enough to reach national targets set in the RBM National Strategic Plan. In order to reach them, districts will have to continue to use the agreed package of technically sound strategies, but with an emphasis on scaling up their implementation, tailored to district-specific situations. The increased level of activities required to scale-up, though often understood by Directors of District Health Services as the team learned through discussion, are not consistently reflected in district annual plans of work. Activities to scale up have been found most often linked to specific projects, rather than as activities integrated into annual workplans. There is evidence to suggest that this may partially be a result of a history of unmet resource requirements, which encourages under-ambitious resource-based planning.

It is envisaged that structured dialogue with DHMTs that builds on simplified RBM guidance during the MTEF/BPEM plan of work development period may result in building district capacity to develop needs and outputs-based (not resource-based) plans to take advantage of a supportive environment that is responding by increasing the total resource envelope available to the health sector.

These needs and outputs-based plans may not only allow for improved allocation of available resources to further progress toward targets, but also expose real “gaps” in resource (financial, human resource, and otherwise) requirements for scaling up. As the various partners in the health sector have different comparative advantages (technical assistance, expertise in NGO mobilization, etc), outputs-based district plans, with clear resource needs and “gaps” would allow partners to respond directly to identified district needs – for instance, technical assistance

to improve malaria case-management training or NGO involvement to improve ITN distribution capacity.

Given the increasingly important role of District Assemblies in health, these structured district discussions to assist in determining needs and inputs, could bring together Directors of District Health Services with District Chief Executives to encourage active collaboration between the two to accelerate progress toward priority health outcomes. Guidelines that could assist in the collaboration have been developed by Health Partners and could be operationalized in the district discussions.

Finally, it is important that any discussions to build district capacity in needs-based priority setting and planning build on existing lines of responsibility to support accountability and ownership. The RHMT together with the Program Managers for priority health concerns, for instance, could guide the process and solidify their stewardship over district activities and progress, although the districts themselves would be responsible for implementation.

### *5.1.3 Addressing Resource Constraints – Timeliness and Amount*

#### *Timeliness*

There have been critical problems in timeliness of disbursements from the GOG and Health Fund. However, it is important to note that the latter has performed substantially better than the former. Nevertheless, late (or lack of any) disbursements have brought district plans and ambitions to a standstill in the first quarter of 2003. In many instances, key malaria control activities have been included in annual MTEF plans, but have not been implemented as a result of late disbursement from the Health Fund. Though there is some debate as to the sufficiency of the overall amount of resources that are being made available through the Health Fund, there is no doubt that the unreliability of resource flows is a crucial obstacle to the implementation of district plans

This topic is covered in greater depth in the 2002 Health Sector Review. Key Health Partners have expressed a readiness to address the erratic resource flow issues. For instance, as GOG funds are usually delayed for the first two quarters, there is a willingness on the part of Health Partners to “front-load” their disbursement into the Fund to smooth resource flow, and allow districts to begin planned implementation at the start of the year. In addition, there is some discussion among partners as to whether they could shift to a bi-annual, rather than quarterly, disbursement to reduce the reporting burden in the health sector.

GOG financial projections for health are necessary for any adjustment in Partner resource flows (i.e. whether or not to “front-load”) and it is strongly recommended that GOG and Partners resolve the issue as soon as possible so that disbursements can be adjusted beginning 2004.

#### *Amount*

Though most accept that the health sector is underfunded in general, it remains unclear whether or not the overall available resource amount in the system is insufficient for current capacity.

The allocation of those available resources in the system to support implementation of priority district level activities, such as malaria control, though, is another issue. Currently, approximately 42% of available resources are directed to the district level. However, only a fraction of this is used for activities, perhaps as a result of late disbursement of funds, which encourage spending on commodities as it may be too late to implement key components of annual workplans.

In 2003, Health Partners – namely the World Bank and the Royal Netherlands Embassy – have increased substantially their contributions to the Health Fund. Through its Health Sector Support Project II, the World Bank will increase beginning 2003 its five-year contribution from approximately US \$25 million to US \$90 million (including grant financing of US \$32 million) while the Netherlands Embassy has increased its five-year support from approximately US \$3 million to US\$ 70 million. As the annual “ceilings” for district BMCs are calculated based partially on Health Fund and GOG allocation, and assuming at least 42% allocated to district level, the amounts available to districts to plan in 2004 should be considerably greater than that available in 2003.

If districts were to develop 2004 workplans based on needs and activities to scale-up, it is envisaged that the increased resources being made available to districts could be targeted toward these planned activities to have an impact on priority health concerns, such as malaria. Not only could districts take better advantage of increased resources from the Health Fund, but also additional support could be aligned with documented district needs to fill any remaining gaps. Similarly, additional available resources could be targeted to needs-based district plans to allow for implementation of activities consistent with a district’s own annual ambition.

It is important to note that, in general, the issue of financing new commodities for priority health concerns will likely not be addressed through improved district prioritization, planning, and budgeting. For instance, a new national antimalarial policy is in the final stages of development and may endorse a shift toward artemisinin-based therapies that are significantly more expensive than chloroquine. Even if the current drug cash and carry revolving fund is used (though there are plans for phase-out in favor of health insurance), an initial investment will be necessary to accompany the policy change. Similarly, and arguably of greater urgency given the growing evidence of existing community demand, a strategy to procure and subsidize ITNs for vulnerable groups (under-fives and pregnant women) may require an analysis of different options to mainstream the policy into the existing SWAp arrangement. ITNs to date have largely been brought into the country by WHO and Unicef, and supplied to the target groups through the NMCP and district structures. The GHS may now be looking to the Global Fund to scale-up the ITN strategy nationwide. In the long-term, however, (and perhaps the short-term if the GFATM proposal is unsuccessful), the MOH/GHS and Health Partners will need to examine options and endorse action that leads to vulnerable groups being granted access to affordable ITNs.

#### *5.1.4 Supporting districts to move from demonstration initiatives to integrated implementation*

There is observed tension in Ghana between sponsored projects and sustainable approaches to financing and development such as the SWAp. Donor and disease-specific projects have been

accused of encouraging a vertical mindset that undermines the sector-wide approach, specifically the aspects pertaining to decentralization. This mission sought to neither prove nor disprove these accusations, but only to recognize the tension and advise on a way forward to encourage complementarity of effort. While projects, such as the Unicef-sponsored ITN ones in the Upper East region, have often succeeded in demonstrating impact and encouraging demand, the link to sustainability and scaling-up is not always obvious. For instance, the Unicef project has succeeded in generating an extraordinary demand for ITNs (one that far surpasses supply). Though the project may not be sustainable, it did demonstrate the value and acceptability of the ITN voucher-scheme intervention. As districts will likely not be able to look to Unicef again to support such an activity, they will have to look toward the existing financial arrangements through the SWAp to determine how best to link the project's success with the existing financing mechanisms – GOG, DPF, District Assemblies/HIPC, etc.

The shift from project to mainstreamed activity may not be a simple one, and districts will likely require support in integrating former projects into BMC plans. Furthermore, certain projects, if districts choose to integrate them, will have commodity implications at regional and national levels and it is envisaged the interaction between the RHMT and DHMT during the proposed district discussions to improve planning for scaling-up would allow for the “flagging” of such implications for discussion at the national level with Health Partners.

## 6.0 RECOMMENDATIONS

The following recommendations came out of the mission for the RBM partners:

- Districts would benefit from immediate support to elaborate 2004 workplans based on needs and capacity to absorb/target increased resources and meet national targets for priority health concerns, including but not limited to malaria. This support could be provided within the framework of existing national systems to promote institutionalization of the process and clear ownership at all levels.
- Partners should take up the issues raised in the main mission report for discussions at the Health Summit.
- In the medium to long term, partners must ensure that pledged resources are made available to support the plans developed by the districts.
- The process started in Ghana has provided valuable lessons for countries implementing RBM activities in the context of health sector-wide approaches, and there is a need to share lessons with RBM Partners active in other SWAp countries. Specifically, the need for partners to be more proactively involved in the planning process of countries, particularly at the district level is crucial if efforts at scaling up will have any chance of success.

**ANNEXES**

## **ANNEX A: Proposed Timing and Method of Work**

*May 2-20*

Joint RBM Partner mission to discuss current district implementation levels and constraints to scaling-up

- *Participated in GHS Public Health Retreat, Bolgatanga*
- *Held focus group discussion with 6 district directors in Upper East Region*
- *In-depth district consultations in Bolga and Bongo districts (Upper East)*
- *Further district, district assembly, and regional level consultations in Eastern and Volta Regions*
- *Reviewed 2<sup>nd</sup> round proposal to GFATM and advised drafting with Director and Program Manager of 3<sup>rd</sup> round proposal to scale-up to all districts*
- *Consultations with Health Partners*

*May 19*

Debrief Health/RBM Partners on preliminary findings

*May 20-June 8*

Small task team of senior Health/RBM Partners (3-4) to manage this agenda item for the Health Summit.

*May 21-30*

Draft mission report and disseminate findings and suggested next steps to support needs-based district planning

*June 9-11*

Health Summit

*June 12-??*

- Debriefing for Regional Directors of Health Services
- Orientation for outputs-based district discussions team

*June – August*

- Proposed district level discussions with all 110 districts to capture priorities and needs in 2004 POW

*September*

- Share findings with RBM Partners at RBM Board Meeting and present a possible mechanism to provide country support for RBM in the context of sector-wide approaches

*October*

- Discuss the developed needs-based plans and mobilize necessary support to implement at MOH-Partner Planning Summit

## **ANNEX B: List of Persons Consulted**

### **District Level**

District Directors (6) Group in Bolgatanga, Upper East Region  
E.K. Deffor – District Coordinating Director Ho District Assembly, Volta Region  
Mr. Steve Okrah, Budget Analyst Ho District Assembly  
Dr John Marfo, Bongo District, UER (with the DHMT)  
Dr William Doudu, DDHS, Bolgatanga, UER (with the DHMT)  
Dr Albert Antobre-Boateng, Suhum-Kraboaa-Coaltar, Eastern Region (with the DHMT)  
Dr Quaye, DDHS, New-Juaben District, Eastern Region  
Mrs. Nkrumah-Mills, DDHS, Asuogyaman District, Eastern Region (with the DHMT)  
Dr G K Siaw, District Chief Executive, Asuogyaman District, Eastern Region  
Dr Margaret Kweku, DDHS, Ho District, Volta Region (with the DHMT)  
Dr. Joseph Adomako, DDHS Amansie West, Ashanti Region

### **Regional Level**

Dr Nsire Agana, SMO/PH Upper East Region  
Regional Health Services Administrator, Upper East Region  
Regional Health Services Administrator, Eastern Region

### **National Level**

Dr Constance Marfo, NMCP Programme Manager  
Dr George Amofah – Director, Public Health GHS  
Dr EY Osei, Head Disease Control Unit, GHS  
Mr. Manu, Financial Controller of the Ministry of Health

### **Partners**

Evelyn Awittor – World Bank  
Sandra Baldwin - DFID  
Melville George – WHO  
Jan van der Horst – Netherlands Embassy  
Jan Paehler - USAID  
Hanne Thorup - DANIDA  
Basilio Antonio Toth – Embassy of Italy  
Prof. Isabella Quakyi, Director, School of Public Health, Legon

**ANNEX C: Roll Back Malaria Joint Partner Mission Team**

*Week 1:*

- **James Banda (RBM Secretariat)**
- **Mark Amexo (WHO NPO/MAL)**
- **Suprotik Basu (World Bank / RBM Secretariat)**

*Week 2-3:*

- **Mark Amexo (WHO NPO/MAL)**
- **Suprotik Basu (World Bank / RBM Secretariat)**
- **Tuoyo Okorosobo (WHO MAL)**
- **Kojo Yeboah-Antwi (Malaria Consortium)**