Annual Progress Report 2007

Submitted by

The Government of

GHANA

Date of submission __14th May 2008_____

Deadline for submission 15 May 2008

(to be accompanied with Excel sheet as prescribed)

Please return a signed copy of the document to:
GAVI Alliance Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Raj Kumar, rajkumar@gavialliance.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French, preferably in electronic form. These can be shared with GAVI partners, collaborators and general public.

This report reports on activities in 2007 and specifies requests for January – December 2009

Signatures Page for ISS, INS and NVS

For the Government of …… GHANA ……..……

Ministry of Health:

Title: …… MINISTER OF HEALTH ……

Signature: ……

Date: 13TH MAY 2008……

Ministry of Finance:

Title: ……

Signature: ……

Date: 13TH MAY 2008……

We, the undersigned members of the Inter-Agency Co-ordinating Committee endorse this report, including the attached excel sheet. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
DR. FRANK NYONATOR, DIRECTOR OF POLICY, PLANNING MONITORING AND EVALUATION & ACTING CHAIRMAN OF ICC	GHANA HEALTH SERVICE		
DR. JOSEPH AMANKWAAH, DIRECTOR PUBLIC HEALTH	GHANA HEALTH SERVICE		
DR. K. O. ANTWI-AGYEI, EPI MANAGER	GHANA HEALTH SERVICE		
DR. JOAQUIM SAWEKA, COUNTRY REPRESENTATIVE	WORLD HEALTH ORGANIZATION		
	UNICEF		
W. A. MENSAH, CHAIRMAN, GHANA NATIONAL ROTARY POLIO PLUS COMMITTEE	ROTARY INTERNATIONAL		
DR. EDWARD ADDAI, DIRECTOR OF POLICY, PLANNING MONITORING AND EVALUATION,	MINISTRY OF HEALTH		
MRS ERNESTINA DJOKOTOE, PRESIDENT	GHANA REGISTERED MIDWIVES ASSOCIATION		

Signatures Page for HSS

Not Applicable

For the Government of ……..……

Ministry of Health:

Title: ……

Signature: ……

Date: ……

Ministry of Finance:

Title: ……

Signature: ……

Date: ……

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name) endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The HSCC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date

Progress Report Form: Table of Contents

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided.

1. Report on progress made during 2007

1.1 Immunization Services Support (ISS)

Are the funds received for ISS on-budget (reflected in Ministry of Health and Ministry of Finance budget): Yes/**No**
If yes, please explain in detail how it is reflected as MoH budget in the box below.
If not, explain why not and whether there is an intention to get them on-budget in the near future?

The situation as reported last year has not changed.
ISS funds are not predictable since we are on reward and the funds are regarded as extra-budgetary earmarked funds and when we receive confirmation of funds a budget is prepared and submitted to the ICC for approval.

The immunisation service support reflects in the Programme of Work (POW) of the Ministry of Health (MoH). Currently the Ministry of Finance and Economic Planning (MoFEP) are aware of all resource inflows into the health sector. However not all of them reflect in the MoFEP budget (including GAVI ISS). However they are reported on and audited in the MoH financial statement, which is widely circulated.

There are discussions with the MoFEP to include a number of inflows from Donor Pooled Sources and Global Health Initiatives that are not reflected in the Government Medium Term Expenditure Framework (MTEF) budget.

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

Management of the ISS funds followed the same mechanism as reported in previous reports, i.e., GAVI funds are lodged in the dollar account of the Ghana Health Service (GHS). This account is a pooled one and has funds from other donors lodged in it. The signatories are the Director General and the Financial Controller of the Ghana Health Service. A proposal for the disbursement of GAVI funds for 2006 was presented by the EPI secretariat to the ICC. The proposal was extensively discussed and endorsed by the ICC. The release of funds follows the procedures of the Ministry of Health with checks by Internal Audit/External Audit and also from Health Partners.

The budget and workplan for using the ISS funds are approved by the ICC. Request are then submitted to the director PHD who oversees the EPI programme for approval. Processing for payment is done through the central accounting system and funds are then released to the EPI office or to Regions/districts, as appropriate, for implementation.
This mechanism for management of the ISS funds is working well.

As reported last year the procurement procedure remains cumbersome and slow; but is not peculiar to GAVI funding alone.

1.1.2 Use of Immunization Services Support

*In 2007, the following major areas of activities have been funded with the GAVI Alliance **Immunization Services Support** contribution.*

Funds received during 2007 _____$355,000_____
Remaining funds (carry over) from 2006 _____$1,908,000_____
Balance to be carried over to 2008 ____$355,000_____

Table 1: Use of funds during 2007*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0				
Injection supplies	0				
Personnel	0				
Transportation	66,167	2,000 (3%)	15,555 (23%)	48,833 (74%)	0 (0%)
Maintenance and overheads	13,776	9,437 (100%)			
Training	120,090	0(0%)	11,478 (100%)	0 (0%)	0(0%)
IEC / social mobilization	39,560	0(0%)	0(0%)	39,560(100%)	0(0%)
Outreach	164,835	0(0%)	0(0%)	164,835(100%)	0(0%)
Supervision	12,500	10,500 (100%)			0(0%)
Monitoring and evaluation	322,736	0(0%)	29,181(9%)	293,555(91%)	
Epidemiological surveillance					
Vehicles	230,710	0 (0%)	0 (0%)	230,710(100%)	
Cold chain equipment	550,000	0 (0%)	20,807 (4%)	529,193(96%)	
Other (specify) Rehabilitation of DHMT building and Regional cold room, 60 computers, 60 printers, 60 UPS, 15 laptops, 12 Photocopiers, 13 video cameras, 13 digital cameras, 12 coloured printers	387,626	49,605(13%)	151,868 (39%)	186,154 (48%)	0 (0%)
Total:	1,908,000	115,470(6%)	267,696(14%)	1,524,834(80%)	0 (0%)
Remaining funds for next year:	355,000				

If no information is available because of block grants, please indicate under 'other'.

We could not utilize the ISS funds of $355,000 because we located it only in March, 2008. The funds will thus be used in 2008.
Please find attached the minutes of the minutes of ICC meeting of 5th February, 2007, when the allocation of funds was discussed.

Please attach the minutes of the ICC meeting(s) when the allocation and utilization of funds were discussed.

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

EPI Performance Jan – Dec 2007

Introduction

- The Expanded Program on Immunization (EPI) was launched in Ghana in 1978 and has since 1985 been operational in all 10 regions and ALL DISTRICTS.
- EPI) in Ghana aims at protecting every child in Ghana from nine common childhood communicable diseases; namely, tuberculosis, poliomyelitis, diphtheria, neonatal tetanus, whooping cough, hepatitis B, haemophilus influenza type b, measles and yellow fever
- EPI has made giant strides as shown by increasing high coverages in particular and the immense contribution towards achieving MDG 4 and 5 in general, all in the overall context of child survival and poverty reduction.
- The mission is to promote and provide immunization services in a comprehensive manner with a view to
  - Reducing the magnitude of the problem due to vaccine-preventable diseases (VPDs) with the help of current and new technologies
  - Contributing to the overall poverty reduction and
  - Strengthening health services.

National EPI Programme objectives for 2007 were as follows:

- To improve coverage to 87% for all antigens by the end of Year 2007
- To reduce morbidity and mortality due to vaccine-preventable diseases
- More than 80% of districts to attain Penta3 coverage of more than 80%
- To maintain Ghana as a polio-free country
- To maintain zero mortality due to measles

2007 KEY ACTIVITIES

- Strenghthen Routine EPI
  - Increase Immunization Coverage through RED
  - Reduce wastage
  - Address high and negative drop outs
  - Support hard-to-reach districts
  - Improve technical support and supervision
- Accelerated Disease Control Activities
- Surveillance for Vaccine Preventable Diseases
- New vaccines and Innovations
  - Start plans for Pneumococcal vaccine introduction in 2010
- Research / Studies
- Address system-wide barriers to immunization

Summary of EPI Financing

- GAVI - $1.9 million for Immunization Service Support
- GAVI - $3.4 million for vaccines and devices
- GOG (MOH) - $3.5million for vaccines and devices
- GOG – Salaries of staff
- UNICEF - $174,000
- WHO - $60,300
- GLAXO SMITH KLINE $30,000

Achievements

The year 2007 was one of the remarkable years in the history of the EPI - even though there were a lot of challenges , immunization coverages have improved. For the first time Ghana has achieved the Global target of more than 80% of districts attaining coverage of more than 80% for Penta3 and no district in Ghana is below 50%. However some of the districts recorded negative drop outs.

Highlights of 2007 achievements were as followed:

1. Penta3 increased from 751,000 (84%) in 2006 to 805,079 (88%) in 2007: In terms of absolute figures 54,079 extra children were immunized :
2. Measles and yellow fever coverage were 89% and 88% respectively, with TT2+ for pregnant women at 71%.
3. The coverage of other antigens in 2007 in all cases was better than for 2006

4. Five new de Monfort incinerators were constructed in selected districts to improve waste management. Safety boxes and Ad syringes and needles were used in all immunization centres to ensure injection safety practices.

5. Since September 2003, there has not been any reported case of wild polio virus and this is mainly due to the successful NIDs and improved routine immunizations in the country
6. Since 2003, there has not been any reported case of death from measles
7. For the first time 83% of districts obtained Penta 3 coverage of more than 80%.

8. Ghana successfully presented documentation for polio certification at the 9th annual general meeting of the African Regional Certification Commission (ARCC) in Brazzaville in October which was accepted. No wild polio virus was isolated during the year. Non-polio AFP rate was 1.52 with 79% stool adequacy.

9. National Pentavalent 1 – 3 drop out rate was 4 % with highest rate of 6% from two regions: Greater Accra and Northern regions.

10. No vaccine shortage was recorded in any districts or regions.

Details of performance are as follows:

Timeliness /Completeness

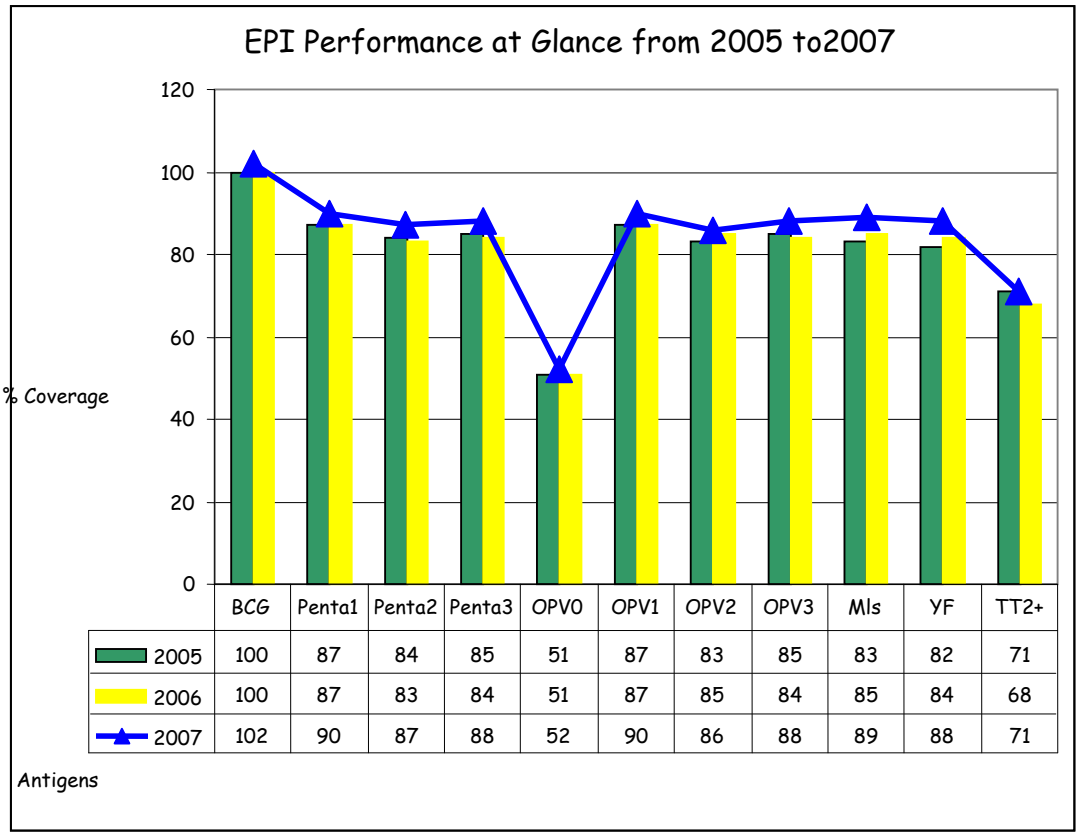
A total of 1,656 reports were received from January to December with 1570reporting on time. (This accounted for 95% of Report Received on time) with March recording the highest of 19 districts out of 86 districts reports received late. The table below shows the monthly timeliness and completeness of reports submission by regions

Timeliness and Completeness of 2007 EPI Report							
Regions	# of districts report per month	Total reports received	# on time	# Late	% Timely	%Lateness	% Completeness
ASH ANTI	21	252	243	9	96.4	3.6	100
BRONG AHAFO	19	228	227	1	99.6	0.4	100
CENTRAL	13	156	156	0	100.0	0.0	100
EASTERN	17	204	187	17	91.7	8.3	100
G REATER ACCRA	6	72	66	6	91.7	8.3	100
NORTHERN	18	216	210	6	97.2	2.8	100
UPPER EAST	8	96	79	17	82.3	17.7	100
UPPER WEST	8	96	80	16	83.3	16.7	100
VOLTA	15	180	180	0	100.0	0.0	100
WESTERN	13	156	142	14	91.0	9.0	100
National	138	1656	1570	86	94.8	5.2	100

National Immunization Performance at a glance :

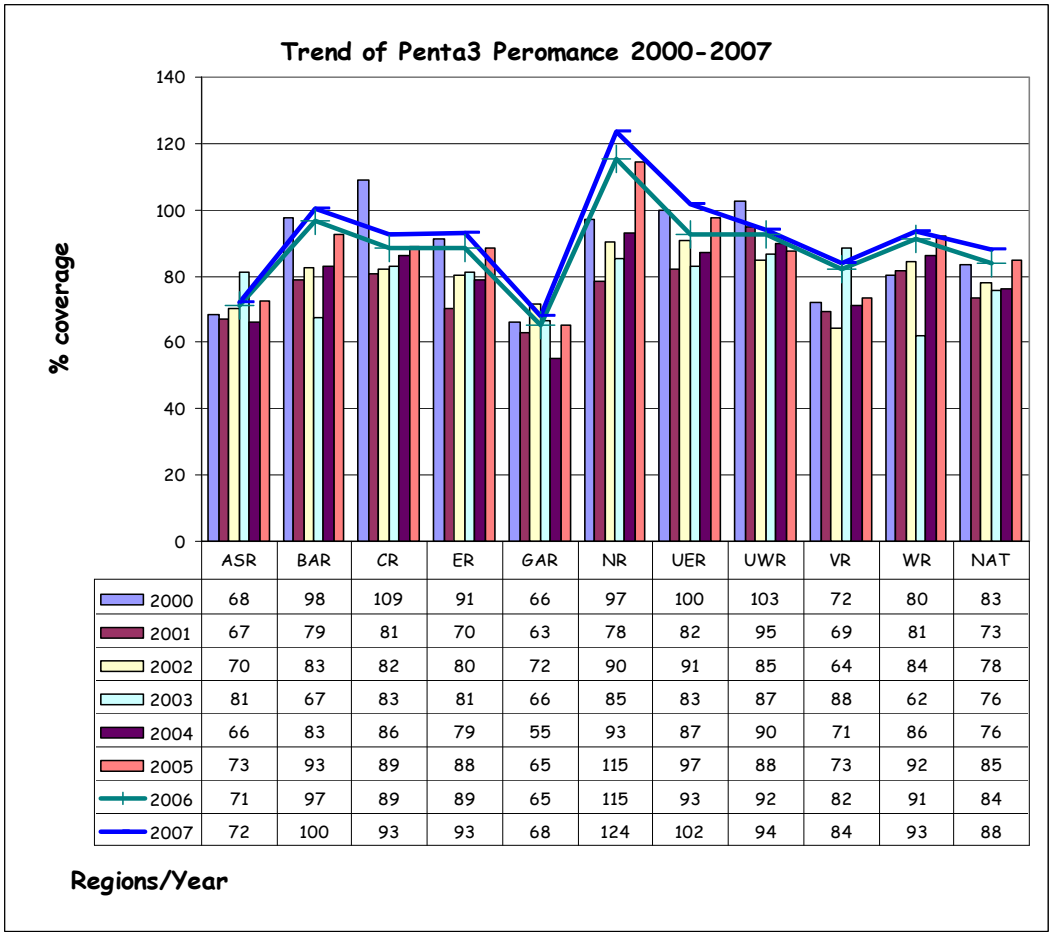
EPI Performance at Glance 2005-2007						
	2005		2006		2007	
Antigens	Performance	%	Performance	%	Performance	%
BCG	865,344	100	888556	100	938,488	102
Penta1	760189	87	774,220	87	827,558	90
Penta2	731882	84	741,463	83	794,286	87
Penta3	733,750	85	751000	84	805,079	88
OPV0	441988	51	449,010	51	479,723	52
OPV1	764871	87	771,722	87	822,168	90
OPV2	730333	83	751,130	85	789,757	86
OPV3	740,761	85	746792	84	803,243	88
Mls	718,872	83	759,222	85	812,083	89
YF	714,937	82	749,233	84	807,807	88
TT2+	618,404	71	608,843	68	651,704	71

More than 54,000 extra children were vaccinated with Penta 3. Generally performance for 2007 better than for 2006 for all antigens



	BCG	Penta1	Penta2	Penta3	OPV0	OPV1	OPV2	OPV3	Mls	YF	TT2+
2005	100	87	84	85	51	87	83	85	83	82	71
2006	100	87	83	84	51	87	85	84	85	84	68
2007	102	90	87	88	52	90	86	88	89	88	71

There have been significant improvements especially in 2007 as coverage for all antigens have increased

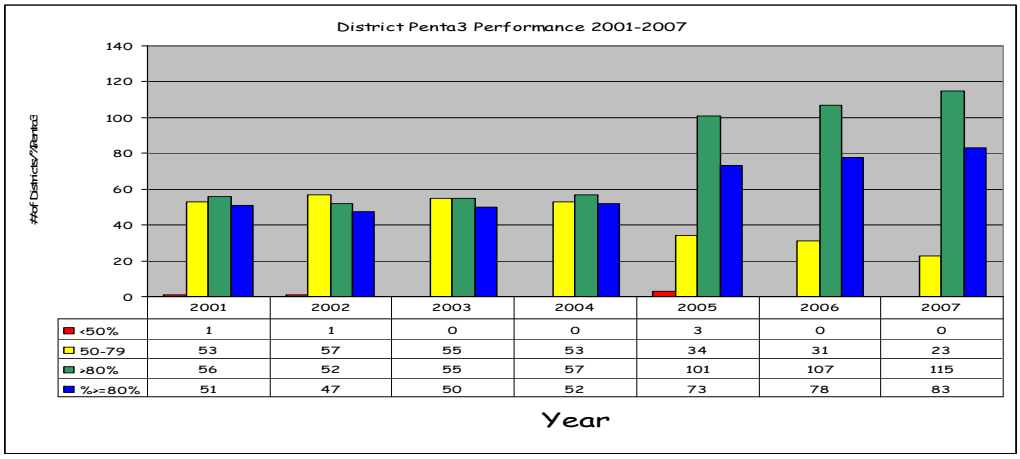


	ASR	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	NAT
2000	68	98	109	91	66	97	100	103	72	80	83
2001	67	79	81	70	63	78	82	95	69	81	73
2002	70	83	82	80	72	90	91	85	64	84	78
2003	81	67	83	81	66	85	83	87	88	62	76
2004	66	83	86	79	55	93	87	90	71	86	76
2005	73	93	89	88	65	115	97	88	73	92	85
2006	71	97	89	89	65	115	93	92	82	91	84
2007	72	100	93	93	68	124	102	94	84	93	88

Penta3 trend from 2000 to 2007 by Regions : Figure above shows trend of Penta3 performance from 2000 to 2007by the regions. Generally performance by the regions have seen improvements with 7 regions attaining coverages of over 80% for Penta 3. However 3 regions, namely Volta, Greater Accra and Ashanti are still below 80% coverage. National average was 88% (using birth cohort as denominator) and is more than the set target of 87%. The 88% coverage for 2007 have seen an increased of 4% over the previous year.

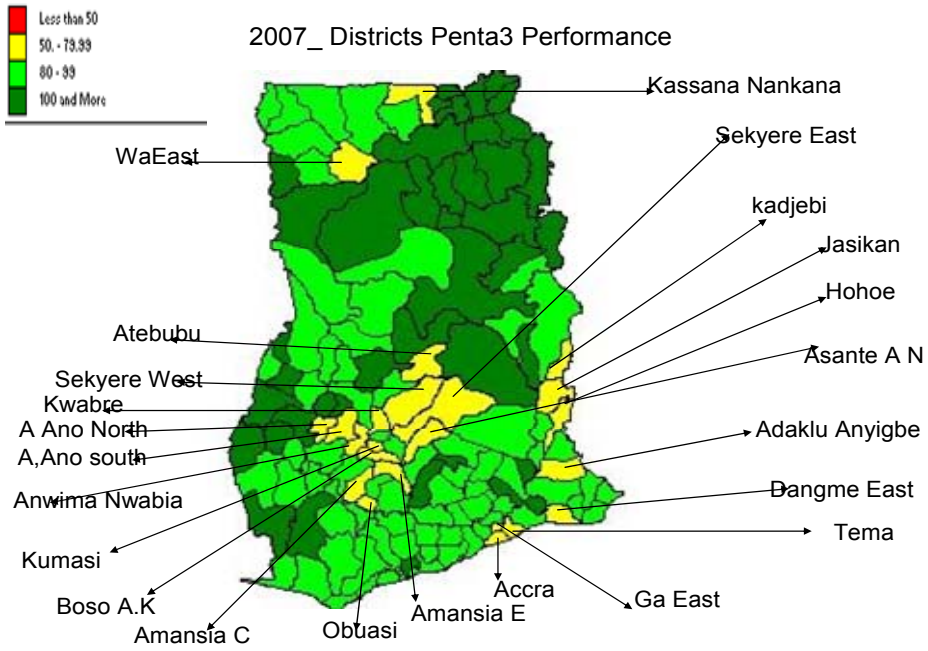
District Penta 3 performance

- For the first time Ghana has achieved the Global target of more than 80% of districts attaining coverage of more than 80% for Penta3 as 115 (representing 83%) out of the 138 districts, achieved Penta 3 coverage of 80% and above.
- No district recorded Penta 3 coverage below 50%
- The trend of district Penta 3 performance is shown in figure below



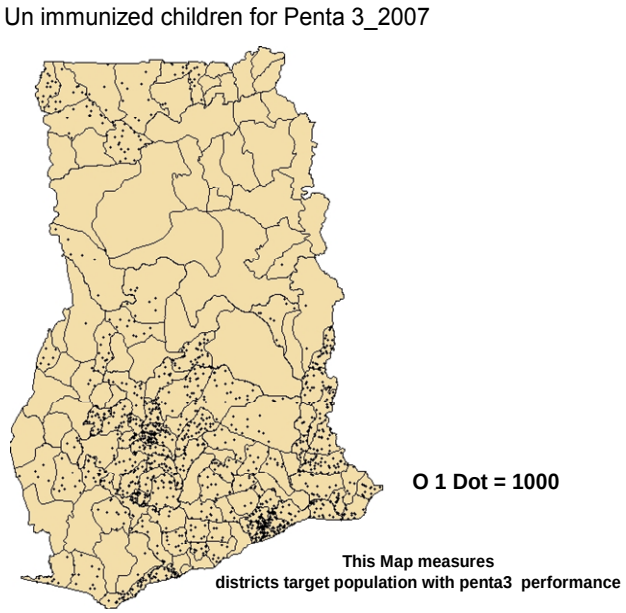
	2001	2002	2003	2004	2005	2006	2007
<50%	1	1	0	0	3	0	0
50-79	53	57	55	53	34	31	23
>80%	56	52	55	57	101	107	115
%>=80%	51	47	50	52	73	78	83

Out of the 23 districts with coverages of Penta 3 less than 80% 12 were from the Ashanti Region, 4 from Greater Accra, 4 from Volta Region and one each from Brong Ahafo, Upper East and Upper West Regions. See Figure below:

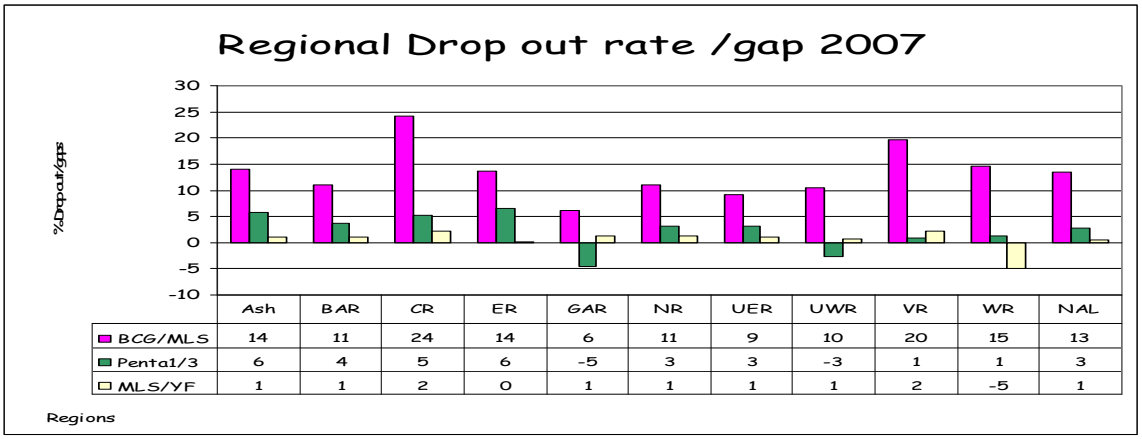


Unimmunized Children

The challenge is to reach the 110,480 children unreached with the third dose of the Pentavalent vaccine.



Drop-out rate by Regions

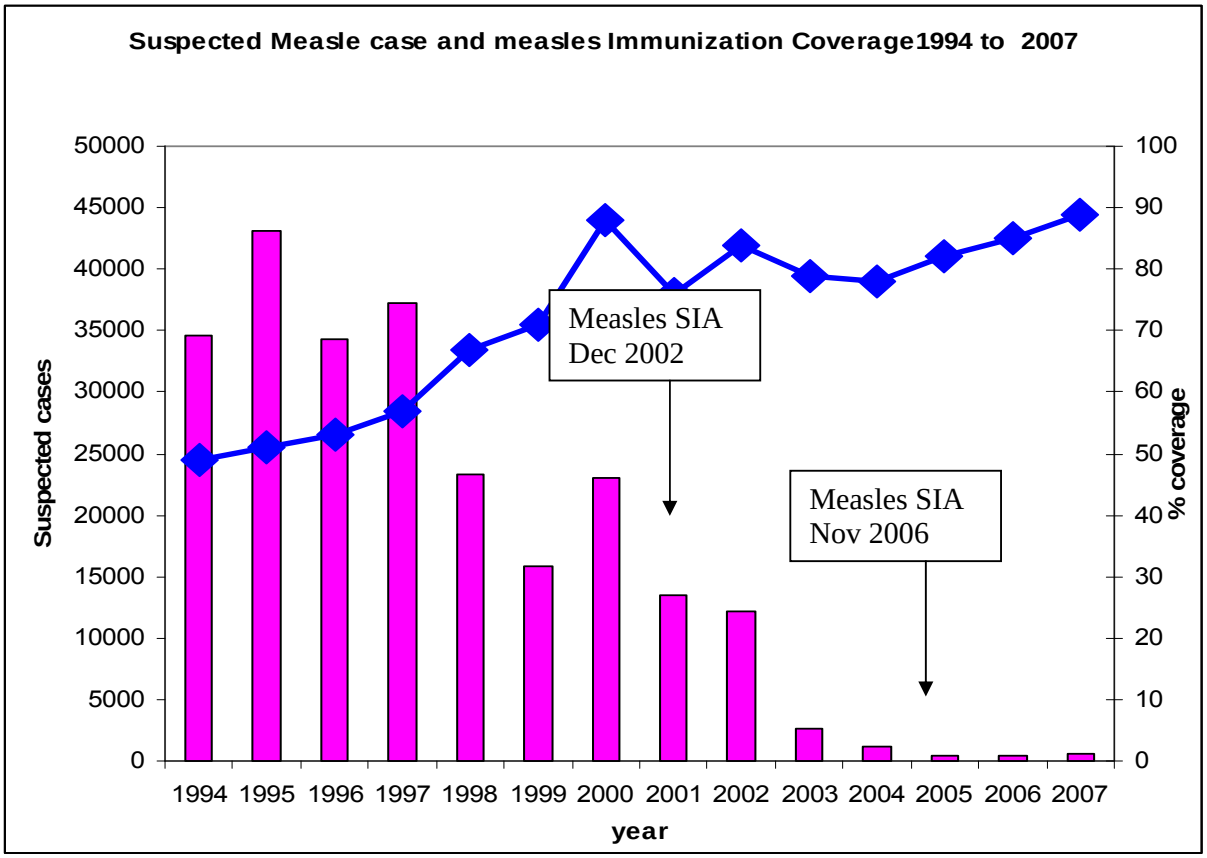


Negative Penta 1-3 drop out for GAR and UWR needs investigation, whilst WR has to look at disparity between Measles and YF which are given on same day and should be equal

Wastage Rates by regions

Regional Vaccine Wastage Rates 2007						
Regions	BCG	Penta	Polio	MLS	YF	TT2+
Ashanti	42%	4%	27%	26%	22%	22%
Brong Ahafo	36%	2%	22%	21%	20%	28%
Central	27%	4%	25%	23%	22%	37%
Eastern	41%	5%	26%	28%	25%	60%
Greater Accra	49%	6%	32%	27%	21%	33%
Northern	19%	6%	15%	24%	23%	22%
Upper East	48%	3%	24%	27%	28%	55%
Upper West	50%	3%	31%	30%	29%	47%
Volta	46%	4%	26%	34%	33%	36%
Western	35%	4%	21%	20%	15%	35%
National	39%	4%	25%	25%	23%	37%

Accerelated Measles Control



Measles cases have dropped drastically from 34,671 cases in 1994 to 408 suspected cases 6 confirmed in 2006 whilst in 2007 only 7 were confirmed out of 588 suspected cases reported.

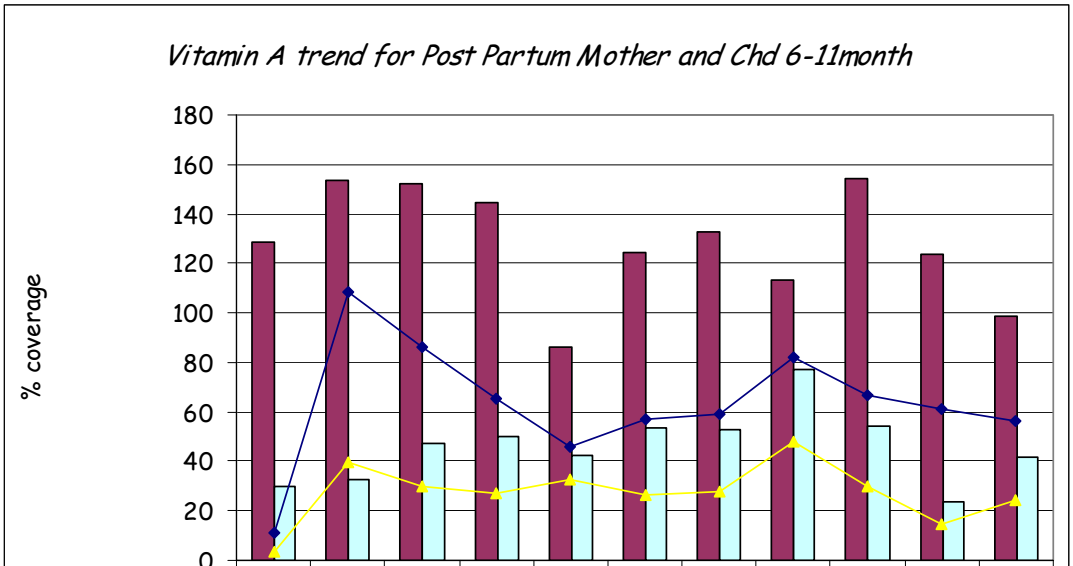
Vaccine Preventable Disease Trends

Reported case of vaccine preventable disease 1994-2007														
Year /Diseases	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Measles	34671	43177	34273	37281	23335	15895	23068	13457	12130	2642	1186	434	**408**	**588**
Confirmed Measles	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	60	62	6	7
Confirmed Rubella	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	175
NNT Cases	144	165	105	109	100	78	80	57	70	39	42	30	29	12
NNT Death	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14	10
Y F Suspected	79	0	13	6	0	0	0	1	0	0	1	2	7	0
Pertusis	1689	1368	1141	600	819	794	636	150	572	0	0	0	0	0
Confirmed polio	0	0	9	2	23	3	1	0	0	8	0	0	0	0
AFP	39	27	25	35	180	108	265	345	230	193	157	171	168	71

NA = Data not available

Vitamin A supplementation within Routine EPI

The reporting for Vitamin A as well as coverages have seen much improvement as compared to those of 2006



	ASH	BAR	CR	ER	GAR	NR	UER	UWR	VR	WR	Ghana
2007_6_11	129	154	152	144	86	124	133	113	154	124	99
2007_Post Part	30	33	47	50	42	54	53	77	54	24	42
2006_6-11m	11	108	86	65	46	57	59	82	67	61	56
2006_post Part	3	39	30	27	33	27	28	48	30	15	24

Regions

Integrated Maternal and Child Health Campaign 2007

As a group, children under five are still the most vulnerable to illness and death. Morbidity and mortality rates among young children remain high in Ghana, with about 80,000 children under five dying each year, mostly from preventable causes. Globally, out of 191 countries, Ghana ranks near the bottom (42nd) with respect to under-five mortality. Maternal mortality remains high in Ghana, and the proportion of supervised deliveries, although rising slowly, is still only about 50%.

The Ministry of Health in its Programme of Work (POW) for 2007 included a focus on scaling up coverage of the National Health Insurance Scheme, with provision of adequate funding to support services for exempt categories such as all children under 18 years. Scaling up interventions against diseases of public health importance under the POW 2007, primarily through the High Impact Rapid Delivery (HIRD) strategy, included increasing coverage of insecticide treated nets among young children and pregnant women, twice-yearly provision of Vitamin A supplements and deworming for children, and increasing the proportion of supervised deliveries. In addition, there was the expressed need to accelerate activities to improve maternal health.

A successful National Child Health Campaign was carried out in November 2006, piggy-backing on the national measles campaign with polio immunization, vitamin A supplementation, and long-lasting insecticide-treated nets (LLINs) for all children under 2 years of age. This was a very successful event, despite the logistical challenges involved, and public education efforts now continue to ensure proper utilization of the LLINs. While the full impact of the 2006 campaign is yet to be realized, it is clear that campaigns do indeed have a positive impact, as there have been no measles deaths in Ghana since the 2002 measles campaign.

In order to further accelerate efforts in Ghana to improve the health and well-being of women and children, another integrated campaign was conducted as part of Ghana's 50th anniversary celebrations from **November 28-30, 2007**. This campaign, which was conducted under the theme "Healthier mothers and children for Ghana's Golden Jubilee Year and beyond" focused not only on young children, but also on pregnant and post-partum women, in order to make it a truly **"Maternal and Child Health Campaign"**. The coverages which were very encouraging are presented below:

National Summary- Integrated Maternal and Child Health Campaign Nov 2007

Intervention/Service	Target pop	Total Immunized/given	Percent coverage (%)
Polio Vaccination	4,582,797	4,599,929	100.4
Vit A (6-59months)	4,124,517	4,134,435	100.2
Vit A (Post-partum)	458,280	153,686	33.5
ITN (0-11months)	916,559	1,101,040	120.1
ITN (Pregnant Women)	458,280	349,933	76.4
Mebendazole	2,749,678	2,368,769	86.1

The success story of immunizations in Ghana

- Since September 2003, there has not been any reported case of wild polio virus and this is mainly due to the successful NIDs and improved routine immunizations in the country
- Since 2003, there has not been any reported case of death from measles
- Measles cases have dropped drastically from 34,671 cases in 1994 to 408 suspected cases (6 confirmed in 2006 whilst in 2007 only 7 were confirmed out of 588 suspected cases reported.

Challenges

However there were challenges in implementation of our programmes, some of which are listed below:

- Some Districts have not been reporting on the vaccine use/logistics.
- Data inaccuracies resulting in reported negative wastage and negatives dropouts in some districts. Some of the hard copies are different from the electronic copies
- Regions not analysing immunization data along side the logistics data.
- Some districts are recording over 100% coverage due to **DENOMINATOR PROBLEMS**
- **Poor flow of funds to districts.**

Conclusion:
Performance on the whole is encouraging but there is more room for improvement, and we urge regions (especially Greater Accra and Ashanti) to address problems of low coverage so that EPI Ghana can see better performance this year and beyond.

1.1.3 Immunization Data Quality Audit (DQA)

Next* DQA scheduled for ___2013_____

Data Quality Audit was conducted in 2002.
A Data Quality Self Assessment (DQSA) was conducted in 2007 with summary report below::

In September 2007, the Diphtheria–Tetanus–Pertussis-Hib-HepB 3 (Penta 3) data for children less than one year old for the year 2006 was audited from the health unit level through to the National level in six (6) randomly selected regions. The general objectives of the data quality self-assessment were to: Determine the Accuracy and consistency of reported numbers of immunizations; and assess the quality of the immunization systems at various levels. The objectives were achieved by examining data and the information system in operation and evaluating the quality of the components (recording practices, storage/reporting, monitoring and evaluation, denominator, system design, timeliness and completeness) of the country's immunization programme and giving recommendations for improvement.
The National EPI office had an overall Quality of the System Index score of 69.2% compared to the Quality of the System Index score of 59.1% for 2001. The Verification Factor was 0.739 for 2007 compared with the Verification Factor of 0.872 in 2001. A major finding at this level was the unavailability of back-up system for the national immunization data.
The average Quality of the System Index score was 85.0% at the district level. This ranged from 71% to as high as 95%. Officers had difficulties in the calculation of wastage rates and drop-out rates which were major performance indicators and monitoring tools in the EPI programme.

The health unit level recorded an average Quality of the System Index score of 73.6%. Recording practices remained a problem at the health unit level though the level had a fairly good Quality of the System Index score of 74.0%. Different tally sheet books were used at this level to collect data which left room for data inconsistencies.

Key Issues
Recording practices
Different recording books made recording very cumbersome and made errors inevitable. There were inconsistencies in the heading of the recording books in use.
Storage\ Reporting:
Except in one region, there was absence of electronic and written data recovery system for EPI in the country. Filing of hard copy reports at the various levels was not encouraging. Regions complained of the national level not providing regular feedback on reports received and performances. It was noted however that delayed feedback was provided during review meetings.

Monitoring/Evaluation:
Three of the six districts visited displayed graphs and charts showing their performance and other indicators in the audit year. The computation of these indicators was however very difficult at the sub-district and health unit levels.

Key Recommendations
1. Recording practices:
A standardized CWC register should be made at the national level and distributed to the operational level.
2. Storage\ Reporting
The programme management has to seek support to establish guidelines and procedure for data backup. All levels should be encouraged to get files for every district and also file reports from districts according to date and properly filed on shelves.
3. Monitoring/Evaluation:
Introduce "time tracking" for EPI data management (date/time on all computer files/print-outs, reports, archive files, tables/charts etc). Half-yearly training on the use of EPI monitoring charts for all levels for all antigens should be instituted. Supervision at all levels should be improved.
Conclusion
The audit has thus shown that the Quality of the System Index score improved over the last five years in the EPI Programme. However, the Verification Factor has reduced over the same period. This supports the recommendation that improvements are needed at the health unit level in recording and reporting practices.

**If no DQA has been passed, when will the DQA be conducted?*
**If the DQA has been passed, the next DQA will be in the 5th year after the passed DQA*
**If no DQA has been conducted, when will the first DQA be conducted?*

What were the major recommendations of the DQA?

Has a plan of action to improve the reporting system based on the recommendations from the DQA been prepared?

YES [ ] *NO* [x]

If yes, please report on the degree of its implementation and attach the plan.

Not Applicable

Please highlight in which ICC meeting the plan of action for the DQA was discussed and endorsed by the ICC.

Please report on studies conducted regarding EPI issues during 2007 (for example, coverage surveys).

A study on "Evaluation of Vaccine Wastage Sentinel Monitoring" was conducted with the following recommendations:

1. There is the need to retrieve excess vaccines (Measles, OPV, TT) immediately from all levels
2. Vaccine management training for operational level staff (district, sub district, facility levels) should be carried out as an immediate step
3. Meeting with the regions to provide feedback on the vaccine wastage monitoring project
4. Vaccine Management Training should be owned by Regions and Districts so that they can factor it into their budgets (they should include it in their quarterly monitoring visits)
5. Regular Monitoring and Integrated Supportive Supervision will encourage the people on the project to work better
6. Strict adherence to vaccine storage regulations
7. In the light of the ongoing power crisis, pending when we would have thermo-stable vaccines, alternative power sources should be considered
8. National staff to have an orientation on solar/gas fridges regulation/management
9. To retrieve excess vaccines immediately after campaigns from facility to regional levels

A draft report is attached

1.1.4. ICC meetings

How many times did the ICC meet in 2007? ***Please attach all minutes.***
Are any Civil Society Organizations members of the ICC and if yes, which ones?

The ICC met 5 times – 4 were regular and one emergency.. Minutes of ICC meetings are attached.
The Civil Society Members on the ICC so far are

1. Paediatric Society of Ghana
2. Ghana Registered Midwives Association
3. Ghana Red Cross Society
4. Rotary International - Ghana National Polio-Plus Committee

Plans are well advanced to include the Christian Health Association of Ghana (CHAG)

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2007

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB) and dates shipment were received in 2006.

Vaccine	Vials size	Doses	Date of Introduction	Date shipment received (2007)
DTP-HepB+Hib	(2 dose vial)		**Jan 2002**	**See table below**
Yellow Fever	(10 dose vial)		**1992**	**See table below**
Yellow Fever	(5 dose vial)		**2005**	**See table below**

PROCUMENT BY GAVI FUNDS

Vaccine/Devices	Quantity procure with GAVI fund	Expected Delivery date	Date delivered
DTP-HepB+Hib (2 dose vial)	838100	Jun-07	Jul-07
DTP-HepB+Hib (2 dose vial)	838000	Sept-07	Nov-07
Yellow Fever (10 dose vial)	341000	Mar-07	Mar-07
Yellow Fever (10 dose vial)	340700	Jun-07	Sept -07
AD Syringes	895200	jan-07	May-07
AD Syringes	893100	Mar-07	Jun-07
Reconstitution Syringes (2.0 ml)	465,100	Mar-07	May-07
Reconstitution Syringes (2.0 ml)	465,100	Jun-07	Jun-07
Reconstitution Syringes (5.0 ml)	15,100	Mar-07	May-07
Reconstitution Syringes (5.0 ml)	15,075	Jun-07	Jun-07

Please report on any problems encountered.

No problems were encountered with the deliveries for the GAVI funded vaccines and devices. However there was delay in payment for the MOH part, due to cash flow problems.

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

Not Applicable

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were received on: _____Not Applicable_____

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

Not Applicable

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

The last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) was conducted in _____*Not Applicable*_____

Please summarize the major recommendations from the EVSM/VMA

Not Applicable

Was an action plan prepared following the EVSM/VMA: Yes/No

If so, please summarize main activities under the EVSM plan and the activities to address the recommendations.

Not Applicable

The next EVSM/VMA* will be conducted in: ____2009_____

**All countries will need to conduct an EVSM/VMA in the second year of new vaccine support approved under GAVI Phase 2.*

1.3 Injection Safety

1.3.1 Receipt of injection safety support

Received in cash/kind *Not Applicable*

Please report on receipt of injection safety support provided by the GAVI Alliance during 2007 (add rows as applicable). Not Applicable

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

Not Applicable

1.3.2. Progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded. ur injection safety support ended in 2005. Since then the Government of Ghana has been paying for injection safety supplies. Construction of incinerators continued in 2007 with the balance of our Injection safety funds carried forward and we report as follows:

- At the beginning of the year the Estate Management Department (EMD) in collaboration with the EPI agreed to procure 50 units (list of selected sites attached) of modified demontfort incinerators in the 28 newly created districts and 22 strategic health facilities in the country.
- Funds (GH¢ 78,200.00) for local procurement of materials (cement, metal fabrications, sand and stones, timber among others and certain skilled labour in the regions for the construction of the incinerators were released in July 2007 to the Regional Directors of Health.
- The following items were however procured centrally for distribution, namely;
- Laminated user guides for the training of operators (GH¢ 400)
- Protective clothing { goggles, gloves, Wellington boots, overalls and nose guides} (GH¢1,517.50)
- Granulates (GH¢. 3,450.00)
- Procurement of bricks in collaboration with the Stores Supplies and Drug Management (SSDM) Division has been outstanding since June 2007, although the necessary processes were followed. Due to delay in the procurement of the bricks for construction only five new incinerators were completed during the year. Work is in progress for many to be completed in 2008.

Winneba Hospital Incinerator, May 2007.

Apam Catholic Hospital, May 2007.

Please report how sharps waste is being disposed of.

1. Incinerators have been constructed for 115 districts and we are in the process of constructing incinerators for the 23 new districts. Sharps waste are destroyed by incineration and for areas where there are no incinerators they are burnt in pits.
2. Complete incineration of the needles has been problematic because high temperatures are not achieved during burning. As a further step towards injection safety we introduced into the system a needle destruction device. A free sample was tried at the Maamobi Polyclinic and they gave a favourable recommendation. The Clinical Engineering Unit of the GHS has also evaluated it and given a positive recommendation. We are also considering needle cutters for areas without incinerators.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

- Inadequate funding is a major problem
- Creation of new districts – 32 newer districts have been created in 2007 by the government and each of them is demanding an incinerator, which is outside our original plan.

2.3.2. Statement on use of GAVI Alliance injection safety support in 2007 (if received in the form of a cash contribution) *Not Applicable*

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

Not Applicable

2. Vaccine Co-financing, Immunization Financing and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization

The purpose of Table 2.1 is to help GAVI understand broad trends in immunization programme expenditures and financing flows. In place of Table 2.1 an updated cMYP, updated for the reporting year would be sufficient.

	2007	2007	2008	2009
	Actual	Planned	Planned	Planned
Expenditures by Category				
Vaccines	5,394,399	9,658,405	13,321,720	13,648,410
Injection supplies	3,948,613	772,127	1,991,022	2,132,296
Cold Chain equipment	650,000	1,218,656	1,300,000	1,400,000
Operational costs	NA	12,664,291	13,101,848	13,295,662
Other (please specify) vehicles, equipments, renovations, training	1,418,000			
Financing by Source				
Government (incl. WB loans)	3,474,563#	17,419,979	18,208,379	18,672,469
GAVI Fund	7,770,450	6,893,500	11,506,211	11,803,898
UNICEF	172,000	NA	NA	NA
WHO	60,300	NA	NA	NA
Other (please specify) (GSK)	30,000	NA	NA	NA
Total Expenditure	11,411,012	24,313,479	29,714,590	30,476,368
Total Financing	11,507,313	24,313,479	29,714,590	30,476,368
Total Funding Gaps	NA	0	0	0

shows only expenditure for vaccines and devices

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the coming three years; whether the funding gaps are manageable, a challenge, or alarming. If either of the latter two, explain what strategies are being pursued to address the gaps and what are the sources of the gaps — growing expenditures in certain budget lines, loss of sources of funding, a combination…

The financing of immunisation expenditure for vaccines and injection supplies were met for the reporting year. Though this was a challenge, it was possible because the sector has immunisation as a top priority among its programmes. In 2007, funding to the district and sub district levels increased considerable as part of efforts to achieve MDG 4 and 5. This was sufficient to address the delivery of immunisation services. However there remain gaps in the area of meeting the entire need of cold chain equipment and incinerators (especially as 32 new districts have been created in 2007), This is being addressed in the next phase of the High Impact Rapid delivery (HIRD) strategy to accelerate the achievement of MDGs 4 and 5. The rate of scaling is however slow, and support from partners in this direction would be much appreciated
For vaccines the deficit between the actual and planned resulted as we had balances by the close of the year especially after the campaign which was used for the routine. The injection supplies excess was because we did not add the GAVI componenet to the planned budget but was included in the actuals.

Table 2.2: Country Co-Financing (in US$)

Table 2.2 is designed to help understand country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete a separate table for each new vaccine being co-financed.

For 1st GAVI awarded vaccine. Please specify which vaccine (ex: Yellow Fever)	**2007**	**2007**	**2008**	**2009**
	Actual	Planned	Planned	Planned
Co-financing amount (in US$ per dose)				
Government	0.351	0.351	0.30	0.30
Other sources (please specify)	0	0	0	0
Total Co-Financing (US$ per dose)	0.351	0.351	0.30	0.30

Please describe and explain the past and future trends in co-financing levels for the 1st GAVI awarded vaccine.

Under GAVI Phase 1 we kept Ghana's part of co-financing up to 45% per dose and is committed to payments during the second phase.

For 2nd GAVI awarded vaccine. Please specify which vaccine (ex: DPTHepBHib)	**2007**	**2007**	**2008**	**2009**
	Actual	Planned	Planned	Planned
Co-financing amount (in US$ per dose)				
Government	1.62	1.62	0.15	0.15
Other sources (please specify)	0	0	0	0
Total Co-Financing (US$ per dose)	1.62	1.62	0.15	0.15

Please describe and explain the past and future trends in co-financing levels for the 2nd GAVI awarded vaccine.

The MoH developed a plan in the FSP to co-finance vaccines over a ten year period. Though the proportions of co-financing were not as planned, Ghana was committed to co-financing its vaccine procurement during the first phase of GAVI vaccines award. The major challenge was dealing with changes in the financing policies by government and development partners. Now Development partners are moving their funds towards the Multi Donor Budget Support.

We were obviously facing difficulties in making good Ghana's co-payments for Pentavalent vaccines, especially for the past 3 years as we experienced cash flow problems towards the end of our last 5-year "Programme of Work" and at the beginning of our current one which started in 2007.

The Government was saddled with Avian influenza to fight, whilst demands by health workers for increased salaries (though justified) resulted in huge salary bills, which took a huge chunk of funds for health services to the detriment of funding for commodities and services.

We were therefore pleased to receive your letter of March 2007 which indicated a new co-financing policy, which we felt would be a big relief to Ghana. Thus our next Programme of Work for 2007 – 2011 took advantage and was based on the new policy and this was reflected in our computation of vaccines for the 2006 Progress Report.

We wish to re-state our commitment to provide ALL vaccines currently needed by our EPI Programme and to introduce others in future. However in view of current financial difficulties we wish to confirm our interest in going by your new policy direction with respect to co-payments which we find more sustainable and easier to manage.

Table 2.3: Country Co-Financing (in US$)

The purpose of Table 2.3 is to understand the country-level processes related to integration of co-financing requirements into national planning and budgeting.

Q. 1: What mechanisms are currently used by the Ministry of Health in your country for procuring EPI vaccines?			
	Tick for Yes	List Relevant Vaccines	Sources of Funds
Government Procurement- International Competitive Bidding			
Government Procurement- Other			
UNICEF	√	BCG, Oral Polio Vaccine (OPV), Pentavalent (DPTHepB Hib), Measles and Yellow Fever (YF) Tetanus Toxoid (TT)	
PAHO Revolving Fund			
Donations			
Other (specify)			

Q. 2: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Proposed Payment Schedule	Date of Actual Payments Made in 2007	
	(month/year)	(day/month)	
1st Awarded Vaccine (specify) YF	Nov 2006	Mar 2007	150
2nd Awarded Vaccine (specify) DPTHepB Hib	Nov 2006	August 2007	240
3rd Awarded Vaccine (specify)			

Q. 3: Have the co-financing requirements been incorporated into the following national planning and budgeting systems?	
	Enter Yes or N/A if not applicable
Budget line item for vaccine purchasing	Yes
National health sector plan	Yes
National health budget	Yes
Medium-term expenditure framework	Yes
SWAp	Yes
cMYP Cost & Financing Analysis	Yes
Annual immunization plan	Yes
Other	

Q. 4: What factors have slowed and/or hindered mobilization of resources for vaccine co-financing?
1. The decisions by Development partners to move their funds towards Multi Donor Budget Support
2. Increasing demand from other interventions, especially to meet international targets .g. MDGs
3. Demands by workers for increase in salaries(though justified) resulted in huge salary bill which went to the detriment of budget for commodities and service as the health budget remained the same.
4. Natural disasters like flooding which increased government's expenditure
5. Conflicts in the Northern part of the country which has resulted ib government spending a lot on peace keeping

3. Request for new and under-used vaccines for year 2009

*Section 3 is related to the request for new and under-used vaccines and injection safety for **2009**.*

3.1. Up-dated immunization targets

Confirm/update basic data approved with country application: figures are expected to be consistent with those reported in the WHO/UNICEF Joint Reporting Forms. Any changes and/or discrepancies **MUST** be justified in the space provided. Targets for future years **MUST** be provided.

Please provide justification on changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the WHO/UNICEF Joint Reporting Form in the space provided below.

No major change. However we have expressed interest in switching over from a 2-dose DPTHepBHib to a single dose formulation when available.

Table 5: Update of immunization achievements and annual targets. Provide figures as reported in the JRF in 2007 and projections from 2008 onwards.

Number of	Achievements and targets									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
DENOMINATORS										
Births	849,830	916,559	941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Infants' deaths	47,830	58,660	60,091	61,557	63,059	64,598	66,174	67,789	69,443	71,137
Surviving infants	802,000	857,899	881,215	905,164	929,764	955,031	980,985	1,007,644	1,035,026	1,063,152
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP (DTP1)*										
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with 3rd **dose** of DTP (DTP3)*										
NEW VACCINES **										
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DPTHepBHib * ..... *(new vaccine)*	774,220	827558	845,966	868,957	892,573	916,830	941,746	967,338	993,625	1,020,626
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with 3rd **dose** of DPTHepBHib *(new vaccine)*	751,000	805,079	828,342	850,854	873,978	897,729	922,126	947,185	972,925	999,363
Wastage rate till 2007 and plan for 2008 beyond*** ……. *(new vaccine)*	3%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Infants vaccinated / to be vaccinated with **Yellow Fever**	749,233	771,740	828,342	850,854	873,978	897,729	922,126	947,185	972,925	999,363
Wastage rate of *** **Yellow Fever**	20%	23%	23%	20%	20%	20%	20%	20%	20%	20%
INJECTION SAFETY****										
Pregnant women vaccinated / to be vaccinated with TT	608,843	651,704	941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Infants vaccinated / to be vaccinated with BCG	888,556	938,488	941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Infants vaccinated / to be vaccinated with Measles (1st dose)	759,222	812,083	828,342	850,854	873,978	897,729	922,126	947,185	972,925	999,363

* Indicate actual number of children vaccinated in past years and updated targets (with either DTP alone or combined)
** Use 3 rows (as indicated under the heading **NEW VACCINES**) for every new vaccine introduced
*** Indicate actual wastage rate obtained in past years
**** Insert any row as necessary

3.2 Confirmed/Revised request for new vaccine *(to be shared with UNICEF Supply Division)* for 2009

In case you are changing the presentation of the vaccine, or increasing your request; please indicate below if UNICEF Supply Division has assured the availability of the new quantity/presentation of supply.

As indicated last year we have expressed interest in switching over from a 2-dose DPTHepBHib to a single dose formulation and have fully discussed with UNICEF Supply Division which would inform and procure for us as soon as supplies are available.

Please provide the Excel sheet for calculating vaccine request duly completed

Remarks

- **Phasing:** Please adjust estimates of target number of children to receive new vaccines, if a phased introduction is intended. If targets for hep B3 and Hib3 differ from DTP3, explanation of the difference should be provided
- **Wastage of vaccines:** Countries are expected to plan for a maximum of 50% wastage rate for a lyophilized vaccine in 10 or 20-dose vial; 25% for a liquid vaccine in a10 or 20-dose vial; 10% for any vaccine (either liquid or lyophilized) in a 2-dose vial, 5% for any vaccine in 1 dose vial liquid.
- **Buffer stock:** The buffer stock is recalculated every year as 25% the current vaccine requirement
- **Anticipated vaccines in stock at start of year 2009:** It is calculated by counting the current balance of vaccines in stock, including the balance of buffer stock. Write zero if all vaccines supplied for the current year (including the buffer stock) are expected to be consumed before the start of next year. Countries with very low or no vaccines in stock must provide an explanation of the use of the vaccines.
- **AD syringes:** A wastage factor of 1.11 is applied to the total number of vaccine doses requested from the Fund, excluding the wastage of vaccines.
- **Reconstitution syringes:** it applies only for lyophilized vaccines. Write zero for other vaccines.
- **Safety boxes:** A multiplying factor of 1.11 is applied to safety boxes to cater for areas where one box will be used for less than 100 syringes

Table 7: Wastage rates and factors

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

3.3 Confirmed/revised request for injection safety support for the year 2009

Table 8: Estimated supplies for safety of vaccination for the next two years with …… *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 8a, 8b, 8c, etc. Please use same targets as in Table 5)* *Not Applicable*

		Formula	2009	2010
A	Target if children for ….. Vaccination (for TT: target of pregnant women) *(1)*	#		
B	Number of doses per child (for TT: target of pregnant women)	#		
C	Number of ….doses	A x B		
D	AD syringes (+10% wastage)	C x 1.11		
E	AD syringes buffer stock *(2)*	D x 0.25		
F	Total AD syringes	D + E		
G	Number of doses per vial	#		
H	Vaccine wastage factor *(3)*	Either 2 or 1.6		
I	Number of reconstitution syringes (+10% wastage) (4)	C x H X 1.11/G		
J	Number of safety boxes (+10% of extra need)	(F + I) x 1.11/100		

1 Contribute to a maximum of 2 doses for Pregnant Women (estimated as total births)

2 The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area.

3 Standard wastage factor will be used for calculation of reconstitution syringes. It will be 2 for BCG, 1.6 for measles and YF

4 Only for lyophilized vaccines. Write zero for other vaccines.

If quantity of current request differs from the GAVI letter of approval, please present the justification for that difference.

4. Health Systems Strengthening (HSS)

This section only needs to be completed by those countries that have received approval for their HSS proposal. This will serve as an inception report in order to enable release of funds for 2009. Countries are therefore asked to report on activities in 2007.

NOT APPLICABLE

Health Systems Support started in: _____

Current Health Systems Support will end in: _____

Funds received in 2007:	Yes/No	
	If yes, date received: (dd/mm/yyyy)	
	If Yes, total amount:	US$ _____
Funds disbursed to date:		US$ _____
Balance of installment left:		US$ _____

Requested amount to be disbursed for 2009 US$ _____

Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No
If not, why not? How will it be ensured that funds will be on-budget? Please provide details.

Please provide a brief narrative on the HSS program that covers the main activities performed, whether funds were disbursed according to the implementation plan, major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. More detailed information on activities such as whether activities were implemented according to the implementation plan can be provided in Table 10.

Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation?

In case any change in the implementation plan and disbursement schedule as per the proposal is requested, please explain in the section below and justify the change in disbursement request. More detailed breakdown of expenditure can be provided in Table 9.

Please attach minutes of the Health Sector Coordinating Committee meeting(s) in which fund disbursement and request for next tranche were discussed. Kindly attach the latest Health Sector Review Report and audit report of the account HSS funds are being transferred to. This is a requirement for release of funds for 2009.

Table 9. HSS Expenditure in 2007 in expenditure on HSS activities and request for 2009 (*In case there is a change in the 2009 request, please justify in the narrative above)*			
Area for support	**2007 (Expenditure)**	**2007 (Balance)**	**2009 (Request)**
Activity costs			
Objective 1			
Activity 1.1			
Activity 1.2			
Activity 1.3			
Activity 1.4			
Objective 2			
Activity 2.1			
Activity 2.2			
Activity 2.3			
Activity 2.4			
Objective 3			
Activity 3.1			
Activity 3.2			
Activity 3.3			
Activity 3.4			
Support costs			
Management costs			
M&E support costs			
Technical support			
TOTAL COSTS			

Table 10. HSS Activities in 2007	
Major Activities	**2007**
Objective 1:	
Activity 1.1:	
Activity 1.2:	
Activity 1.3:	
Activity 1.4:	
Objective 2:	
Activity 2.1:	
Activity 2.2:	
Activity 2.3:	
Activity 2.4:	
Objective 3:	
Activity 3.1:	
Activity 3.2:	
Activity 3.3:	
Activity 3.4:	

Table 11. Baseline indicators *(Add other indicators according to the HSS proposal)*						
Indicator	**Data Source**	**Baseline Value[1]**	**Source[2]**	**Date of Baseline**	**Target**	**Date for Target**
1. National DTP3 coverage (%)						
2. Number / % of districts achieving ≥80% DTP3 coverage						
3. Under five mortality rate (per 1000)						
4.						
5.						
6.						

Please describe whether targets have been met, what kind of problems has occurred in measuring the indicators, how the monitoring process has been strengthened and whether any changes are proposed.

[1] If baseline data is not available indicate whether baseline data collection is planned and when
[2] Important for easy accessing and cross referencing

5. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	14/05/2008	
Reporting Period (consistent with previous calendar year)	2007	
Government signatures	X	
ICC endorsed	X	
ISS reported on	X	
DQA reported on	X	DQSA was done in 2007. DQA was in 2002
Reported on use of Vaccine introduction grant	NA	*Already reported on in 2001*
Injection Safety Reported on	X	
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)	X	
New Vaccine Request including co-financing completed and Excel sheet attached	X	Covers only routine EPI
Revised request for injection safety completed (where applicable)	NA	Support ended in 2005
HSS reported on	NA	Application will be submitted in October 2007
ICC minutes attached to the report	X	
HSCC minutes, audit report of account for HSS funds and annual health sector evaluation report attached to report	NA	

6. Comments

ICC/HSCC comments:

The ICC recognises the progress being made by Ghana over the past three years in ensuring the purchase of vaccines. We are happy that with the bridge financing GAVI alliance is providing more subsidies for Yellow fever and the Pentavalent vaccines, which we hope would boost the ability of the country to sustain the EPI system.

As in 2006 and 2007 payment for Ghana's part of the pentavalent vaccine and the full cost for the other vaccines have been very challenging to the country due to cash flow problems. The new policy will be a big relief to us and would probably enable us to consider introduction of other new vaccines into the Ghana Immunization programme in the near future.

.

We hope the single dose pentavalent would be available to us as soon as possible to further reduce the cost of devices and facilitate storage

The ICC is eagerly awaiting the health systems strengthening support as it is hoped would be beneficial to the increasing the coverage of immunizations.

The ICC is charging the Technical Sub-Committee to develop a criteria for institution of an award system to good performing districts to serve as an incentive for better performance.

~ End ~