RSSH Gaps and Priorities Annex – Template

**Date Published:** 12 May 2023

The purpose of this annex is to help applicants go through a structured process that results in a prioritized RSSH request that is fully supported by, and informed by the needs of the HIV, TB and/or malaria disease programs. It is also meant to inform the program split discussions. We therefore encourage applicants to complete this annex early in country dialogue.

**Section 1 – Analysis of RSSH priorities, including those related to community systems strengthening, based on programmatic gaps**

Identify the top three[[1]](#footnote-2) priorities for RSSH (by module [[2]](#footnote-3)) for each disease program (HIV, TB and malaria) and briefly explain how investing in these areas will help to address specific programmatic gaps while contributing to RSSH and pandemic preparedness.

|  |  |  |
| --- | --- | --- |
| Disease component | Top three RSSH priorities (by module), including those related to community systems | Link with specific programmatic challenges and/or priorities to ensure quality |
| HIV | 1.  2.  3. |  |
| TB | 1.  2.  3. |  |
| Malaria | 1.  2.  3. |  |

**Section 2 – Cross-cutting RSSH priorities and the prioritization process**

Based on the analysis above and a joint dialogue between HIV, TB, malaria and RSSH stakeholders: (1) Select the cross-cutting RSSH areas (mapped to modules) that will be included in each funding request[[3]](#footnote-4); (2) summarize why these RSSH areas have been prioritized between the disease programs and RSSH stakeholders; (3) explain the approach used to collaboratively discuss and prioritize these areas; and (4) summarize how these priorities are aligned with those articulated in the national health sector plan and other key national policies and strategies. The details of the interventions and activities, including a detailed rationale and expected outcomes, should be outlined in the funding request.

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| Describe the response here: |

**Section 3 – Funding gap analysis**

For the priorities identified in Section 2 (which should be further described in the funding request), fill in the funding gap analysis table below. Alternatively, applicants can include a funding gap analysis table using their own format. List assumptions and sources of data as relevant.

|  |  |  |
| --- | --- | --- |
| Module | Intervention | Funding gap analysis |
|  |  | A. Total amount needed:  B. Total amount funded and by whom:  C. Gap (A-B):  D. Global Fund investment:  E. Remaining gap (C-D):  Assumptions:  Data sources: |
| Add lines as needed |  |  |

RSSH Gaps and Priorities Annex – Instructions and Illustrative Examples

This Annex should be filled in and included with the Funding Request submission when the applicant is requesting RSSH support in the funding request. As per the [Applicant Handbook](https://www.theglobalfund.org/media/4755/fundingmodel_applicanthandbook_guide_en.pdf), it is strongly recommended to include the entire RSSH request in one funding request (disease or standalone RSSH), rather than dividing it across the different disease funding requests.

This Annex provides information about an applicant’s RSSH priorities by disease (Section 1) and how these were further prioritized into a coherent RSSH funding request aligned with the national health sector plan (Section 2). Applicants are also asked to provide information about existing funding, funding gaps and how the funding request fills these gaps (Section 3).

A full description of the priorities listed in this annex should be included in the funding request (rationale, activities, alignment with critical approaches, etc.). Note that content provided in the funding request should not be duplicated in the RSSH priorities and gaps annex. Kindly refer to information provided in each of the documents as needed.

**Section 1 – Analysis of RSSH priorities, including those related to community systems strengthening, based on programmatic gaps**

Identify the top three priorities for RSSH (by module) for each disease program and explain how investing in these areas will help to address specific programmatic gaps and/or address priorities to ensure quality HIV, TB and malaria services while contributing to broader health system strengthening and pandemic preparedness. It is recommended to prioritize up to three areas as this is a prioritization process, however countries can list more than three areas if needed. RSSH investments should contribute to the essential public health functions, leveraging support to high-quality health services oriented to the populations’ evolving needs to achieve universal health coverage.[[4]](#footnote-5) The guiding questions in the [RSSH Information Note](https://www.theglobalfund.org/media/4759/core_resilientsustainablesystemsforhealth_infonote_en.pdf) should be used to facilitate the country dialogue.

One to two sentences can be included for each priority, plus an additional two to three sentences to describe how the priority area addresses challenges within the disease program. This information should supplement the information provided in the funding request, which provides the context of the health sector and a clear rationale for the request. Supporting documentation (e.g., national strategies, evaluations, etc.) should also be included as appropriate.

The table below provides illustrative examples:

|  |  |  |
| --- | --- | --- |
| Disease component | Top three RSSH priorities (by module), including those related to community systems | Link with specific programmatic challenges and/or priorities to ensure programmatic quality |
| HIV | 1. Laboratory systems strengthening  2. Health products management forecasting, and supply planning (quantification)  3. Community system strengthening | 1. Persistent challenges in sample transport and results return systems for early infant diagnosis (EID)  2. Challenges with a) sufficient stocks available for differentiated service delivery of ARVs for patients who are doing well on treatment and b) inadequate quantities of condoms and lubricants in prevention programs.  3. Challenge with capacity of community-based organizations (CBOs) to provide integrated services for HIV and TB and referral to higher level services. |
| TB | 1. HRH and quality of care  2. Community systems strengthening  3. Laboratory systems strengthening | 1. Challenge with implementation and quality of care for TB cases due to HRH shortages and maldistribution of the health workforce, including CHWs.  2. Challenge of TB case finding at the community level due to poor capacity of TB CBOs and lack of integration into the PHC system.  3. Challenge with TB diagnostics including integrated sample transportation. |
| Malaria | 1. Human resources for health and quality of care  2. Health products management / warehouse and distribution systems  3. Monitoring and evaluation systems | 1. Challenge with quantity, distribution and quality of care provided by health workers, including community health workers, for case management at PHC level and in the community.  2. Challenges with a) supply chain management, products’ quality monitoring and resistance monitoring (applicable to ITNs, RDTs & ACTs) and b) last mile kitting and distribution of ACTs and RDTs for CHWs.  3. Need to improve and evolve malaria surveillance and data collection tools and processes to enable continuous quality improvement (CQI) and accurate surveillance. |

**Section 2 – Cross-cutting RSSH priorities and the prioritization process**

Based on the analysis above, disease and RSSH stakeholders should meet jointly to prioritize the cross-cutting RSSH areas they want to include in each funding request. The results of this meeting should be described in this section, as follows.

First, briefly summarize which RSSH areas have been prioritized across the diseases for inclusion in the funding request(s). In general, applicants should prioritize only a few areas, and ensure they are well designed and adequately funded. Make sure to map the areas to the relevant RSSH modules as its important to correctly classify the areas into the correct modules and interventions. The interventions, activities, and alignment with the relevant critical approaches for lab, human resource and health product management systems, should be fully explained in the funding request.

Second, explain why these areas have been prioritized and how they support the disease programs. This may include potential synergies between the various areas (e.g., how human resources for health and monitoring and evaluation systems may be complementary). Applicants should also consider how integrated service delivery, enhanced private sector engagement and digital health systems can strengthen the disease programs and primary health care.

Third, explain the process undertaken to prioritize these areas. For example, one or more meetings were held, and stakeholders included relevant HIV, TB, malaria and RSSH colleagues. Minutes can be attached as needed.

Finally, explain how these priorities are aligned with those articulated in the national health sector plan and other national policies and strategies, including community systems, human resources for health, quality of care, health products management, health financing, laboratory and/or private sector policies.

Below is an illustrative example:

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| Based on the above analysis and three subsequent discussions hosted by the CCM between the disease programs and RSSH stakeholders, the CCM decided to focus this funding request on the following areas: human resources for health (including community health workers), community systems strengthening, laboratory systems, and health product management systems. Stakeholders included directors of the relevant parts of the Ministry of Health, including the National Laboratory Director, HRH Director, HMIS Director, Quality of Care Director, plus others such as private sector, professional bodies, CHWs representatives.  Discussions considered Global Fund’s comparative advantage and future coordination with other development partners on this work. Human resources for health (HRH) and quality of care for community health workers was selected as partner x supported the definition of service delivery models and the development of care protocols, and this could be further leveraged by identifying key HRH competence gaps at facility and community level. Funding will strengthen HRH planning and quality improvement processes linked to integrated supportive supervision to improve quality of care for all three diseases.  Labs, community systems strengthening, and health product management systems were also selected as they all hinder the three disease programs and need to be addressed. Labs will focus on xyz, community systems strengthening will focus on abc and health product management will focus on xyz, with the aim to improve abc and strengthen the disease programs.  The request ties to the main priorities outlined in pages x-x of the national health strategic plan, and links to priorities outlined on pages x-x of the national lab directorates strategic plan, pages x-x of the national HRH plan, and pages x-x of the national supply chain plan (all attached). |

**Section 3 – Funding gap analysis**

Complete the funding landscape table below for the relevant RSSH modules that are the main cost drivers in the funding request. Alternatively, applicants can include a funding gap analysis table using their own format if one already exists (for example using the costing tables in costed national strategies).

The purpose is to analyze the funding landscape and funding gaps for the key modules (and interventions if the data is available) and demonstrate how Global Fund investments will help address the funding gap.

As part of the funding request, these tables should align with and complement the following information:

* If applicable, ensure consistency with data provided in the RSSH annex with the data included in the detailed gap tables of the Funding Landscape Template and/or RSSH co-financing commitments included in the Funding Landscape Template, the Funding Request, and/or the commitment letter.
* The funding gap analysis should include Global Fund allocation and C19RM funding as relevant.
* The analysis from the Community Health Worker (CHW) Programmatic Gap Tables should inform the costing of the funding gap for CHWs in the RSSH Annex.
* Assumptions and data sources should be included.

The table below provides illustrative examples:

|  |  |  |
| --- | --- | --- |
| Module | Intervention | Funding gap analysis |
| Laboratory systems |  | A. Total amount needed: 30 million (based on lab assessment)  B. Total amount funded & by whom: US$15 million funded by EU, 2 million from C19 funding, plus US$3 million of domestic financing.  C. Gap (A-B): US$10 million  D. GF investment: US$3 million  E. Remaining gap (C-D): US$7 million  Assumptions: EU funding will cover 2 years, and government commitments will cover three.  Data sources: EU, Ministry of Finance, Lab systems operational plan. |
| Health product management systems | Sustainable health care waste management system | A. Total amount needed: US$30 million (based on National Strategic Plan for Healthcare Waste Management)  B. Total amount funded & by whom: US$10 million (infrastructure) funded by World Bank, US$5 million (infrastructure) by JICA, plus US$5 million by domestic financing, including public-private partnership for extended producer responsivity.  C. Gap (A-B): US$10 million  D. GF investment: US$3 million (TA)  E. Remaining gap (C-D): US$7 million  Assumptions: JICA funding covers 2 years, WB funding covers 3 years  Data sources: JICA, WB, government budgets, National Strategic Plan for Healthcare Waste Management |
| Human resources for health | Community health workers: integrated supportive supervision | A. Total amount needed: US$4 million (8000 CHWs based on CHW Programmatic Gap Analysis Tables)  B. Total amount funded & by whom: US$1 million funded by UK FCDO (500k), plus C19 funding wave 1 (500K) (2000CHWs based on CHW Programmatic Gap Analysis Tables))  C. Gap (A-B): US$3 million  D. GF investment: US$2 million (4000 CHWs based on CHW Programmatic Gap Analysis Tables)  E. Remaining gap (C-D): US$1 million  Assumptions: Analysis based on CHW gap analysis tables, which estimate that a total of 8000 CHWs need integrated supervision @ 500USD/CHW. FCDO commitment covers first year. Only half of these will be covered by GF investments.  Data sources: CHW Programmatic Gap Analysis Tables, FCDO, Community health worker strategy and operational plan |

1. It is recommended to identify three areas each, as this is a prioritization process. However countries can list more than three areas if needed. [↑](#footnote-ref-2)
2. The RSSH modules are: (1) Community Systems Strengthening; (2) Health Products Management Systems; (3) Monitoring and Evaluation Systems (4) Health sector planning and governance for integrated people-centered services, including private sector engagement; (5) Health financing systems; (6) Human resources for health and quality of care; (7) Laboratory Systems; (8) Medical Oxygen and respiratory care system. For more information refer to the [Global Fund’s Modular Framework Handbook](https://www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf). [↑](#footnote-ref-3)
3. In general, it is recommended to prioritize only a few areas and ensure they are well designed and adequately funded. Ensure to map the areas to the relevant modules, as its important to correctly classify the areas into the correct modules and interventions. [↑](#footnote-ref-4)
4. Essential public health functions, health systems and health security: developing conceptual clarity and a WHO roadmap for action. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO. And [UHC Compendium: Health interventions for universal health coverage](https://www.who.int/universal-health-coverage/compendium) [↑](#footnote-ref-5)