FUNDING REQUEST
Tailored to Material Change

SUMMARY INFORMATION			
Applicant	GHANA CCM		
Component(s)	**MALARIA**		
Principal Recipient(s)	GHANA HEALTH SERVICE (GHS) AND ANGLOGOLD ASHANTI MALARIA CONTROL LTD. (AGAMaL)		
Envisioned grant(s) start date	1ST JANUARY, 2018	Envisioned grant(s) end date	31ST DECEMBER, 2020
Allocation funding request	*103,724,222*	Prioritized above allocation request	*46,621,165*
GF Initial Allocation	*111,531,421*		

SUMMARY INFORMATION			
Applicant	GHANA CCM		
Component(s)	**RSSH**		
Principal Recipient(s)	GHANA HEALTH SERVICE (GHS)		
Envisioned grant(s) start date	1st January, 2018	Envisioned grant(s) end date	31st December, 2020
Allocation funding request	*12,150,015*	Prioritized above allocation request	4,528,000

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying *Funding Request Instructions: Tailored to Material Change*;
- Refer to the *Information Note* for each component as relevant to the funding request, and other guidance available, found on the Global Fund website;

- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in Annex of the Instructions;
- Ensure consistency across documentation before submitting.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related guidance for more information.

This funding request includes the following sections:

Section 1: Context related to the funding request
Section 2: Program elements proposed for Global Fund support, including rationale
Section 3: Planned implementation arrangements and risk mitigation measures
Section 4: Funding landscape, co-financing and sustainability
Section 5: Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context and highlight the need for material change to programming. It should refer to the existing and latest sources of information available, particularly (but not limited to) national health plans and other national strategy documents. This information is critical for justifying the choice of interventions under the funding request.

To respond, refer to additional guidance provided in the *Instructions.*

MALARIA

1.1 Background: Material Change triggers	
Indicate below the area(s) of change that most accurately describes the need for revising the programming of certain areas. Refer to the *Instructions* and the *Operational Policy Note on Access to Funding and Grant-making* (*forthcoming*) for material change definition and triggers.	
1. Epidemiological contextual updates	
Are there any relevant changes in the country's epidemiological context as compared to the previous funding request (e.g. important changes in trends in incidence/notification rates or prevalence, key drivers of the epidemics, emerging high risk behaviors, drug/insecticide resistance, or coverage of interventions in the general population or specific key populations based on the latest surveys or other data sources)?	☒ Yes ☐ No
2. National policies and strategies revisions and updates	
Are there new approaches adopted within the national policy or strategy for the disease program (e.g. Test and Treat guidelines for HIV, short-term regimens for MDR-TB, shift in interventions from Malaria control to pre-elimination, expanded role of the private sector)?	☒ Yes ☐ No
3. Investing to maximize impact towards ending the epidemics	
Referring to available evidence and inputs from technical partners and key stakeholders, does the current program continue to be relevant, and is it progressing and generally on track to achieve results and impact?	☒ Yes ☐ No
4. Alignment with 2017 – 2022 Global Fund Strategy Objectives 2 and 3	
Objective 2 to Build Resilient and Sustainable Systems for Health	
Are changes in Resilient and Sustainable Systems for Health (RSSH) investments needed in order to maximize Reproductive Maternal Neonatal and Child Health impact, (RMNCH) or other RSSH areas?	☒ Yes ☐ No
Objective 3 to Promote and Protect Human Rights and Gender Equality	
Is there a need for intensifying efforts to address human rights and gender-related barriers to services and to ensure appropriate focus on interventions that respond to key and vulnerable populations?	☐ Yes ☒ No
5. Effectiveness of implementation approaches	

Are the current implementation arrangements effective to deliver on the program objectives and anticipated impact (including the Principal Recipient and the main sub-recipients)?	☒ Yes ☐ No
6. Sustainability, transition and co-financing	
Are there changes in domestic or international financing (e.g. due to withdrawal of a major donor or significant increase in domestic allocation/funding), resulting in material impact on funding availability for programmatic interventions and sustainability?	☒ Yes ☐ No
Is your country's 2017-2019 Global Fund allocation for the disease component is significantly lower as compared to the current grants' spending levels[1]?	☒ Yes ☐ No
7. Others:	
Specify:	

Resilient and Sustainable Systems for Health (RSSH)

1.1 Background: Material Change triggers	
Indicate below the area(s) of change that most accurately describes the need for revising the programming of certain areas. Refer to the *Instructions* and the *Operational Policy Note on Access to Funding and Grant-making* (*forthcoming*) for material change definition and triggers.	
1. Epidemiological contextual updates	
Are there any relevant changes in the country's epidemiological context as compared to the previous funding request (e.g. important changes in trends in incidence/notification rates or prevalence, key drivers of the epidemics, emerging high-risk behaviors, drug/insecticide resistance, or coverage of interventions in the general population or specific key populations based on the latest surveys or other data sources)?	☐ Yes ☐ No X N/A
2. National policies and strategies revisions and updates	
Are there new approaches adopted within the national policy or strategy for the disease program (e.g. Test and Treat guidelines for HIV, short-term regimens for MDR-TB, shift in interventions from Malaria control to pre-elimination, expanded role of the private sector)?	☐ Yes ☐ No X N/A
3. Investing to maximise impact towards ending the epidemics	
Referring to available evidence and inputs from technical partners and key stakeholders, does the current program continue to be relevant, and is it progressing and generally on track to achieve results and impact?	☒ Yes ☐ No
4. Alignment with 2017 – 2022 Global Fund Strategy Objectives 2 and 3	
Objective 2 to Build Resilient and Sustainable Systems for Health	
Are changes in Resilient and Sustainable Systems for Health (RSSH) investments needed in order to maximise Reproductive Maternal Neonatal and	☒ Yes

[1] We suggest to compare the new allocation amount with the current spending on a yearly basis, past and/or forecasted. For example using the last year spending multiplied by 3.

Child Health impact, (RMNCH) or other RSSH areas?	☐ No
Objective 3 to Promote and Protect Human Rights and Gender Equality	
Is there a need for intensifying efforts to address human rights and gender-related barriers to services and to ensure appropriate focus on interventions that respond to key and vulnerable populations?	☒ Yes ☐ No
5. Effectiveness of implementation approaches	
Are the current implementation arrangements effective to deliver on the program objectives and anticipated impact (including the Principal Recipient and the main sub-recipients)?	☐ Yes ☒ No
6. Sustainability, transition and co-financing	
Are there changes in domestic or international financing (e.g. due to withdrawal of a major donor or significant increase in domestic allocation/funding), resulting in material impact on funding availability for programmatic interventions and sustainability?	☒ Yes ☐ No
Is your country's 2017-2019 Global Fund allocation for the disease component is significantly lower as compared to the current grants' spending levels[2]?	☐ Yes ☐ No X N/A
7. Others:	
Specify:	

[2] **We suggest to compare the new allocation amount with the current spending on a yearly basis, past and/or forecasted. For example using the last year spending multiplied by 3.**

1.2. Summary of country context
Given the above, a) Describe the reasons for programmatic changes which form the basis of your funding request, as applicable (e.g. refocusing to high impact interventions, epidemiological changes, alignment with the latest normative guidelines, changes to funding landscape, etc.) b) As applicable, specify how these changes relate to key and vulnerable populations and human-rights and gender considerations; c) Describe how the request builds on lessons-learned from existing and other donors' programs. (maximum 1 page per component)

[*Applicant response*]: **This grant is being submitted together with the RSSH request.**

MALARIA

Efficiency savings identified through a rigorous budget revision in early 2016, enabled extension of IRS and Private Sector Copayment Mechanism (PSCM) to 2017. Following the impact on severe malaria (protective efficacy of 48% in Upper West)[3], SMC was expanded to an additional region (Upper East). Malaria parasite prevalence reduced from 26.7% (2014) to 20.4% (2016) {*DHS 2014, pg 201; MIS 2016, M.Annex 1*}; malaria mortality reduced by 40% from 2010-2015 [*2016 WMR, pg 71*].

We intend to sustain the gains made in the past grant and maximize impact (see section 2 for details) by maintaining the scope and scale of case management, SMC, IPTp, vector control, including maintaining the current balance between ITNs and IRS *(M.Annex 2)* in the next grant. The PRs for the malaria grant remain unchanged {Ghana Health Service (GHS), AngloGold Ashanti Malaria Control Limited (AGAMal)}. Few programmatic changes however, will be made as listed below and detailed in section 2.

a) **Reasons for programmatic changes forming basis for funding request**;

i)Resistance to Pirimiphos methyl for IRS in Obuasi, increased from 5% (2015) to 28.3% (2016). In other IRS areas however, it remains effective (susceptibility: 98-100%). *[Refer draft Insecticide Resistance Management Plan (IRMP),pg.23-25].* To mitigate the resistance in Obuasi and avoid its emergence in other areas, the IRMP, which outlines rotation of current and next generation insecticides, will be adopted for implementation from 2017.

ii) Changes to refocus high impact interventions: *ITN mass campaign distribution will be changed* from the current rolling (30 months) to one consolidated campaign (6-8 months); to reinvest transactional cost savings and minimize time spent on implementation. This will include enhanced targeting to disadvantaged and vulnerable populations, such as hard-to-reach locations and teenage girls who sleep at market places.

Private sector co-payment mechanism (PSCM) will continue, but resources will be reallocated from urban and non-critical rural areas[4] to higher return rural areas, thus ensuring access of quality and affordable ACTs to vulnerable and under-served populations, while addressing sustainability issues (see section 2 for details).

Malaria vaccines will be piloted in 2018 in selected districts by WHO, PATH and Government of Ghana (GoG), with support from the GF catalytic funding, UNITAID and GAVI but will not affect implementation of existing malaria interventions in these areas.

iii) Changes in Funding Landscape: GoG has increased the health sector budget by 35% from $852,895,049 (2017) to $1,149,640,148 (2019) *(Annual budget statement 2017 Financial Year, appendix 4b, c &d)*. USAID/PMI contribution has reduced from $28m (2015-2017) to $26m (2018-projected). There is currently no commitment from DFID for SMC (DFID supported SMC in the past). There has been a 19% reduction in the GF 2017-2019 funding

[3] Ansah et al; SMC Evaluation Report, 2016, pg. 17
[4] NMCP, Draft PSCM Rapid Assessment Report, 2017, pg 27-32

allocation as compared with current grant spending. To offset the effect of the reduction in funding, whilst expanding geographical coverage for IRS, including in prisons, the country signed an MOU with NGenIRS, to subsidize insecticides in 2016 from US$25 to US$15 per unit; this will continue in the next grant period. Against Malaria Foundation (AMF) increased support in ITN procurement from 2.7 million ITNs in 2016 ($7,209,000) to 3.6 million nets (US$ 7,560,000) in 2018.

b. Vulnerable and Key population: Current interventions aim at universal coverage of the entire population of Ghana, but given the higher vulnerability of children under five and pregnant women, efforts are made to increase coverage of these groups, with IPTp and ITNs through ANC; ITNs through EPI and community management of malaria, through CHPS, to enhance treatment coverage in hard to access rural areas. In addition, we will target orphanages, hard-to-reach locations (e.g. island communities) and teenage girls sleeping at market places ("Kayayei"). IRS in prisons will protect about 13,000 inmates from malaria. The proposed continuation of PSCM, coupled with community management of malaria, will ensure rural poor continues to benefit from affordable ACTs.

c. **Key lessons learnt were**:

i) "Last mile distribution" is key to ensuring commodities reach end users, hence the joint application with RSSH request.
ii) Use of more interpersonal SBCC instead of mass media, improves on ITN utilization[5];
iii) Withdrawal of IRS leads to upsurge in malaria parasitaemia (even where there are ITNs), thus need for continuity; for instance, parasite prevalence in UER increased from 11% in 2014 to 14% in 2016.
iv) Institutionalizing on-the-job training and supportive supervision based on lessons learnt from PMI improves performance; enforcing testing before treatment leads to rationale use of ACTs[6].

RSSH

a) Country context

Despite all the gains made by the programmes (HIV, TB, malaria) over the years, various reviews have shown that, but for systematic challenges in the areas of Procurement and Supply Chain Management (PSCM), Financial Management (FM), Community Systems Strengthening (CSS), Human Resource for Health (HRH) and Health Management Information System (HMIS), greater impact could have been achieved (*Holistic Assessment Reports 2015; Ghana Supply Chain Economic Case Study, 2016).*

PSCM: The health sector has approved the Supply Chain Master Plan (2016). Key strategies in the SCMP including Framework Contracting, LMD, LMIS, Quality Assurance and Optimisation of Warehousing, are being implemented with support from GF, USAID, US Government and GoG. Currently, there are still episodes of expiry of health commodities. There are also delays in distribution of health commodities to health facilities resulting in stock outs *(Ghana Supply Chain Economic Case Study, 2016 pp 55-60).* The absence of a comprehensive LMIS has contributed to challenges in inventory control and management of health commodities (stock out and expiration). Last Mile Distribution (LMD) has been initiated in six (6) regions with support from Global Fund, USAID and GoG from 2016. These current efforts need to be further strengthened and expanded to ensure commodity availability and timeliness at service delivery points.

[5] Megan A. Prilutski, A brief look at effective health communication strategies in Ghana; http://www.elon.edu/docs/e-web/academics/communications/research/vol1no2/04PrilutskiEJFall10.pdf

[6] Amo-Sakyi et al ; Using Outreach Training and Supportive Supervision (OTSS) to monitor adherence to updated malaria case management guidelines in the Eastern region of Ghana;

FM: Government of Ghana has put in place a PFM Act, GIFMIS and revised the Procurement Act (Public Procurement Act 951). The current Global Fund grant is supporting the three programmes to improve on the timeliness of reporting programme expenditure and assurance mechanisms. Current challenges in financial management include accounting for advances, timely reporting of financial statements, adherence to financial management and control procedures and delays in grant implementation and absorption capacity. The new Public Financial Management Act 2016 (PFMA) Act 921 introduces sanction regime that promote commitment control, transparency and accountability in use of resources. There is the need to build capacity for implementation in the new Acts[7].

CSS: Healthcare services are increasingly being made available at the community level through the implementation of CHPS, e.g. PMTCT and iCCM. This results in increased responsibilities to manage the add-on services. However, community-level response and contribution to this effort is suboptimal, because of inadequate resources and weak collaboration between the community-level health structures and the activities of CSOs. There is the need to improve collaboration between CHPS and CSOs, and support CHPS in its primary function of providing health services. CSOs on the other hand will spearhead social mobilization, advocacy, monitoring and reporting.

HMIS: The health sector is using DHIMS as the main heath data repository for reporting all health information (health indicators) for decision making; (though coverage gaps still exist in the private sector). The e-tracker which is transactional software was successfully piloted in 86 facilities in 4 districts. Currently, GOG, GF, UNICEF and GAVI are supporting its expansion to cover EPI, MCH, TB, Malaria and HIV services. The expansion of the e-tracker includes the provision of tablets, training in the e-tracker and availability of internet connectivity. The priority target for the e-tracker is at the community level (CHPS Zones).

b) Impact on vulnerable and KPs, human rights and gender considerations

In small communities, key and vulnerable populations face a higher risk of stigma and discrimination due to the decentralization of healthcare services (e.g ARV) to the community level.

c) Lessons learnt

i. PSCM: Initial implementation of LMD in 6 regions has improved commodity availability at the service delivery points in these regions and shows strong local support by the Regional Health Management Teams.[8,9]
ii. FM: The use of electronic financial management and monitoring tools coupled with capacity building improved accuracy and timeliness of reporting for auditing of programs at the national level. However, this needs to be scaled up to the regional and decentralized level.
iii. CSS: Collaboration between community stakeholders, program staff and healthcare facilities improved service uptake and immunization coverage on hard to reach areas[10].
iv. HMIS: The deployment of e-Tracker in GHS has shown to be effective in reducing manual reporting at the community level. Additionally, e-Tracker has further led to increased timeliness in reporting as well as retention of patients in care.[11].

[7] Budget Statement and Economic Policy of Government of Ghana for 2017 Financial year; pp38

[8] Ghana Supply Chain Economic Case Study, (2016).

[9] Last Mile Distribution of Health Commodities in Ghana Transportation Resources Needs 2016
[10] Gavi HSS, ISS, CSO Support Evaluation Report 2015 pp 14, Ministry of Health
[11] GHS Health Information Exchange Implementation by CHIM; https://www.google.com.gh/?gfe_rd=cr&ei=X8UiWe2rM8Kp8wegmZeQAg#q=etracker+ghana+health+service+ppt; accessed on 22 May 2017

SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget.

To respond, refer to additional guidance provided in the *Instructions.*

2.1 Funding request

Describe the funding request for the disease program(s) by specifying the changes to the current funded program, taking into account the existing programmatic and financial gaps that now need to be addressed, and how the changes in certain program areas affect the scope/scale of the Global Fund investments.

Additionally, outline in particular:

a) The changes to the (i) Performance Framework such as impact on targets, geographic coverage, or the diversity/quality of the service packages, (ii) budget

b) How the proposed revisions will ensure:
   i. continued scale up where feasible;
   ii. effective and efficient use of Global Fund investments;
   iii. maximum impact for ending epidemics HIV/AIDS, TB and malaria;

c) How the proposed investment ensures appropriate focus on building resilient and sustainable systems for health, and key and vulnerable population programs as applicable.

For joint applications: ensure the answer appropriately reflects the separate disease programs in addition to cross-cutting modules where appropriate, and expected coordination and resulting efficiencies and impact achieved from the joint programming.

Ensure also that that the funding request meets the focus of application requirement[12] as outlined in the allocation letter.

(maximum 3 pages per component)

[*Applicant response*]:

MALARIA

This request will help reduce malaria parasite prevalence among children aged 6-59 months, from 20.4% in 2016 to 14% by 2020; and inpatient malaria deaths from 4.4/1000 persons in 2016 to 2/1000 persons by 2020 (*see Performance Framework [PF]).*

We will continue to implement case management (public, community and private), SMC, IPTp, ITNs and IRS, supported by program management, M&E and IE&C.

The prioritized total funding need for malaria for 2018-2020 is $256,991,839. The Government of Ghana (GoG) and key partners, will contribute $23,423,248 (9%) and $ 83,223,204(32%) respectively, for the period 2018-2020, leaving a funding gap of $ 150,345,387(59%), of which $ 103,724,222 (69%) is requested within allocation and 46,621,165 (31%) in the above allocation *(M.Annex 3)*

Prioritization within allocation was based on first, impact on mortality; then, malaria prevalence; focus on vulnerable populations; negative impact if intervention is withdrawn and availability of alternative source of funding. Prioritization was done in consultation with key

[12] Refer to the Global Fund 2017 Eligibility List for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund Sustainability, Transition and Co-Financing Policy.

stakeholders such as CSOs, private sector, academia, parliamentary select committee on health and donor partners *(see M.Annex 4).*

Case Management

Malaria diagnostic test rate (Microscopy & RDT) will be improved from 77% in 2016 to 100% by 2020, while increasing rational use of ACTs by treating 100% of confirmed malaria cases. We will continue with health facility based diagnosis and treatment (public and private). To sustain continuous competence of prescribers in diagnosis and treatment, onsite training and supervision (OTSS) by PMI will continue in five regions, whilst Global Fund support in the remaining five regions will start in 2017 and continue in the next grant.
iCCM has been integrated into Community Health Planning and Services(CHPS) strategy which includes malaria management. (*CHPS Implementation Guidelines 2016, p.g 1-5*). This is in line with the Government's CHPS Policy which envisages expansion of CHPS from coverage of 4,400 functional CHPS zones to 6,548 by 2020 (*DHIMS Analysis*). This integration will benefit community based management of malaria. Children treated with ACTs at the community level will increase by 14%: from 1,249,910.00 in 2016 to 1,421,770 by 2020. All (100%) ACTs and RDTs will be procured through this application.

The total funding need for case management is $72,219,441, out of which GoG and PMI are contributing $11,616,905 (16%) and $ 26,152,000 (36%) respectively; leaving $ 34,450,536 (48%), all of which is requested within allocation, from the Global Fund. This request will cover facility-based treatment sites (public and private sector). It includes ACTs, RDTs, injectable artesunate and supportive interventions such as, efficacy monitoring and IE&C.

The total ACT need for health facilities (2018-2020) is 19,594,918, comprising 11,463,026 (58.5%) for public sector, including community level through CHPS and 8,131891 (41.5%) for private sector facilities (to be fully funded by private sector). Out of the public sector needs, 4,000,000 (35%) is covered by PMI and the rest, 7,463,027(65%) is requested within allocation.

The total RDTs need (2018-2020) is 53,432,113 comprising 31,257,786 (58.5%) for public sector, including community level and 22,174,327 (41.5%) for the private sector (to be fully funded by private sector). Out of the public sector needs, 6,500,000 (21%) is covered by PMI and the rest, 24,757,786 (69%) is requested within allocation.

The total injectable artesunate need (2018-2020) is 5,874,328 out of which 1,350,000 (23%) is covered by GoG (900,000) and PMI (450,000) and the rest, 4,524,328 (77%) is requested within the allocation (*see programmatic gap analysis*).

Out of the total request of $34,450,536 for case management, $28,938,589 (84%) is for commodities and $5,511,947 (16%) is for continuing existing supportive interventions including quality assurance ($37,611) and pharmacovigilance ($119,175); working together with Pharmacy Council and Food and Drugs respectively. The existing system for reporting all adverse reactions to antimalarial drugs, will be improved by ensuring active reporting by prescribers and consumers through the existing channels.

<u>Private Sector Copayment Mechanism (PSCM)</u>

PSCM will continue, but to ensure better targeting for impact, it will be limited to rural areas[13], to benefit vulnerable and under-served populations, viz. increased access to quality assured and affordable ACTs, through pharmacies and licence chemical sellers. An MOU will be signed with first-line buyers to ensure compliance, re-enforced by monitoring, in collaboration with Pharmacy Council.
A process has been initiated to transition from the current co-payment program, through a phased approach: from urban and rural to rural only; then, to total weaning off. To ensure that vulnerable and rural groups, benefiting from PSCM, are not disadvantaged, the transition plan will leverage on a strengthened community case management, through CHPS, supported by an improved NHIS. By the time the co-payment is phased out from the rural

[13] NMCP, Draft PSCM Rapid Assessment Report, 2017, pg 27-32.

areas, CHPS will be fully operational. Throughout all these phases, ACT prices, ACT availability and access of affected populations to case management, will be closely monitored.

In the 2015-2017 grants, the amount allocated for PSCM was $22,028,574. The current request is $ 7,394,924, representing a 66% reduction; $2,103,159 (28%) is requested within allocation to co-pay 2,242,585 doses and monitor ACTs prices and access. The rest will be requested for, under PAAR.

Vector Control

There will be no overlap between Long Lasting Insecticide Nets (ITNs) and Indoor Residual Spraying (IRS) *[see M.Annex 5]*. Within the allocation, 6% of the population will be covered by IRS while 94% by ITNs as shown in *Table 1*.

Table 1: Population to be covered by IRS and ITNs in Ghana within Allocation, 2018-2020

Population per Intervention/Year	2018	2019	2020
IRS	1,731,563 (6%)	1,778,357 (6%)	1,826,422 (6%)
ITNs	28,312,818 (94%)	29,017,134 (94%)	29,738,956 (94%)
Total	30,044,381	30,795,491	31,565,378

ITNs: For this request, the proportion of households with at least one insecticide-treated net will increase from 73% (2016) to 82% (2020), due to mass campaign and better targeting.

ITN mass campaign distribution will be changed from the current rolling (30 months) to one consolidated campaign (6-8 months); to ensure transactional cost savings and minimize time spent on implementation. This will include enhanced targeting to disadvantaged and vulnerable populations, such as hard-to-reach locations and teenage girls who sleep at market places, in collaboration with partners including CSOs/NGOs. There will be concurrent regional planning and execution as against previous sequential implementation. Routine distribution of ITNs will continue nation-wide (excluding IRS areas) targeting pregnant women through ANC, children under five through EPI, and school children through school distribution (in collaboration with Ghana Education Service). In the year of mass campaign (2018), there will be no routine distribution in schools. Interpersonal SBCC will be implemented through CSOs/NGOs at community level, to enhance use of ITNs.

The total ITNs need for the 2018 mass campaign would have been 15,729,344 nets. However, due to a spill-over of 4,247,300 nets, covered by GBF 2017 budget, the need is now 11,482,044 nets. Out of this, 7,900,000 (69%) is funded by partners (PMI-4,300,000 and AMF-3,600,000), leaving a gap of 3,582,044 (31%), all of which, is being requested for, within the allocation.

The total ITNs need for routine distribution for 2018-2020 is 9,078,033 (ANC-3,134,481; EPI-3,134,481; Schools-2,809,072). Out of this, 2,600,000 (28%) is funded by PMI, leaving a gap of 6,478,033, all of which is being requested for, within the allocation.

A total of $27,435,042 is being requested within allocation. This amount will cover: $10,465,290 for mass campaign in 2018; $15,260,748 for routine; $1,253,301 for IEC and $455,703 for insecticide resistance monitoring, in 20 existing sentinel sites, spread across the country,

IRS: IRS implementation is being sustained in 19 high transmission districts (PMI is covering 7 in Northern region; whiles GF through AGAMal, covers 11 in Upper West and Obuasi in Ashanti region within allocation) {*M. Annex 5*}. A population of 1,826,422 in (310,860 households) will be covered by 2020 *(Table 1)*.
To address the emerging insecticide resistance, the programme will continue with its on-going monitoring, finalization and implementation of IRMP [*Draft IRMP, 2017, pg. 27-32*]. The

existing arrangement with NGenIRS, which has helped expand coverage to 4 new districts (PMI-1 in NR, AGAMal-3 out of 10 districts in UER) at no additional cost, provides further opportunity to access co-paid 3rd generation insecticides.

IRS funding need for the country is $64,783,428, out of which $16,650,000 (26%) is available from partners (15,150,000-PMI, $1,500,000-AngloGold Ashanti Company Limited), leaving a gap of $48,133,428 (74%). Out of this, $17,292,924 (36%) is being requested for 12 districts (Obuasi and Upper West-11) in 2018-2019 and Obuasi in 2020 within allocation. The rest is being requested for under PAAR [*see section 5 for details*].

Although the total IRS target population is only 6% of the country, these constitute the poorest and most vulnerable communities living in the high burden area, thereby rendering the investment worthwhile. Evidence from MICS 2011 and MIS 2016 reveal the combined impact of IRS and SMC in addition to other interventions, have led to one of the fastest reductions in disease burden (>60%) over a period of 5 years (2011 – 2016), as compared to 25% reduction in overall prevalence in Ghana [*Refer M.Annex. 1, UWR*].

Specific Preventive Interventions (SPI)

Intermittent Preventive Treatment (IPTp): Nationwide coverage of IPTp will be maintained and the proportion of pregnant women attending antenatal clinics, who receive three or more doses of IPTp, will increase from 36.4% (2016) to 61% by 2020. This will be achieved through continuous collaboration with Reproductive, Maternal, Neonatal, Child and Adolescent Health program and CSOs/NGOs. Previously IPTp was initiated by only midwives but community health and general nurses are being trained by the family health division to be able to initiate IPTp to improve coverage.

SP tablets needed for 2018 are 8,111,983 which are covered by GoG (26%) and PMI (74%). The SP need for 2019-2020 is 14,213,081 out of which, 10,659,811 (75%) is covered by GoG, leaving a gap of 3,553,270 (25%), all of which is requested within allocation; as there is currently no commitment from partners (including PMI) for 2019-2020.

For 2018, GoG and PMI will cover 100% SP financial need ($292,721 [26%] and $831,600.00 [74%] respectively). For 2019-2020 however, GoG will cover 75% ($1,969,933) of SP needs whilst 25% ($656,644) is being requested within allocation. In addition, $ 2,126,290 is being requested for supportive interventions (2018-2020) within allocation. The programme will conduct high level advocacy to ensure timely procurement of quality SP.

Seasonal Malaria Chemoprevention (SMC): Current implementation of SMC will be maintained at coverage of at least 85.5% (of 1,719,111 under five populations) for all four rounds in Upper West (UWR) and Upper East regions (UER) regions, by 2020.

The total financial need is $ 19,027,963; out of which $8,539,067 (45%) is being requested within allocation for whole of UER and UWR for 2018-2020: ($1,743,768 for AQ-SP; $ 6,795,299 for orientation, IE&C, dosing, data management, supervision and pharmacovigilance). There is currently no commitment from partners for SMC, including DFID, which supported SMC in the past. So the rest, which is an expansion to Northern region, is being requested under PAAR.

Surveillance, Monitoring and Evaluation (SM&E)

This grant request will continue to cover malaria specific M&E activities such as OTSS; data quality reviews; sentinel surveillance for antimalarial drug efficacy; parasite prevalence; insecticide resistance; NGOs/CSOs activities; efficacy and durability of ITNs. In addition, Malaria Indicator Survey, will be undertaken, on impact and outcome indicators (such as household net ownership, usage for under 5 and pregnant women). This grant will also complement the PMI-funded OTSS approach, and the significant data strengthening work done in the current grant.

Support for integrated web-based District Health Information Management System (DHIMS) is integrated in the RSSH request (e.g e-tracker implementation), which seeks to enhance efficiency for evidence-based data analysis to support management decisions at national and decentralized level (*see RSSH obj 4*).

The total prioritized funding need for SM&E is $14,193,229; out of which, GoG will contribute $4,393,800 and PMI will support with $2,337,000 leaving a gap of $7,462,430; all of which, is being requested within allocation for 2018-2020. Funding for some of the activities includes: OTSS -$2,346,278; Antimalarial Efficacy Testing- $53,340; Efficacy and durability of LLINs-$80,978; Sentinel sites for parasite prevalence-$355,741; Insecticide Resistance Monitoring-$455,704 and Monitoring of CSOS/NGOs-$150,549.

Programme Management

Programme management will be strengthened to ensure efficient and effective implementation of interventions, with improved coordination of partners, through technical working groups and implementation partners meetings; as well as supervision of all malaria control activities. The allocation request will continue to cover cost of utilities, stationery, regional and national stakeholders' meetings; maintenance of vehicles, infrastructure and office equipment. Besides these, there will be effective, efficient and accountable use of financial resources, as well as strengthened in-country procurement and supply chain system under the RSSH request (*RSSH obj 1&2*).

The total prioritized need for Programme Management for 2018-2020 is $10,302,297 with available resources amounting to $6,644,166 (GoG-2,189,166 and PMI-$4,455,000) leaving a gap of $3,658,131; all of which, is requested under allocation. Funding for some of the activities for GHS/NMCP includes: malaria program review-$59,588; procurement of office supplies-52,237; HR cost – $1,351,435, Utility service – $82,856 and external audit cost – $238,521.

How proposed investment ensures appropriate focus on RSSH and key and vulnerable population: RSSH strategy [*see RSSH Annex 2*], will augment malaria-specific HSS activities such as procurement and distribution of commodities, financial audits, data quality reviews and supportive supervision, which have been included in this grant.

Investments in IRS, ITNs, PSCM and ACTs procurement for community case management will benefit rural poor, hard-to-reach locations and teenage girls sleeping at market places. IRS in prisons will protect inmates from malaria.

RSSH

The objectives of the RSSH and its interrelationship in addressing the challenges identified in the programmes are presented in RSSH Annex 2. A summary budget for the key interventions is in RSSH Annex 1.

Module 1: Procurement and Supply Chain Management Systems

Objective 1: To improve timely availability of quality commodities at the service delivery points

Support the ongoing development and implementation of a functional LMIS

The current request is to further improve accessibility and visibility of consumption data of health commodities for the three diseases. Specifically, the capacity at all levels will be built on LMIS; there will be continuous monitoring and evaluation to ensure technical adherence. Global Fund is supporting LMIS and Last mile distribution, with US$310,876, and some technical support from USAID. GoG has also committed US$2million for 2017. An amount of US$2,164,010.50 is being requested within allocation and US$970,000 above allocation for the development of a transition plan that addresses Service Level Agreements, maintenance and capacity building.

Implement Last Mile Distribution (LMD)
The request to implement LMD will ensure commodity availability and security at all levels (Refer to HIV, TB and Malaria funding requests). There will be orientation of Regional Medical Store Staff, District Directors, Medical Superintendents, Hospital Administrators; printing and dissemination of ordering tools and delivery schedules; pre LMD implementation assessment; evaluation of LMD and conduct monitoring and supervision at the Regional Medical Stores and health facilities. GAVI is currently supporting capacity building for regional level supply chain managers with an amount of US$50,000.00. Currently, implementation has started in 6 Regions and US$1,943,272.32 is being requested to continue implementation in the 6 regions and initiated in the remaining 4 Regions.

Standardization and Optimization of Warehousing: This request will be used to standardize and optimize warehousing at all levels. Specifically, warehousing and distribution policies will be developed; resources will be provided for licensing and standardization of CMS, RMSs and Teaching Hospitals and a warehouse will be constructed in one region. **An amount of US$1,426,814.08 for, within the allocation.**

Module 2: Financial Management Systems
Objective 2: To enhance the effectiveness, efficiency and accountability in the use of financial resources
This funding request will be used to develop software systems and automate accounting and expenditure processes at all levels. This will help improve accountability and timeliness of financial reports. Capacity for planning, financial analysis, coaching and mentoring (at sub-district level) would be strengthened. Supervision and monitoring would be strengthened to address challenges in accounting for advances and efficiency in resource use. Standard surveys (NHA and NASA) would be undertaken annually to track health expenditure including those on the three diseases (TB, HIV and Malaria). In addition, such surveys would be institutionalized to reduce the cost of the process in future. The total funding request for this objective is US$2,407,438.42. This includes US$391,606 for NHA and NASA; US$676,285 for automation and integration of accounting and internal control systems and processes; US$599,152 to strengthen monitoring and supervision systems and US$ 740,396 to build capacity in financial management including planning and budgeting.

Module 3: Community Responses and Systems
Objective 3: To strengthen community systems for social accountability and policy advocacy to improve access and service quality
The funding request is to support community-led social accountability and advocacy efforts to complement Government's effort in strengthening CHPS towards universal health coverage.

Strengthen Non-State Actors (NSA) access to training and other resource materials: Despite the investments for capacity building of NSAs, there still is a gap in their technical know-how as well as access to relevant documents. This negatively impacts on their capacity for analysis and advocacy for appropriate reforms in favour of vulnerable populations. A website will be created to provide one-stop shop to all relevant materials and documents. This will be managed by one of the network CSOs. A budget of US$19,706 is being requested to support this effort.

Enhance social mobilisation at the community level: Findings from CHPS evaluation CHPS strategy documents that CHMCS have weak social mobilisation capacity at the community level, which constrains the implementation of the CHPS strategy. In this request, CHMCs will be equipped to mobilise communities (infected and affected) to advocate for service access and quality including ART, TB, MCH and PMTCT services. An amount of US$388,878 is requested to enhance the capacity of CHMCs to mobilise communities (affected and infected) to demand improved access and quality of services.

Strengthen community level monitoring and reporting: This funding request will support CSOs to track and report on service access and quality using existing community scorecards

and scoreboards covering availability and access to ARVs and TB drugs as well as quality of care concerns. A total of US$$624,824 is requested to support this activity.

Strengthen advocacy and social accountability at all levels: While the regional SAMCs have been very effective monitoring and advocacy at the national level, advocacy at the decentralised and community levels require attention. Under this activity, SAMCs will continue to be strengthened and scale-up to the district and community levels. GAVI and Global Fund have allocated $20,000 and $50,000 respectively to support advocacy activities. However, a total of US$929,847 is required for this activity.

CSS Project Coordination and Management: To effectively coordinate the activities of the SR and other SSRs to implement these activities, a budget of US$652,840 is being requested to support the implementation of this activity.

Module 4: Health Management Information Systems and M&E

Objective 4: To improve availability of strategic information for decision making at all levels

Scale-up of e-Tracker: This request will be used to scale up the e-tracker from 4% coverage of health facilities to 40% by 2020, to ensure reliable coverage data to monitor programme effectiveness and clients' retention in care. The e-Tracking system which is integrated with DHIMS2 has been deployed for monitoring MCH services in 86 facilities in four districts and TB treatment follow-up in 113 TB burdened districts. A phased scale-up of this initiative to track PMTCT, MCH, EID, TB treatment, OPD, ART and HTS services has been planned. UNICEF is providing US$ 50,358 to deploy e-Tracker to 54 PMTCT sites in Eastern region in 2017 while Global Fund's data strengthening funds (US$1.5M) is also deploying OPD e-Tracker in 1000 CHPS Zones and Health Centers in Ghana. The request is to fill a funding gap of US$474,147.

Implementation of Human Resource Information System integrated with DHIMS2: This funding request will be used to develop and implement a functional Human Resource Information System (HRIS) linked with DHIMS2. It will provide accurate and reliable human resource information to support strategic and operational decision-making and to link service data to staff productivity. An amount of US$353,713.60 is being requested within allocation.

Second line data quality audit for TB, HIV/AIDS and Malaria: This funding request is to strengthen the availability of quality and timely data for programmatic decision. The Centre for Health Information Management (CHIM) undertakes a quarterly second line data quality assurance for the three GF programmes and others. An amount of US$200,000 is being requested to strengthen the availability of quality and timely data for programmatic decision.

Implement National Health Workforce Account (NHWA) including Health Labour Market Assessment: This funding request is to implement National Health Workforce Account (NHWA) to ensure the availability of accurate and timely HRH data for decision making. The 2014 Holistic Assessment of the health sector programme of work captured the need for Ghana to undertake a comprehensive health labour market assessment to generate evidence for strategic HRH investment. This will ensure availability information for planning the right numbers and skill mix of workforce for the Global Fund-supported programmes among others. An amount of US$117,997.60 is being requested within allocation.

Support the implementation of Task-Sharing including HIV, TB, Malaria services: This funding request is to support the implementation of the task-sharing initiative in the management of HIV and TB comorbidities. GHS has developed a Task-Sharing policy to help scale up key interventions for the attainment of health targets including the 90-90-90 HIV treatment targets. The cost of implementing the task-sharing policy is US$261,107 of which WHO provided US$21,000 for policy development and baseline survey. MAF also provided US$120,000 to support task-sharing implementation in MCH. An amount of US$120,107.40

to implement task-sharing in HIV and TB comorbidities management, is being requested within allocation.

Grant Management: An amount of $388,623.63 is requested for the smooth implementation of the RSSH program. The Ghana Health Service will ensure the effective coordination and implementation oversight of the RSSH and report to the Global Fund Country Coordinating Mechanism for TB/HIV and Malaria. Also, RSSH post implementation review will be undertaken to document lessons learnt and recommendations.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s).

To respond, refer to additional guidance provided in the *Instructions*.

3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers or flow of funds or commodities?	☐ Yes ☒ No

If yes,

a) Outline the reasons and the key changes from past implementation arrangements to give an understanding of grant operationalization. You can provide an updated Implementation Arrangements Map;
b) Detail how representatives of women's organizations, key populations and people living with the disease(s) as applicable will actively participate in the implementation of this funding request;
c) Include a description of procurement mechanisms for the grant(s).

(maximum ½ page)

[*Applicant response*]:

MALARIA

a) We do not propose major changes in implementation arrangements at the PR level for the malaria grant because, both PRs (GHS/NMCP and AGAMal) have demonstrated capacity to implement past grants. The burn rate, as at 31 December 2016 for GHS/NMCP, is 95% whilst that for AGAMal, is 94%; and both are projected to be over 95% by 31st December 2017. The two PRs (GHS/NMCP, AGAMAL) performed with grant rating of B1 each. To accelerate gains made, the PRs will introduce the signing of MOUs and key performance indicators (KPIs) with SRs and implementing agencies. Collaboration with USAID/PMI, WHO and other partners will continue. This grant is being submitted together with RSSH request, which will be implemented by GHS/PPME (*refer M. Annex 8*). Malaria grant will benefit from RSSH as systemic challenges in grant implementation, such as “last mile distribution”, CSS and financial management will be addressed. (*RSSH Annex 2*).

b) The development of the proposal had inputs from NGOs/CSOs as well as all stakeholders through well-attended malaria country dialogue processes (*Refer to M.Annex 6*). Womens’ groups and other NGOs/CSOs, will continue to participate in implementation, especially at the community level, to improve uptake of malaria interventions as implementing partners. Additionally, “Kayayei” associations will be beneficiaries. Moreover, all these groups will also be involved through their representatives, in the CCM oversight committees, to monitor grant implementation.

c) Procurement arrangement for malaria grant is through MOH/GHS, AGAMal, and Pooled Procurement Mechanism of Global Fund. MOH/GHS and AGAMal procurement is guided by the Public Procurement Amendment Act (Act 914, 2016), which provides guidelines for methods and controls to be used, as well as punitive measures to be applied. The Act provides mechanisms to mitigate procurement risks and assures value for money.

RSSH

a) The MOH/GHS is the PR for the RSSH grant. In Ghana Health Service (GHS), primary responsibility for the management of TB, HIV and Malaria grants including RSSH, has been elevated to the Office of the Director General to improve grant performance. The Office of the Director General (DG) and the Ministry (PPME) will have a strong oversight in the management of grants. Strengthening the DG's offices and the Ministry (PPME) would not affect the current management and reporting structure and processes of the GF grant

b) At the CCM emergency meeting on February 15 2017, a team was constituted to develop the RSSH proposal. The RSSH proposal development commenced among other things with a country dialogue on the 29th of March 2017 with the participation of 69 stakeholders. The representation is shown in RSSH Annex 3.

c) The Public Procurement Act 663 (2003), and its Amendment Act 194 (2016) will provide the basis for procuring all goods, works and services under this grant. In line with the provision of the Acts, all procurements will be done on competitive basis and where sole sourcing is necessary, permission will be sought from the Public Procurement Authority (PPA). There is a Minister in charge of procurement in the Office of the President for scrutinizing procurements beyond given thresholds. Within the Ghana Health Service, the Stores, Supplies and Drugs Management Division, will be responsible for the adherence and compliance to the Procurement Act. All these mechanisms are to ensure value for money and mitigates against procurement risks.

MALARIA

3.2 Key implementation risks
Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding from the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context. Applicant response in the table below.

Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
Insecticide resistance	Worsening insecticide resistance may result in reversal of gains; increase in morbidity and mortality.	1. Finalize and implement insecticide management plan which outlines rotation of insecticides, monitoring of insecticide resistance etc. (*see draft insecticide resistance management plan attached*).	4th Quarter 2017

		2. Continue arrangement with NgenIRS to assure affordable 3rd generation insecticides through co-payment mechanism	1st Quarter 2018
Financing	Inadequate system of internal controls especially at the regional/district levels, may result in financial mismanagement /inefficient use of funds	Enforcement of Public Financial Management Act, 2016 (Act 921). To complement this, the routine technical monitoring will include monitoring receipts and acquittals of funds at regional levels and by SRs/IPs. [*see RSSH section 2.2 and 2.3*]	1st Quarter 2018
	Poor management oversight may result in inability to meet donor requirements and duly account for the use of funds	Pursue high level advocacy for timely release of Government counterpart funds, through intensified engagement with key government agencies (such as finance ministry). Scale-up Financial Resource Tracking Tool to cover all known sources of funds and review current financial accounting systems to capture and report on partner support (*see RSSH interventions 2.5 and 2.6*)	
	Failure to re-imburse facilities for NHIS claims may result in non-adherence to case management protocols leading, to increased case fatality	The new government has started paying off NHIS arrears. In the month of May, an equivalent amount of US$24,319,809 has been paid[14]. Currently, another amount, equivalent of about US$38,000,000 is in the process of being transmitted to the facilities.	
Programmatic	Inadequate communication between region/districts and facilities on the availability of commodities, leads to mal-distribution, resulting in shortage of quality-assured commodities in	1. Implement the ‘‘last mile distribution’’ strategy at sub-regional levels in collaboration with key partners. (*refer RSSH obj 1*)	1st Quarter 2018

[14] http://citifmonline.com/2017/05/23/weve-disbursed-ghc-60-m-to-service-providers-nhia/

Storage and distribution	some places, and expiry in over stocked areas Mal-distribution leads to expiry of drugs and loss of malaria commodities	2. Expand Logistic Management Information System (LMIS) across all level (*refer RSSH obj* 1).	
Add rows for additional key risks as necessary			

RSSH

3.2 Key implementation risks - RSSH			
Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding from the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context. Applicant response in the table below.			
Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
Program and performance risk	Inadequate coordination of programme activities at national, regional and District levels.	● Development and deployment of a dashboard for monitoring implementation. ● Strengthen managerial capacities and oversight function to improve synergy in the implementation of programme activities at National, Regional and District Levels. ● Intensify quarterly evaluation of program implementation at CHPs level and address gaps identified	>End of first year >Continuous throughout project implementation period
	Low absorption capacity and slow implementation of activities due to competing demand	● Development and deployment of a dashboard for monitoring implementation. ● Improve planning and programming of activities at the implementing level	>End of first year Continuous throughout the implementation period
	Delays in implementation of activities which could	○ Introduce enforcement mechanisms for timely disbursement of funds. ○ Strengthen managerial capacities	

	affect the achievement of performance targets	and oversight function to improve synergy in the implementation of programme activities at National, Regional and District Levels. o Implement quarterly monitoring and feedback as well as stakeholder review o Development and deployment of a dashboard for monitoring implementation.	
	Inadequate partnership between CSOs and health managers at policy and local levels	Strengthen CSOs participation in policy dialogue, planning, implementation and monitoring and evaluation at the national and decentralised levels.	Continuous throughout the implementation period
	Interference of socio-cultural norms on advocacy outcomes at community level	Readjusting sensitization approaches and messages by community opinion leaders to the community members	Early second year of implementation
	The financial transaction involved in contracting a vendor for LMIS is above the threshold for approval at the MoH. There is a risk that getting approval from MoF could drag beyond 30th September 2017	Intensive follow up and discussions with officials of the MoF to expedite action	By end of September 2017
Financial and fiduciary risk	Challenges of government delaying in honoring its commitment to the three	The Ministry of Health would explore alternative and innovative financing mechanisms to ensure timely payment of government commitments.	Continuous throughout project period

	programmes		
Add rows for additional key risks as necessary			

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY
This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer the Funding Landscape Table(s) and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.*

MALARIA/RSSH

4.1 Funding Landscape and Co-financing	
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? If yes, provide details below.	☒ Yes ☐ No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? If yes, provide a brief description below.	☒ Yes ☐ No
c) Have previous government commitments for the 2014-16 allocation been realized? If not, provide reasons below.	☒ Yes ☐ No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy? If not, provide reasons below.	☒ Yes ☐ No

e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, specify below how realization of co-financing commitments will be tracked and reported.	☐ Yes ☒ No
(maximum 2 pages)	

[*Applicant response*]:

MALARIA/RSSH

a) Mobilisation of extra resources to address both budget shortfalls and potential reduction of donor support has been discussed by the sector. The MoH has established a resource mobilisation unit to work on strategies to mobilise more resources (advocacy at government level for increased budget to health, loans and grants) for the health sector. At the agency level, Ghana Health Service (through PPMED), has started a programme of building capacity for domestic resource mobilisation, with Deloitte and Touche (accounting firm) and exploring possible ways of raising domestic resources through the private sector (NMCP). The current Public Financial Management Act, passed in 2016 is intended to bring efficiencies in government business.

   The non-wage recurrent budget increased by 1000% (Ghc3.6mil to Ghc365mil) between 2016 and 2017. About 17% of the 2017 non-wage recurrent budget has been allocated to HIV/AIDS commodities (ARVs and laboratory reagents)[15]. These positive signals from the new government give hope for recovery of an increasing government allocation for Goods and Services to the health sector.

b) The health sector has developed a health financing strategy (HFS) and implementation plan. Implementation of the plan has started with funding from government and development partners. More specifically, the Global Fund is supporting the MoH through the current grants, to strengthen financial management resource tracking and reporting. Department for International Development (DFID) has provided support to the GHS to improve the accounting software used at national and regional levels, training in the Public Financial Management Act, revision of MoH audit and financial management manual. Additionally, with support from the World Bank project (loan), Maternal Child health and Nutrition Improvement Project (MCHNIP) is resulting in strengthening of managerial capacity. There is also a WHO-led efficiency assessments and HFS strategy with activities to map donor funding to prepare for transition. Government has reviewed the NHIS scheme and recommendations towards improving the scheme has been outlined in a draft report, which has been submitted to the President. This funding request includes support for strengthening accountability and reporting. These strategies are key to the sustainability and prioritization of current investments.

c) The GoG met its 20% threshold for 2014-2016, but not the individual commitments such as ITNs distributions and ART procurement.
d) The GoG will meet the current co-financing commitments for the 2017-19 allocation to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy. The proportion of GF allocation, compared with GoG allocation for health for 2018-2020 implementation period, is 6% ($193,981,000/$3,525,952,154).
e) The National Health Accounts (NHA) and National AIDS Spending Account (NASA) would be used to track health expenditure on the three diseases. The NHA will be used to track co-financing commitments.

[15] draft MoH 2017 PoW

MALARIA/RSSH

4.2 Sustainability
Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically, a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions. b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them. (maximum 1 page)

[*Applicant response*]:

(a) Ghana's intervention strategies for fighting malaria are LLINs, IRS, IPTp, SMC and Case Management. During the period 2018 to 2020, Government will be expected to increase funding to procure SPs. Additional funding for SP for 2017, is provided in the government budget and prioritized by the MoH. This will continue through the period 2018 to 2020. The government has received the report on the review of the NHIS and intends to review the benefit package and improve its coverage especially in rural and vulnerable populations. MoH will work with government in this review to explore possibility of including SP as part of the package of free services for pregnant women and children covered under the NHIS.

(b) The MoH is exploring domestic resources to support priority health interventions. Working with health partners (JICA, Result for Development and Delloitte and Touché), the MoH is strengthening its capacity for generating the evidence for advocacy and develop mechanism for increasing domestic and external resources to the health sector. The MoH is in the process of establishing a Resource Mobilization Department at MoH headquarters. Government domestic resources to health are expected to increase rapidly during the period 2018-2020 due to Ghana transitioning from some Overseas Development Assistance. Increasing government contribution to the MoH budget will be challenging. However, government will consider innovative financing options to generate new revenue streams such as loans, fees, taxes and bond raising. The MoH will also consider efficiency and cost saving strategies. The Ministry is undertaking cross programmatic efficiency analysis on GFATM and EPI and the result is expected to provide evidence to influence programmes' implementation to enhance efficiency. As part of efforts to improve efficiency in resource use, better utilization of resources (starting with Global Fund), GHS will establish a Programme Coordinating Unit under the office of the Director-General (DG) to strengthen oversight and communication between programmes, DG, MoH and Development Partners. The health financing strategy (and implementation plan) proposes revenue mobilization and pooling strategies that will raise extra resources for health. A private sector-led malaria foundation has been established in 2017 with the objective of mobilizing additional funding to support malaria control in Ghana.

MALARIA

SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST
All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below.
Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the within allocation amount). Applicant response in the table below.
[C*omponent*] – *Copy table as needed, if your funding request includes more than one component*

	Module	Amount requested [*Specify US$ or*	Brief Rationale, including expected outcomes and impact (how the above allocation request builds on the allocation)
1	IRS -Upper West (2020)	6,587,160	This request will continue to cover a population of 847,515 (136,696 households) in UWR, in 2020. The budget for UWR for 2018-2019 is requested for within the allocation request.
2	IRS - Upper East (2018-2020)	24,253,344	This request will cover a population of 1,180,463 (203,528 households) in 13 districts UER (2018-2020). IRS was stopped in UER due to non-funding of the above allocation request under NFM1. This request to cover UER is to reverse the upsurge of malaria parasitemia among the poor and vulnerable population. There was an increase in parasitemia from 11.8% to 14.3% between 2014 and 2016 in UER (while UWR and NR regions recorded decreases). This is inspite of the fact that ITNs were distributed in all communities in the Upper East Region following IRS cessation. ITNs distribution (mass and routine) for UER has been planned for within allocation. However, since there will be no overlap between IRS and ITNs, should this IRS request for UER be approved, there will be no ITNs distribution, thus freeing up the funds

			intended for ITN in UER, for other key activities.
3	Private sector co-payment mechanism	5,291,765	The above allocation request constitutes 72% of total estimated cost for continuation of the private sector co-payment mechanism; which will be targeting rural deprived and remote locations, amongst the poorest, to benefit the vulnerable and under-served, by increasing access to quality-assured and affordable ACTs. It is likely that a rapid reduction or loss of the co-payment will have a negative impact on these populations, reducing access to treatment and increasing the current inequities in access. For this grant therefore, in addition to the $2,000,000 requested within allocation (28% of estimated need), an additional amount of $5,085,446 is requested for above allocation to procure 5,702,272 ACTs. An MOU will be signed with first-line buyers to ensure compliance, re-enforced by monitoring in collaboration with pharmacy council. As stated in section 2, a process has been initiated to transition from the current co-payment program through a phased approach (from urban and rural to rural only, then to complete weaning off), while ensuring that vulnerable groups benefiting from this intervention are not disadvantaged. The transition plan will leverage on a strengthened community case management through CHPS supported by an improved NHIS which covers the vulnerable and rural populations. By the time the co-payment is phased out from the rural areas, CHPS will be fully operational. For all these phases, ACT prices, ACT availability and access of affected populations to case management will be closely monitored.
	SMC – Northern region (2018-2020)	$ 10,488,896	This request is to cover 609,393 children under five in the Northern region with SMC from 2018-2020.
TOTAL AMOUNT (USD)		$ 46,621,165	

RSSH

SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST

All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below.

Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the within allocation amount).

Applicant response in the table below.

[*Component*] – *Copy table as needed, if your funding request includes more than one component*

	Module	Amount requested [*Specify US$ or*	Brief Rationale, including expected outcomes and impact (how the above allocation request builds on the allocation)
	PSCM	US$970,000	This request is for the development of a Transition Plan that addresses Service Level Agreements, maintenance procedures, and training for supply chain managers on the LMIS systems. This will ensure sustained and optimal functioning of the LMIS, thus contributing to increased data visibility and reduce expiries.
	HMIS	US$400,000	Programmes and divisions carry out periodic trainings on DHIMS2 and other areas usually centralised at the regional level with officers from district and facilities levels travelling long distances for such training. The aim is to digitise all DHIMS2 training modules making them accessible to all staff of GHS. The implementation will involve curriculum and manual developments and regular updates as DHIMS2 features keep changing over time. Updates of the GHS HMIS SOP to reflect current needs, recording of all modules on

			DHIMS2 and eTracker data capture and reporting in a studio. Capacity building of DHIMS2 technical team and focal persons and regional administrators.
	HMIS	US$2,500,000	This request is for the implementation of Fionet system, a medical device with a companion for routine data collection and reporting for CHPS and logistic management at the community level. The rationale is to provide a point-of-care platform for seamless integration of programs (Malaria, TB, HIV) including other diseases data capture. It will enhance quality and timeliness of data capture at the community level as well as enhancing diagnostic and protocol adherence and patient monitoring. This data will be integrated into DHIMS2.
	CSS	US$658,000	Provision of training resource for NSAs and assessment of their contribution to GF interventions in Ghana. This activity will provide feedback and lesson learned for future interventions.
TOTAL AMOUNT (USD)		**4,528,000**	

M. Annex 1

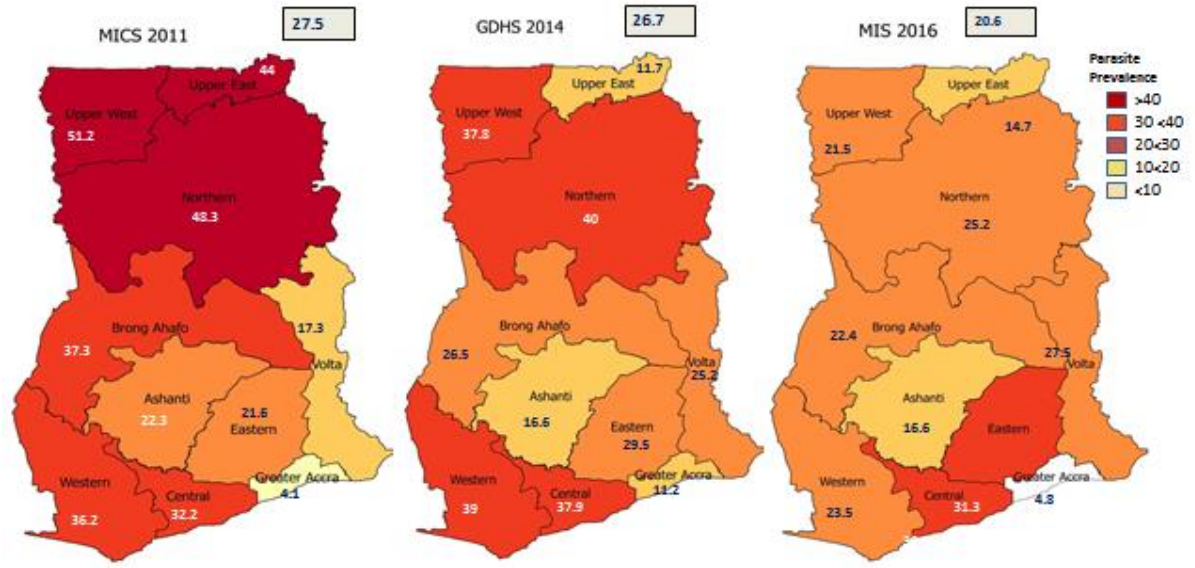


Figure 1: Malaria parasite prevalence among children under five years in Ghana, 2011-2016

M. Annex 2

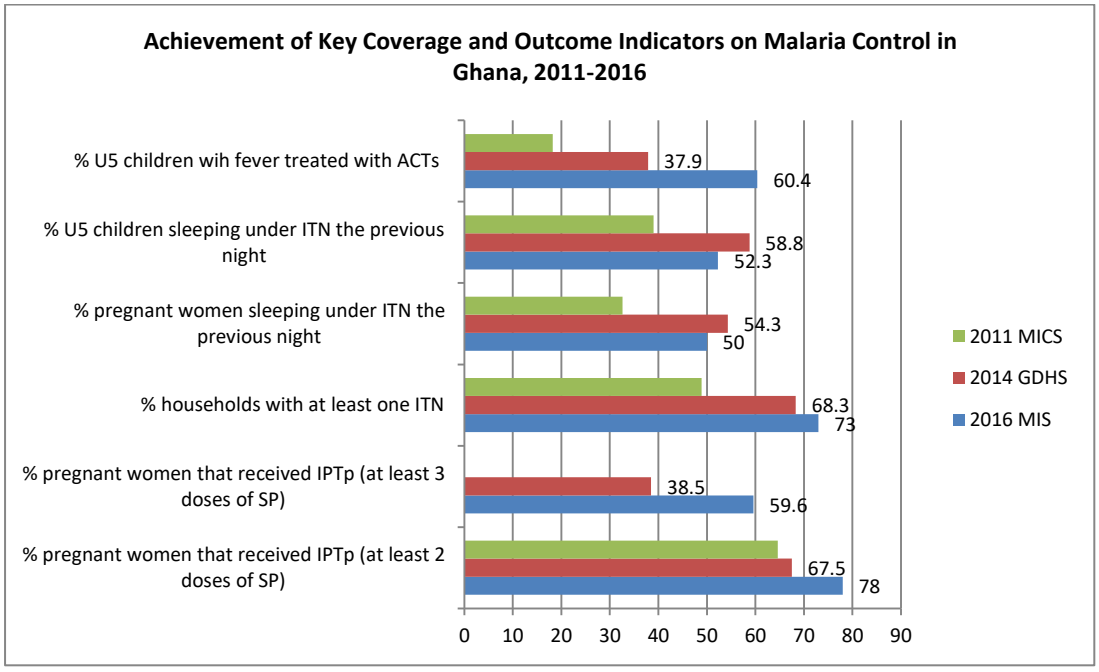


Figure 2: Achievement of key interventions in malaria control in Ghana, 2011-2016

M.Annex 3:

Table 2: Prioritized Funding Need, Available, Gap, Allocation and PAAR (2018-2020)

Year	Need ($)	Available ($)		Gap ($)	Allocation Request ($)	PAAR ($)
		Domestic	External			
2018	100,940,159	6,297,334	38,194,694	56,448,131	44,490,920	11,957,211
2019	77,621,459	8,027,585	22,448,510	47,145,364	33,276,747	13,868,617
2020	78,430,221	9,098,330	22,580,000	46,751,892	25,956,554	20,795,337
Total	256,991,839	23,423,248	83,223,204	150,345,387	103,724,222	46,621,165

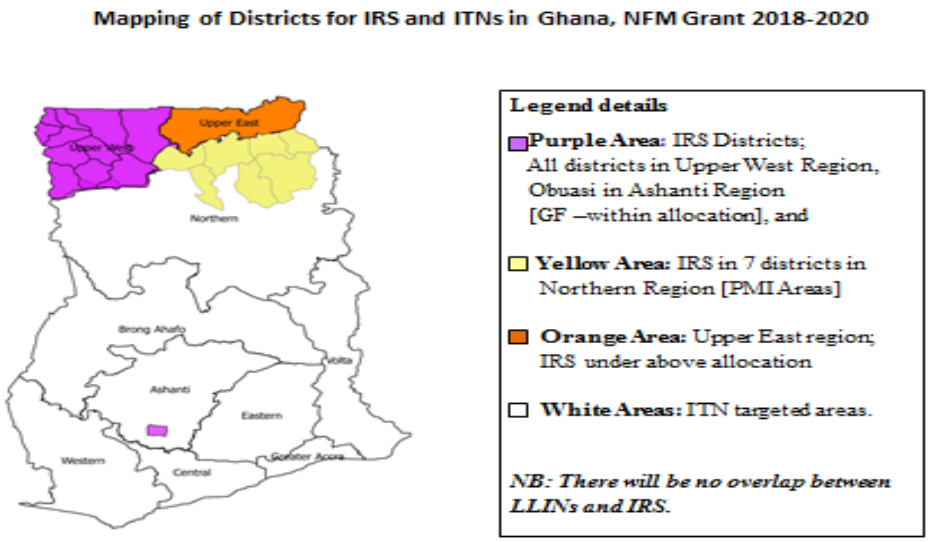
M.Annex 4:

Table 3: Malaria Country Dialogue, Participation by Organization

MALARIA COUNTRY DIALOGUE REPRESENTATION		
Percentage representation	No. of participants	Percentages (%)
CCM	5	9.1
NGO/CSO	5	9.1
Private Sector	5	9.1
Key Affected Population (KAP)	2	3.6
Parliamentary Select Committee	2	3.6
National Pop Council	1	1.8
Korle-Bu Teaching Hospital (KBTH)	1	1.8
MOH	3	5.5
GHS/Programmes	22	40.0
Prisons Service	2	3.6
FBO	5	9.1
Multi/Bilateral	2	3.6
Total	55	100.0

M.Annex 5

Figure 3: Mapping of Areas for IRS and ITNs in Ghana, NFM 2018-2020



M.Annex 6: Allocation Request by Interventions

Table 4: Allocation and PAAR Request by Intervention (2018-2020)

MODULE	Funding Need	Available		Gap	Allocation Request	PAAR
		Domestic	External			
Vector Control: LLIN	61,145,736	0	33,710,694	27,435,042	27,435,042	-
Vector Control: IRS	64,783,428	1,500,000	15,150,000	48,133,428	17,292,924	30,840,505
Case management – Diagnosis & Treatment	79,614,365	11,616,905	26,152,000	41,845,460	36,553,695	5,291,765
Specific prevention intervention : Intermittent preventive treatment in pregnancy (IPTp)	7,924,821	3,723,377	1,418,510	2,782,934	2,782,934	-

Specific prevention intervention : Seasonal malaria chemoprophylaxis (SMC)	19,027,963	-	-	19,027,963	8,539,067	10,488,896
Program Management	10,302,297	2,189,166	4,455,000	3,658,131	3,658,131	-
Other-SM&E	14,193,229	4,393,800	2,337,000	7,462,430	7,462,430	-
Total	256,991,839	23,423,248	83,223,204	150,345,387	103,724,222	46,621,165

M.Annex 7: Commodity Gap, Available, Gap and Allocation Request 2018-2020

Component	Year	Gap ($)	Allocative Request for Commodities ($)	PAAR
LLINs (Mass Campaign)	**2018**	**10,465,290**	**10,465,290**	**-**
	2019			**-**
	2020			**-**
LLINs (Continuous Dist)	**2018**	**5,094,269**	**5,094,269**	**-**
	2019	**5,023,733**	**5,023,733**	**-**
	2020	**5,142,747**	**5,142,747**	**-**
IRS Insecticides	**2018**	**3,361,634**	**3,226,701**	**134,933**
	2019	**3,489,379**	**3,350,891**	**138,488**
	2020	**3,593,165**	**632,556**	**2,960,609**
RDTs	**2018**	**2,883,984**	**2,883,984**	**-**
	2019	**3,337,384**	**3,337,384**	**-**
	2020	**3,862,086**	**3,862,086**	**-**
ACTs	**2018**	**2,219,732**	**2,219,732**	**-**
	2019	**2,448,828**	**2,448,828**	**-**
	2020	**1,987,176**	**1,987,176**	**-**

Inj Artesunate	2018	3,936,643	3,936,643	-
	2019	4,065,393	4,065,393	-
	2020	4,197,363	4,197,363	-
Co-payment	2018	2,774,690	2,000,000	774,690
	2019	2,315,360	-	2,315,360
	2020	1,995,396	-	1,995,396
SP	2018	-	-	-
	2019	312,116	312,116	-
	2020	344,528	344,528	-
AQ+SP	2018	1,370,876	566,964	803,912
	2019	1,405,148	581,138	824,010
	2020	1,440,277	595,666	844,610
Total		77,067,195	66,275,187	10,792,007

M. Annex 8:

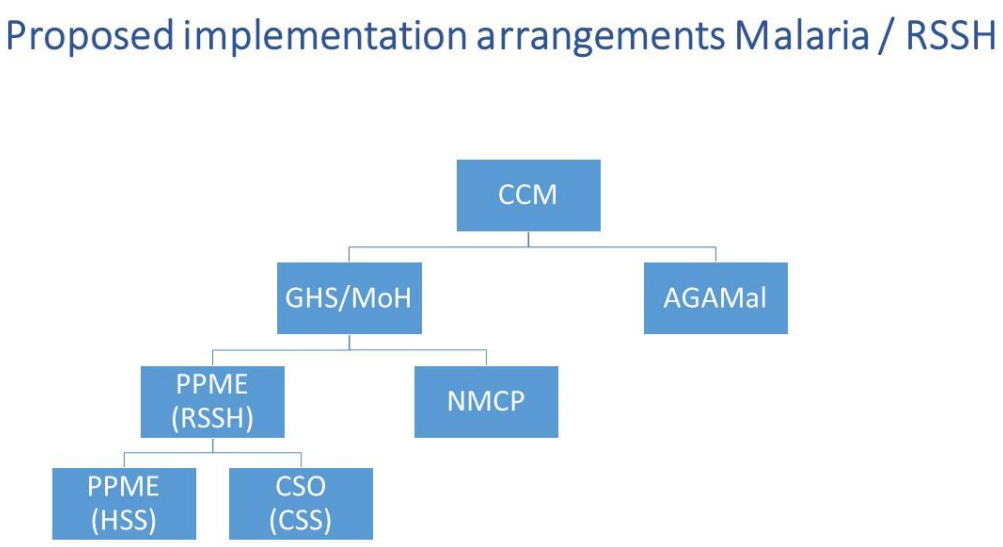


Figure 4: Implementation Arrangement for Malaria and RSSH Grant, NFM 2018-2020

M. Annex 9: List of abbreviations

ACT	Artemisinin-based Combination Therapy
AGAMal	AngloGold Ashanti Malaria Control Limited
AMF	Against Malaria Foundation
ANC	Ante-Natal Clinic
AQ-SP	Amodiaquine - Sulfadoxine-Pyrimethamine
ARV	Antiretroviral Treatment
ATF	Accounts, Treasury and Finance regulation
BCC	Behavior Change Communication
BMC	Budget Management Centre
CCM	Country Coordination Mechanism
CHIM	Centre for Health Information Management
CHMC	Community Health Management Committee
CHPS	Community Health Planning and Services
CMS	Central Medical Stores
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DFID	Department for International Development
DHIMS2	District Health Information Management System 2
DHMT	District Health Management Team
DHS	Demographic Health Survey
EID	Early Infant Diagnosis
EPI	Expanded Programme on Immunization
EU	European Union

FBO	Faith Based Organization
FDA	Food and Drugs Authority
FM	Financial Management
FRL	Fiscal Responsibility Law
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GHC	Ghana Cedi
GHS	Ghana Health Service
GF	Global Fund
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GoG	Government of Ghana
HA	Health Accounts
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Heath
HRIS	Human Resource Information System
HSMTDP	Health Sector Medium Term Development Plan
HSS	Health Systems Strengthening
HTS	HIV Testing and Counselling
iCCM	integrated Community Case Management
IE&C / IEC	Information, Education & Communication
IMF	International Monetary Fund
IP	Implementing Partner
IPTp	Intermittent Preventive Treatment in pregnancy
IRMP	Insecticide Resistance Management Plan
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
KAP	Key Affected Populations
KBTH	Korle-Bu Teaching Hospital
KP	Key Populations
KPI	Key Performance Indicators
LMD	Last Mile Distribution
LLIN	Long Lasting Insecticide treated Nets
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MAF	Millennium Development Goals Accelerated Framework
MCH	Mother and Child Health
MCHNIP	Maternal Child Health and Nutrition Improvement Project
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Surveys
MIS	Malaria Indicator Survey
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework

NASA	National AIDS Spending Assessment
NFM	New Funding Model
NGenIRS	New Generation IRS
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NHWA	National Health Workforce Account
NMCP	National Malaria Control Programme
NR	Northern Region
NSA	Non State Actor
OPD	Outpatients' Department
ODA	Overseas Development Assistance
OTSS	On-site Training and Supportive Supervision
PAAR	Prioritized Above Allocation Request
PF	Performance Framework
PFM	Public Financial Management
PLHIV	People Living with HIV
PLWD	People Living With Diseases
PM	Programme Management
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PPA	Public Procurement Authority
PPME / PPMED	Policy Planning, Monitoring and Evaluation (Division)
PSCM	Private Sector Copayment Mechanism
PSCM	Procurement and Supply Chain Management
PSM	Procurement and Supply Management
RDT	Rapid Diagnostic Test
RHMT	Regional Health Management Team
RMS	Regional Medical Store
RSSH	Resilient and Sustainable Systems for Health
SAMC	Social Accountability Monitoring Committee
SBCC	Social and Behavioural Change Communication
SDHMT	Sub District Health Management Team
SDPs	Service Delivery Points
SHA	System of Health Accounts
SM&E	Surveillance, Monitoring and Evaluation
SMC	Seasonal Malaria Chemoprevention
SOP	Standard Operating Procedures
SP	Sulfadoxine-Pyrimethamine
SPI	Specific Preventive Interventions
SR	Sub Recipient
SSNIT	Social Security and National Insurance Trust
SSR	Sub Sub Recipient
TB	Tuberculosis
UER	Upper East Region

UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
UWR	Upper West Region
VAT/NHIL	Value-Added Tax / National Health Insurance Levy
WB	World Bank
WHO	World Health Organization

RSSH Annex 1

ANNEX 1: SUMMARY BUDGET BY MODULE			
MODULE	**CUSTOM INTERVENTIONS**	**SUMMARY BUDGET (GH¢)**	**SUMMARY BUGET ($)**
Procurement and Supply Chain Management Systems	1.1 Support the ongoing development and implementation of functional Logistics Management Information System (LMIS)	GHC 9,067,204	$2,164,010.48
	1.2 Implement Last Mile Delivery	GHC 8,142,311	$1,943,272.32
	1.3. Standardisation and Optimisation of warehousing	GHC 5,978,351	$1,426,814.08
	PSM TOTAL	GHC 23,187,866	$5,534,096.88
Financial Management Systems	2.1 Develop institutional capacity for Resource Tracking (Health Accounts and National AIDS Spending Assessment (NASA))	2,923,144.00	697,647.73
	2.2 Strengthening monitoring and supervision systems	2,510,446.00	599,151.79
	2.3 Capacity building in financial management including planning and budgeting,	3,102,257.00	740,395.47
	2.4 Automation and integration of accounting and	1,551,320.00	370,243.44

	internal control systems and processes		
	FM TOTAL	10,087,167.00	2,407,438.43
	2.1	GHC 1,640,830	$391,606.21
	2.2 : Strengthen monitoring and supervision for effective financial management	GHC 2,510,446	$599,151.79
	2. 3: Build Capacity of key finance and non-finance managers in financial management tools-SOPs, E-trans. Tool, ATF to enhance compliance to New PFM Act.	GHC 1,181,154	$281,898.33
	2.4: Integrate and Implement GHS Electronic Transactional Tool into ACCPAC	GHC 1,146,610	$273,653.94
	2.5: Scale up financial resource tracking tool to cover all known sources of funding including HIV, TB & Malaria	GHC 1,282,314	$306,041.53
	2.6: Review current financial accounting systems to capture and report on partner support	GHC 404,710	$96,589.50
	2.7 Strengthen decentralised level (Sub-districts and CHPS) management capacity including planning and budgeting	GHC 1,921,103	$458,497.14
	FM TOTAL	GHC 10,087,167	$2,407,438.42
Community Responses and Systems	3. 1. Strengthen NSA access to training and other resource materials	GHC 82,568	$19,705.97
	3.2 Enhance social mobilization at the community level	GHC 1,629,400	$388,878.28
	3.3 Strengthen community level monitoring and reporting	GHC 2,618,016	$624,824.82

	3.4 Strengthen advocacy and social accountability at all levels	GHC 3,602,758	$859,846.78
	3.5 CSS Project coordination, management and administration	GHC 2,735,400	$652,840.10
	CSS TOTAL	GHC 10,668,142	$2,546,095.94
Health Management Information Systems and M&E	4.1. Scale up of e-Tracker	GHC 1,986,676	$474,147.02
	4.2 Implementation of Human Resource Information System integrated with DHIMS2	GHC 1,482,060	$353,713.60
	4.3. Provide secondline data quality audit Bi-annually	GHC 870,660	$207,794.75
	4.4: Implement the National Health Workforce Accounts including Health Labour Market Assessment	GHC 494,410	$117,997.61
	4.5 Support the implementation of Task-Sharing in HIV, TB, Malaria	GHC 503,250	$120,107.40
	HMIS TOTAL	GHC 5,337,056	$1,273,760.38
Program Management	5.1 Grant Management	GHC 1,628,333	$388,623.63
	PM TOTAL	GHC 1,628,333	$388,623.63
	TOTAL REQUEST	GHC 50,908,564	$12,150,015.26

RSSH Annex 2

Alignment of RSSH Objectives to Programme (Malaria, TB, HIV). Challenges, Issues and Concerns

Procurement and Supply Chain Management: To improve timely availability of quality commodities at the service delivery points

Components	No.	Challenges/Issues/Concerns	Addressed In RSSH: Comments
Malaria	**1**	**Inadequate communication between region/districts and facilities on the availability of commodities leading to mal-distribution and shortage of quality assured commodities. Loss of malaria commodities due to disasters, e.g. Fire. And limited warehouse capacities**	**Objective 1 focuses on addressing this concern with target of a functional LMIS at the decentralized levels. Last mile delivery is to be strengthened at the sub-district level to enhance commodity availability at the service delivery points.**
HIV	**2**	**Stockout due to challenges with distribution to facilities (Last mile), 2) Limited warehouses capacity**	
TB	**3**	**About 13.3% of confirmed TB cases were not initiated on treatment. This was largely due to stock-out of TB medicines during the third quarter of 2016, which was related to procurement and supply chain challenges. Apparent (not real shortages) stock out of programme commodities**	
Financial Management: To enhance the effectiveness, efficiency and accountability in the use of financial resources			
Malaria/TB/HIV	**1**	**Low absorption capacity Weak financial management practices. Financial management: Funds sent to regions are not acquitted on time and ACTs sales not accounted for in time.**	**Objective 2, addresses this key concern with a focus on automation of resource tracking and reporting systems, disseminating SOPs and building capacity for compliance and adherence to the public financial management Act. This will contribute to ensure effective resource tracking and accountability.**

			The elevation of primary grant management responsibility to the office of the Director General, Ghana Health Service in the new implementation arrangement for 2018-2020 is expected to ensure optimal absorption of funds.
			RSSH has prioritised institutionalisation and conduct of National Health Account to track all health expenditures including disease specific spending.
	2	**Ensure adequate funds and sustainability**	**Plans to create dedicated account for accruing funds from NHIS levy will improve reimbursement to facilities. The availability of NHIS funds will ensure that facilities are adequately resourced to manage malaria cases.,**
			RSSH support the development and implementation of domestic resource mobilisation plan
Community Systems Strengthening: To strengthen community systems for social accountability			
Malaria	**1**	**iCCM, has been integrated into the CHPS strategy, will continue as part of the RSSH grant.**	**iCCM is currently an integral part of the CHPS implementation strategy. CSS activities at the community levels take account of this in the current RSSH request**

TB	**2**	**Non-prioritization of TB services at operational levels, weak supportive supervision, poor time management, lack of documentation of activities, high staff turn-over, low staff morale**	**Objective 4 of the RSSH complement specific interventions in TB approach with a focus on strengthening decentralised level (District, Sub-districts and CHPS level) management, planning and budgeting. This will improve supportive supervision, timely implementation of activities and reporting. A comprehensive Health Labour Market Assessment will be conducted under the RSSH request to inform strategic HRH interventions for a sustainable and resilient health system**
	3	**Stigma and discrimination of KPs and PLWDs in healthcare settings and communities**	**Objective 3: of community system strengthening with primary focus on CSOs, playing active roles in HIV/TB advocacy at all levels**
HMIS: To improve availability of strategic information for decision making at all levels			
TB/HIV	**1**	**Improve DHIMS 2 eTracker (including an off-line mode) to enhance patient monitoring and reduction in delay in data transfer Issues of Data management: Inadequate resources (funds, human resource)**	**The RSSH request seeks to deploy e-tracker to at least 40% of health facilities in 216 districts in the country DHIMS2 would be scaled-up to embody the integration of human resource information system Second line data quality audit for Global Fund Programmes (TB, HIV/AIDS and Malaria**
TB/HIV	**2**	**High attrition rate and Staff overburdened with work coupled with fact that existing physician-led approach to ART**	**Support under this funding request will be used to build and strengthen capacity for the implementation of the task sharing including HIV,**

		cannot support progress towards 90-90-90.	**TB, Malaria services under objective 4 of the RSSH**

R. Annex 3. Country Dialogue, Participation by Organization

RSSH COUNTRY DIALOGUE REPRESENTATION		
Percentage representation	No of participants	Percentages (%)
Government MDAs	2	2.9
Parliamentary Select Committee	3	4.3
MoH	8	11.6
Agencies of MoH	2	2.9
CSOs	13	18.8
Teaching Hospitals	2	2.9
Traditional Authority	2	2.9
CCM	25	36.2
Academia	2	2.9
Development Partners	3	4.3
CHAG	4	5.8
Women Children and Young People	1	1.4
CHPS/CHOs reps	2	2.9

Total	69	100.00