END NEGLECTED TROPICAL DISEASES IN AFRICA

Ghana

Control of Neglected Tropical Diseases

Annual Work Plan

November 2011 – September 2012

Rev 3

Submitted to: FHI 360

Submitted by: Catholic Relief Services (CRS) - Ghana

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Acronyms and Abbreviations

Alb	Albendazole
APOC	Africa Program for Onchocerchiasis Control
CDD	Community drug distributor
CMS	Central Medical Stores
CNTD	Centre for Neglected Tropical Diseases
CRS	Catholic Relief Services
DHMIS	District Health Management Information System
FGAT	Financial Gap Analysis Tool
FHI360	Family Health International
GES	Ghana Education Service
GHS	Ghana Health Service
ICCC	Intra Country Coordinating Committee
ICT	Information and Communication Technology
IVM	Ivermectin
LF	Lymphatic Filariasis
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
Meb	Mebendazole
MOH	Ministry of Health
NMIMR	Noguchi Memorial institute for Medical Research
NTD	Neglected Tropical Diseases
NTDCP	Neglected Tropical Diseases Control Program
Oncho	Onchocerchiasis
PZQ	Praziquantel
RMS	Regional Medical Stores
SAE	Severe Adverse Events
SCH	Schistosomiasis
SCM	Supply Chain Management
SHEP	School Health Education Program
SMILER	Simple Measurable Indicators for learning and Evidence based Reporting
SSI	Sight Savers International
STH	Soil Transmitted Helminthiasis
TAS	Transmission Assessment Survey
USAID	United States Agency for International Development
WHO	World Health Organization

Background

The "End in Africa" – Ghana project is designed to support the Ministry of Health (MOH)/Ghana Health Service (GHS) as they scale up integrated control programs and the delivery of preventive chemotherapy (PCT) for the following seven Neglected Tropical Diseases (NTDs): Lymphatic Filariasis (elephantiasis); Schistosomiasis (bilharzia or snail fever) Trachoma (blinding eye infection); Onchocerchiasis (river blindness) and three Soil-transmitted helminthes (intestinal worm infections).

Catholic Relief Services (CRS) – Ghana as sub grantee to Family Health International ("FHI 360") is working with the MOH/GHS Neglected Tropical Diseases (NTD) Program to implement this project in Ghana.

The NTD program has progressively reached national scale of implementation of MDAs, covering all endemic districts in the country with PCT for the NTDs stated above. Table 1 below shows the number of districts endemic for the various diseases out of 170 districts in the country and the number undertaking Mass Drug Administration (MDA).

Table 1: Endemic districts under treatment with MDAs

Disease	Number of endemic districts	Number of non-endemic districts	Number of districts needing mapping	Number of districts with ongoing MDA	Number of districts needing MDA, but MDA not yet started
Schistosomiasis	170	0	0	170	0
Soil-transmitted helminthes	11	159	0	170*	0
Lymphatic filariasis	74	96	0	70**	0
Onchocerciasis	40	130	0	73***	0
Trachoma	29	141	0	0****	0

*Due to high reinfection rate, the country's policy is to ensure every school age child is dewormed at least once every year.
**Four districts have broken transmission and have stopped MDA
***All traditional Oncho districts remain on treatment
****Trachoma transmission has been eliminated

This work plan for FY 2012 spells out the planned activities to be implemented under this project for the first year.

Goals for the financial year 2012

The overall goal of the program is to reduce the prevalence of five Neglected Tropical Diseases (Trachoma, Lymphatic Filariasis (LF), Onchocerciasis (Oncho), Schistosomiasis (SCH) and Soil-transmitted Helminthiasis (STH)) to levels that are no longer of public health significance in Ghana by 2015. The program has successfully integrated all five diseases and reached national scale in implementation with all at risk districts receiving treatment for all diseases. The goal for the year is to continue Mass Drug

Administration (MDA) for LF, Oncho, STH and SCH on a national scale, continue surveillance for trachoma and monitor the progress towards achieving the overall control or elimination target for each of the diseases.

Specific Program Activities for FY 2012 are:

- Conduct one integrated round of community-based MDA for LF, Oncho and STH in 121 districts in January/February 2012
- Finalize NTD Master Plan for Ghana for 2011 to 2015 in collaboration with WHO and share with stakeholders
- Identify and select all endemic communities that need SCH treatment
- Conduct one integrated round of school and community based MDA for SCH in 120 districts and STH in 170 districts between May and June 2012
- Hold one national post MDA review meeting in August 2012
- Support TF surveillance activities in 29 districts where blinding trachoma has been eliminated.
- Carry out night blood surveys in 5 LF districts that have completed more than 7 rounds of MDA
- Carry out TAS in 8 districts which have attained an LF prevalence of less than one percent
- Institute post MDA surveillance system in 4 districts that have stopped MDA for LF in collaboration with Disease Surveillance Unit of GHS
- Constitute an Intra Country Coordinating Committee (ICCC) for the NTD program and hold at least one meeting
- Review and implement selected activities in the Communication and Advocacy Strategic Plan.
- Develop a supply chain management strategy to monitor NTD drugs and logistics, and take steps to implement the strategy
- Strengthen M&E at all levels of the program
- Implement FGAT for FY2012 once new version is available
- Hold monthly Task Force meetings

Main Activities

CRS plans to support the GHS NTD Control Program with the following essential activities:

Support NTDCP Planning Process

Identifying populations for MDA

CRS will hold meetings with the NTDCP of the GHS in November 2011 to review all districts and regions targeted for MDA. The list of districts will be mapped out in relation to the various donors that support the program in Ghana to determine where to apply USAID funding. This will ensure USAID funding is complimentary to the program and does not duplicate funding to any districts.

Update Five-year Strategic Plan

The NTD Program, with support from WHO, has developed an NTD master plan from 2011 to 2015. This plan is near completion and needs to be reviewed by stakeholders and finalized. CRS will work with the

program and stakeholders to finalize this document before the end of December 2011. The program will develop work plans annually based on the master plan.

Additional Capacity Building Activities

CRS has worked with the program team to develop a Simple Measurable Indicators for Learning and Evidence based Reporting (SMILER) M&E system for the program. This system will be implemented to improve M&E of the program.

Financial Contribution of Government and Other Donors

Ghana continues to mobilize a variety of donors in support of NTD control. There has been continued support for the Ghana NTD Control Program from the Ministry of Health and current partners WHO, APOC, SSI, Liverpool CNTD, NMIMR in the areas of central support and capacity building, clearance of drugs and logistics, financial and technical support in other MDA activities. WHO supports the program with technical support for individual disease activities and in developing a master plan for NTDs for the country. APOC will provide financial and technical support for additional MDA activities especially in Oncho endemic areas. SSI and CNTD will provide support in the area of technical assistance and for operational research.

The Government of Ghana owns the program and continues to support all program activities by:

- Providing office space, equipment and vehicles for the program
- Providing salaries to all the key GHS staff that work on the program both fully and partially.
- Providing drug import clearance, storage and vehicles for distribution of drugs and other supplies for MDA.

Mapping

No mapping will be done for 2012 financial year as mapping for all diseases have been completed countrywide. The country program intends, however, to narrow down the treatment areas for SCH by re-assessing various communities in endemic districts for risk factors. This will help to refocus treatment on most at risk communities and schools rather than treating whole districts, thus saving on PZQ and other resources including financial for SCH treatment in the future. WHO has provided some funds to kick start the process but the Program will work with other interested partners to complete it. It will just involve national Program personnel working with the regional and district health personnel to selected sub-districts for SCH treatment rather than continuing the treatment of whole districts selected by the predictive maps.

Scaling up NTD National Program[1]

Treatment Projections

Since the program is already treating at scale, this doesn't represent any change in treatments from the previous year.

In January/February 2012, the program will treat 121 districts, covering an estimated population of 7,559,578 for LF and 2,386,078 for Oncho. The 121 districts comprise 60 for LF only, 51 for Oncho only and 10 districts co endemic for both diseases. Twelve (12) other districts in Brong Ahafo Region will be treated for Oncho with funding from APOC.

In May/June 2012, the program will treat an estimated 5,066,184 school children and community members with PZQ for SCH in 120 districts. Through both MDAs, all school aged children estimated at 6,859,637 in all 170 districts will receive at least one dose of albendazole or mebendazole for STH.

Mass Drug Administration[2]

Community based MDA for LF, Oncho and STH is planned to take place in February 2012. Preparatory meetings, training, drugs and supplies distribution and community mobilization for this MDA will start in December 2011. Actual mass administration of drugs to at-risk populations is expected to last for 5 to7 days.

School and community based treatment for SCH and STH is planned to take place in May 2012. This activity will cover 120 districts for SCH and 170 districts for STH. Preparatory meetings with GES/SHEP, trainings, drugs and supplies distribution and community mobilization for this MDA will start in April 2012. Actual drug distribution at the school and community level is expected to last up to one week.

Table 2: Breakdown of districts and estimated populations to be covered for LF/Oncho/STH MDA (February 2012)

NTD	Target Group by age	No. of districts	Targeted Population
LF/STH (Includes 10 LF/Oncho co-endemic districts)	5 years and above (apart from exempted groups)	70	7,559,578
Oncho (Oncho only districts)	5 years and above (apart from exempted groups)	51	2,386,078

[1] The Annual MDA Treatment Projections Form should be incorporated into this work planning as an attachment.
[2] The plan described here focuses on USAID-supported MDA activities only.

Table 3: Breakdown of districts and estimated populations to be covered for STH/SCH MDA (May 2012)

NTD	Target Group by age	No. of districts	Targeted Population
STH	School aged children (5 – 15 yrs.)	170	6,859,637
SCH	School aged children (5 – 15 yrs.)/ Adults at risk	120	5,066,184

The policy of the GHS is to ensure that every school-aged child is de-wormed at least once every year. We are therefore using both the school-based (distribution of ALB for STH only) distribution and the community-based (distribrution of IVM and ALB for LF and STH) distribution to ensure that this is achieved. The high incidence of re-infection of STH is the main reason for this and also the desire to maintain the low prevalence of worm infestation in the country.

The LF program is undertaking treatment in 70 of 170 districts in the country, meaning that 100 districts will not be treated with albendazole during this treatment (February 2012). The assumption is that the coverage of the the eligible population will be 100%. It has been noted that during the school-based distribution, particularly in LF endemic areas and in the Northern part of the country, the school enrolment is low. Therefore the school-based distribution does not reach school-aged children not attending school. Though efforts are made by the program to attract non-enrolled school-aged children to the schools for treatment, very few of them actually get treated.

The best strategy is therefore to combine the community and school-based strategies as a mop-up for each other. Some of the children would therefore receive ALB treatment twice a year, which is recommended when prevalence is high.

The predictive map for Ghana shows thatall districts are endemic for SCH. As per WHO recommendations, some districts with mild endemicity require treatment every othe year. For 2012 one hundred and twenty (120) districts will be treated based on the WHO protocol.

Social mobilization & IEC Materials

Social mobilization for the MDA will be done at all levels starting with the launch of the End NTD in Africa Ghana project in February 2012 as a prelude to the MDA in the same month. Funding will be provided for the regional and district directorates of the GHS for social mobilization activities at their local level. Activities expected to be undertaken include TV and radio messages, announcements in churches and mosques as well as community announcements, community meetings and school announcements. IEC materials to promote MDAs and raise awareness which were produced by the program in the previous year will be distributed for the 2012 MDAs.

Communications and success stories

The program will sensitize regions and districts on guidelines for writing success stories as part of MDA training to look out for and report on successes of the program. These success stories will help in the worldwide promotion of the program as well as building goodwill for continued NTD support.

Drugs and supplies distribution

Drugs for the planned MDA (IVM and ALB) in January/February have been received in country. As shown in Table 4, the Program applied for ALB for STH treatment from GSK in October 2011 and is expected to be delivered in February 2012. The project has also applied for PZQ from FHI which is expected in March 2012. Drugs and other supplies for the impending MDA will be sent from Central Medical Stores in Tema (the National store) then onto all 10 Regional Medical Stores at least two weeks prior to MDA based on a distribution list prepared by the program according to regional "at risk" populations. Distribution to districts will be coordinated at the regional level using the same criteria. It is expected that all supplies will be in stock at the district level at least a week prior to MDA. During the district training, sub districts will pick up their supplies for onward distribution to volunteers.

Table 4 shows drugs available and anticipated to be delivered to the program for MDAs for the year. These estimated NTD drug supplies match the most recent FGAT being completed by the GHS. [3]

Table 4: Drug Estimates

Drug	Source of drug (procured or donated)	Quantity of drug procured or donated	Date of Donation application (MM/YR)	Expected delivery date of drugs (MM/YR)	Observations
IVM	MDP/Merck & Co	33,915,000	May 2011	November 2011	Received in CMS Tema
ALB	GSK	8,862,300	May 2011	November 2011	Received in CMS Tema
*MEB	Feed the Children	6,221,947	NA	August 2010	In stock in CMS Tema
ALB	GSK	7,278,971	October 2011	February 2012	Not yet received
PZQ	USAID	12,160,225	October 2011	March 2012	Not yet received

*Mebendazole is available from GES/SHEP and may be used for STH treatment depending on availability of ALB in time for school-based MDA

Training

To ensure an effective integrated MDA, three cadres of people will be trained. These are health (GHS) and education (GES) staffs at the regional, district and sub-district/circuit levels, teachers at the district level, and community volunteers at the community level. To be able to bring to the fore specific issues in drug and logistics management during the trainings, the FHI 360 SCM Consultant will work with the

3 FHI/USAID will provide information on 2012 FGAT.

program to update the training manual with an appendix on SCM. He will also participate in national level trainings and monitoring of some regional level training. Medical Stores personnel at the national and regional levels will be given orientation in SCM for MDA and will help facilitate trainings at regional and district levels to emphasise the need for adequate drug management. Trainings will focus on:

- MDA supervision and monitoring
- MDA implementation
- Social mobilization for MDA
- Record keeping and reporting after MDA

In most cases, trainings will be limited to one day as training has been ongoing yearly. Trainings will be cascaded from national to regional and to district level. District level trainings will take place about one week before MDA to ensure that issues discussed are fresh in the minds of supervisors and volunteers. For districts that have new staff to be trained, training will be extended to 2 days.

Training for CDDs will be done at the sub district level by trained health workers using existing NTD training manuals. These training manuals have been previously developed and incorporate national protocols for MDA.

SCH and STH MDA will be implemented mainly through the school system. Training will target GHS and GES/ SHEP officers for supervision, and school teachers for drug distribution (Table 5).

Lessons learnt from previous rounds of MDA, as captured in semi-annual reports, will be incorporated into the refresher training at national, regional, district and sub district levels. In this way, lessons learnt will inform changes to strategy to adopt in specific geographical areas.

Early recognition and management of Severe Adverse Events (SAEs) form an important component of the training for health workers and community volunteers. Trainees will be taught to include education on SAEs as part of their social mobilization activities.

Tables 5 and 6 indicate estimated numbers of persons to be trained by category, topic, duration and location.

Table 5: Community based MDA Training Events

Training Group	Topic	No. to be Trained (Based on previous estimates)	No. Training Days	Location	New training or refresher training?
GHS at central level	Community Based MDA Supervision and Monitoring	20	2	GHS Health Education Unit	Refresher
Trainers	Community Based MDA implementation	30	3	TBD (Ashanti Region)	Refresher
Supervisors	Community Based MDA Supervision and Monitoring	3090 (510+2580)	1	Regional/District Administration	*Refresher/New
Drug distributors	Community Based Drug Distribution	20,000	1	Sub-district health facilities	* Refresher/New

* New training possible if supervisors/volunteers have changed

Table 6: School Based MDA Training Events

Training Group	Topic	No. to be Trained (Based on previous estimates)	No. Training Days	Location	New training or Refresher training?
GHS at central level	SCH/STH MDA Monitoring and Supervision	20	1	GHS Health Education Unit	Refresher
Trainers	SCH/STH MDA Implementation	40	1	National level	Refresher
Supervisors	SCH/STH MDA Monitoring and Supervision	510	1	Regional	Refresher
Teachers	SCH/STH Drug distribution	25,000 +1500	1	District	Refresher

Supervision

Routine supervision of activities will be done jointly at all levels during training, health education in the communities and MDAs. The NTD Program Manager will constitute 10 teams of two technical officers and one driver (including CRS staff on the program) to pay monitoring visits to the regions during the periods of training and drug distribution. Regional technical officers will also pay visits to districts during the periods of training and drug distribution to ensure compliance with agreed processes.
Supervision will be done at all levels during drug distribution, to ensure that CDDs conform to national protocols for drug distribution.

GES SHEP national and regional officers will also supervise the training and drug distribution for PZQ and ALB as part of technical teams from the NTDCP and GHS regional and districts. Supervision will jointly be done by the SHEP, GHS officers and GES Circuit supervisors at the district level. Actual drug distribution will be done by school teachers based in schools to be treated. For districts with high prevalence of SCH (above 50%) population groups at risk will be reached through fixed point distribution.

Whilst local capacity to supervise MDA is adequate, regional monitoring to ensure timeliness of reporting has been lacking. The program will therefore provide adequate funding for regional health authorities to effectively monitor MDAs and ensure reporting from the district level.

Short Term Technical Assistance

GHS has identified technical assistance needs in the management of logistics for MDAs, especially once the drugs are distributed to districts and sub districts. Fully-staffed medical stores with good supply chain management practices are observed at the national and regional level; however, these structures are not replicated at the district and sub district level. The management of drugs and other supplies at these lower levels is therefore not adequate. e retrieval and accounting for drugs left over after an MDA are particularly challenging. Technical assistance will therefore be needed to assess the real needs at those levels and to provide recommendations to improve practices of supply chain implementation and management.

Whereas M&E was identified as a challenge, CRS has worked with GHS to develop a SMILER M&E system that will systematically track program activities and M&E needs.

Table 7: Technical Assistance Requirements

Task	Technical skill required	Number of Days required
Improving drug management systems below regional level	Supply Chain Management Consultant (JSI)	14

Financial Management

Financial management of USAID funding will be a key concern of CRS under this project. To ensure compliance with USAID financial reporting guidelines, CRS is recruiting two Finance Officers to support the NTDCP in financial management. These Finance Officers will work with national, regional and district

Finance Officers of the GHS. They will be supervised by the NTD Program Manager with the technical support of the CRS Finance Manager.

MOH Regional Finance Officers have had training in USAID financial reporting requirements, and this will strengthen financial management and grant compliance on the NTDCP. CRS will reassess training needs of the Finance Officers to determine if there are any gaps that need to be filled with training.

Financial sampling

CRS will comply with the need for FHI to perform financial sampling on records following an MDA. Upon completion of the MDA activities, the original receipts and other expenditures will flow from the GHS system to CRS for review and certification. FHI/Regional Hub will in turn conduct financial sampling using CRS's financial data immediately after the reviews and certifications. FHI will then advise CRS on areas needing improvement and/or corrective action after the sampling reviews

FGAT

CRS will work with FHI and GHS on the 2012 FGAT to complete it on schedule by February 2012.

Management of Serious Adverse Events

Volunteers will report cases of SAEs to the nearest health facility who will in turn report to the regional level through the district hospitals and District Health Administration. The Regional Health Administration will forward the reports to the national office of the Ghana NTDCP who will follow-up cases of SAEs.

To strengthen reporting on SAEs, the M&E/ Data manager will contact all regional offices weekly during the period of MDA to monitor SAEs and signal for prompt follow up by program staff. Any reports received will be shared with companies donating drug, WHO and FHI within 24 hours. All SAEs will be investigated. Appropriate documentation of all SAEs will also be maintained.

The program will use the existing GHS structure at all levels to respond to community, district and regional reports of SAEs. This will avoid the situation where the national office will be responding to allegations of SAEs when they are not well informed about actual cases reported at the community, sub district or district level health facilities. SAEs are covered by the national health insurance for insured persons. For the uninsured, the program will make presentations to the National Health Insurance Authority through the DG of GHS to include the management of SAEs when MDAs are carried out as a free package for all.

Transition to Post-elimination Strategy

Lymphatic Filariasis

The program has stopped MDA in 4 districts in the Central Region of Ghana as a result of a transmission assessment survey done in 2010, which showed that transmission had been interrupted.
The WHO protocol is vague on the surveillance process during the two year post cessation period of MDAs. During this period it is expected that a process is put in place to detect mf incidence among

hospital attendants and different groups or populations living in these IUs that have ceased treatment. This has logistic and human resource implications for institutionalizing this surveillance process.

After the two-year period, the Program needs to repeat TAS for the detection of any new infections. The focus of the Program will be the TAS to be conducted after the two year period of surveillance since it would be difficult to influence the health system to implement a surveillance system during the post-cessation period.

The Program therefore hopes to concentrate on undertaking TAS after the two-year post MDA cessation period using the newly developed WHO LF Transmission Assessment Protocol.

Night blood surveys have been conducted in 30 districts (clusters) that have completed up to 7 rounds of LF treatment so far. Whilst results are still being read for the last 15 districts that were surveyed, 8 districts have so far achieved prevalence below 1%. In 2012 10 more districts will conduct night blood surveys.

TAS will be conducted in 8 intervention units (IU) that had mf prevalence below 1% in the 2011 night blood surveys.

Trachoma

A Trachoma surveillance system has been instituted in all 29 districts endemic for trachoma. The system samples 2 communities per district to examine all children 1-9 years old for Trachoma Follicles (TF) and persons above 15 years for Trachoma Trachiasis (TT) annually. Five (5) schools are also sampled per district and school children up to age 9 years are examined for TF. Communities are also assessed for household latrines and portable water sources. A passive surveillance system where health facilities will routinely look out for cases of trachoma is also being put in place. The program will continue to support surveillance activities in these districts in collaboration with Sight Savers International (SSI) and International Trachoma Initiative (ITI)

Facilitation of Collaboration and Coordination

Advocacy

A communication and advocacy strategy for the NTDCP was developed and implemented in the previous sub grant with USAID support. This strategy is now somewhat out-of-date; therefore it will be reviewed for implementation. CRS will work with the GHS to select key activities from the plan. The focus will be on widely disseminating a documentary developed by the program to a national audience via television and targeted presentation to private organizations followed by sourcing support for the program.

Coordination

The program will identify key stakeholders and incorporate them into an Intra Country Coordinating Committee (ICCC) which will be established this fiscal year. The objective of the ICCC is to oversee, monitor and advise on the direction of the country program under the leadership of the GHS. It is expected that the ICCC will meet semi-annually. There will be monthly coordination meetings between GHS, CRS and FHI to monitor project implementation and discuss implementation challenges if any.

Task Force

A taskforce comprising GHS and CRS and FHI will be constituted and will meet on a monthly basis to monitor project implementation.

Cost-efficiencies

The NTD Program is seeking cost efficiencies in program implementation after several years of programming, having reached national scale, and based on integration of individual programs.

- We will pursue Government of Ghana's pledge to exempt the NTD Program from paying customs duties and other clearing charges on medicinal drugs that the program acquires.
- Trainings for MDAs will be limited to one day in most cases, based on the fact that most cadres have been trained year after year. Training will focus on district-specific challenges in the implementation of MDAs.
- Training and IEC materials that have already been developed in the previous program will be used. Where needed, more copies will be reprinted.
- NTDCP will pursue holding one national review meeting in August 2012 after both MDAs have been completed to review them together and set up targets for the next year's MDAs. This will lead to cost savings from that of the earlier program when regional review meetings were held after each MDA. Per diem and hotel rates for GHS partners will be based on the Government of Ghana's approved rates.

Monitoring & Evaluation

Reporting on activities under the Neglected Tropical Diseases Control Program will continue at all levels (community, sub-district and district) and feedback will be provided to all levels by the GHS. Information on reported drug coverage from the districts will be collated at the regions and forwarded to the NTD Control Program Manager at the national secretariat. Working with the NTDCP, CRS will utilize data from these reports to complete the USAID reporting formats within 90 days of completing MDA. An update of drug coverage results will also be submitted with the semiannual reports which will be shared with FHI. Reports on surveys will be submitted to FHI within a month of completing these activities.

CRS will submit semiannual reports to FHI within 30 days after the end of the reporting period (by 30th of April and 30th of October respectively each year) after having been signed off by the NTD Program Manager in compliance with program reporting guidelines.

To ensure data quality, the M&E Officer will carry out periodic data validation at the regional and district levels after each MDA.

After both MDAs are completed, a review meeting will be held at the national level in August to discuss challenges during implementation so as to find ways to improve future MDAs. At the review meeting, regional representatives will present results of their MDAs and discuss challenges; thus, ensuring that results are collated in a timely manner. The review meetings will also determine modalities for the MDA in the ensuing year.

As a means to ensure timeliness in reporting, CRS will provide funding for the program to test the use of ICT (mobile phone) in reporting numbers of persons treated by volunteers on a daily basis during the MDA in one district. This will pilot the effectiveness of mobile phones in reporting MDA coverage. If this proves beneficial, it will be extended to cover one region in 2013.

The NTDCP will work with the PPME unit of the GHS to incorporate data from MDA in the DHMIS.

CRS has supported the program to develop an M&E system called SMILER. It will be used to continuously monitor MDAs and to provide weekly feedback to all regions after MDAs have been completed on districts that have reported and on those for which reporting is pending. This system will be backed up by regular follow up with phone calls and emails to district officers to obtain reports. Working through the GHS hierarchy, pressure will be brought to bear on regional and district authorities to submit reports in a timely manner. Data received will be validated before submission to the donor.

Tools being used currently by the program to collect data are reasonably adequate for collecting data required by USAID. However, CRS will discuss with FHI any issues or gaps that may be encountered in the use of the tools so that FHI will bring them to USAID's attention for review and feedback. No new tools will be introduced.

Cost Share

CRS has two 4x4 vehicles which will be used for the NTDCP. The depreciated cost of those vehicles will be used as cost share. CRS will also purchase one saloon vehicle (town car) for office coordination within Accra. Other costs being financed under cost share will include office expenses (including computers, equipment maintenance and repairs as well as communication costs). CRS is also including contribution from the government in terms of office space and funding operations research in one district in FY 2012 as part of cost share.
CRS Headquarters will also provide administrative oversight and support in terms of Human Resource, Financial reporting and Procurement throughout the project's life.

Travel Plans

CRS Regional Technical Advisor (RTA) will pay a monitoring visit to the project from Senegal in May 2012.

Staffing

The NTDCP secretariat is composed of 7 staff. These are:

1 Program Manager
2 Technical Officers

3 Biomedical Scientists
1 Entomology Technician

CRS will be supporting this team with 5 staff, these are:

1 CRS NTD Coordinator (Technical support Lead)
1 M&E officer
2 Finance Officers
1 Driver

Environmental Monitoring Plan

The program will monitor the effects of its activities on the environment at all levels of implementation. From the district level all reports generated will be in electronic format to reduce the use of stationery. Measuring poles that have been produced by the program will continue to be used and will be stored after each MDA to be available for reuse to reduce the tendency of new ones being procured for each MDA.

Drugs that get expired will be disposed of following GHS approved disposal procedures. All expired drugs from sub district and districts will be returned to the Regional Medical Stores where they will be aggregated. An audit team comprising the Food and Drugs Board, Pharmacy, Stores and Accounts departments will be constituted to audit the drugs and recommend for disposal. Disposal will then be done either by incineration or by burying as recommended by the team.

Timeline

Timeline for Major NTD Activities for End NTD in Africa Ghana Project												
Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Support NTDCP Planning Process												
Launch End NTD in Africa Ghana Project												
Develop SMILER M&E System for program												
Review and finalise 5 year NTD strategic plan document												
Plan and support intergrated MDA campaign												
Train Health Agents, teachers and CHVs												
Carry out Social mobilisation and IEC												
Carry out MDA												
Compile analyse and report on MDA data												
Gather financial justification and reports												
Write and submit reports to donor												
Support surveillance for LF and Trachoma												
Carry out TAS and Night Blood surveys												
Hold National Post MDA Review meeting												
Hold ICCC meetings												
Develop work plan for 2013												

Appendices

Annex 1: Annual MDA Treatment Projections Form.