A DATA-DRIVEN CALL TO ACTION: SUSTAINING GHANA'S MALARIA RESPONSE

BRIDGE THE GAP INITATIVE

AKROS

FROM OUR EXECUTIVE DIRECTOR

Dr Peter Mumba
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As a medical doctor, I've seen the devastating toll malaria exacts, especially on children under five and pregnant women. This knowledge fuels my deep commitment to advancing sustainable, high-impact solutions to end malaria.

In Ghana we are now facing a critical challenge. The recent decline in traditional donor funding—particularly from the U.S. President's Malaria Initiative (PMI)—has placed its malaria control efforts at risk. Without timely action, the country could see a reversal of decades of hard-won progress, particularly in high-burden regions.

The Bridge the Gap (BTG) Initiative was launched to respond to moments like this. Our approach is data-driven, country-led, and focused on rapidly identifying and addressing critical funding shortfalls. In addition to linking countries with global donors, BTG supports the strategic mobilization of domestic resources to ensure long-term resilience.

In Ghana, our collaboration with the Ministry of Health Ghana National Malaria Elimination Program (NMEP) has yielded a robust investment case and activity-level gaps inventory. This report presents that work, outlining the most urgent needs and the pathways—financial and operational—to sustain momentum through 2026.

This is more than a funding roadmap. It is a call to action and a reflection of what is possible when local leadership, technical excellence, and global solidarity converge. With urgency and partnership, I believe we can protect Ghana's progress and advance toward a malaria-free future.

With thanks,

Executive Director
Bridge the Gap Malaria Initiative at Akros

Bridging the Gap in Ghana's Malaria Response: A White Paper on Emerging Financing Gaps and Strategic Priorities

Prepared by:
Bridge the Gap (BTG) Initiative

Date:
November 2025

Disclaimer: The findings presented herein are the independent work of the Bridge the Gap (BTG) Initiative. They do not represent the official policy or position of the Government of Ghana.

Acknowledgements

The findings and recommendations in this report are the independent contributions of the BTG Initiative. However, the development of this white paper would not have been possible without the generous collaboration of the Ghana Health Service and the National Malaria Elimination Program. Their commitment to maintaining momentum in malaria control, despite evolving funding challenges, has been a guiding force behind this work.

We extend special acknowledgement to the technical experts and contributors from the Ghana National Malaria Elimination Program, whose strategic input and dedication were critical in constructing the evidence base and framing actionable recommendations. Their collective technical expertise and commitment greatly enriched the development of this white paper.

We also owe a debt of gratitude to: The BTG Executive Leadership Team, whose backgrounds through the US President's Malaria Initiative, including malaria strategy and policy helped shape the white paper's analytical rigor including Dr. Oliver Lulembo, Dr. Paul Psychas, Dr. Anna Winters, Mr. Sheleme Chibsa, Mr. Presley Musonda, and Mr. Benjamin Winters. Support for data analysis, formatting and review was provided by Ms. Arden Saravis.

We extend our sincere gratitude to the BTG Initiative advisory board members: Dr. Lawrence Barat (former Senior Medical Officer and Technical Lead for USAID PMI Headquarters), and Dr. Peter McElroy (Malaria Branch Chief at the U.S. Centers for Disease Control and Prevention).

Through shared purpose and rapid, impact-focused partnership, we hope this white paper not only highlights critical financing gaps but also catalyzes solutions that protect Ghana's malaria gains and support its path toward elimination.

Dr. Peter Mumba

Executive Director

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Abbreviations

ACTs – Artemisinin-based Combination Therapy
ANC – Antenatal Care
BTG – Bridge the Gap
CHOs – Community Health Officers
CHPS – Community-based Health Planning and Services
CDC – U.S. Centers for Disease Control and Prevention
CHW – Community Health Worker
CY – Calendar Year
DHIS2 – District Health Information System 2
DHS – Demographic and Health Surveys
Dual-AI – Dual-Active-Ingredient
ELT – Executive Leadership Team (BTG)
EPI – Expanded Programme on Immunization
EUV – End-Use Verification
FAR – Foreign Assistance Review
GF – The Global Fund to Fight AIDS, Tuberculosis and Malaria
GhiLMIS – Ghana Integrated Logistics Management Information System
GHS – Ghana Health Service
GOG – Government of Ghana
HRP2/3 – Histidine-rich Protein 2/3
iCCM – Integrated Community Case Management
IAA – Interagency Agreement
IPTp – Intermittent Preventive Treatment in Pregnancy
ITN – Insecticide-Treated Net
IRS – Indoor Residual Spray
LLIN – Long-Lasting Insecticidal Net
LSM – Larval Source Management
MAP – Malaria Atlas Project
MDA – Mass Drug Administration
M&E – Monitoring and Evaluation
MOH – Ministry of Health
MOP – Malaria Operational Plan
MiP – Malaria in Pregnancy
MV – Malaria Vaccine
NMEP – National Malaria Elimination Program
NMSP – National Malaria Elimination Strategic Plan
OR – Operational Research
PDMC – Post-Discharge Malaria Chemoprevention
PMI – President's Malaria Initiative
PPE – Personal Protective Equipment
PSCM – Procurement and supply chain management
RDTs – Rapid Diagnostic Tests
SBC – Social and Behavior Change
SBCC – Social and Behavior Change Communications
SMEO/SMEOR – Surveillance, Monitoring, Evaluation, and Operations Research
SP – Sulfadoxine-Pyrimethamine

SPAQ – Sulfadoxine-pyrimethamine Plus Amodiaquine
STTA – Short-Term Technical Assistance
TES – Therapeutic Efficacy Studies
UNICEF – United Nations International Children's Emergency Fund
USAID – U.S. Agency for International Development
USG – United States Government
WHO – World Health Organization

Executive Summary

Malaria remains a major public health concern in Ghana, a country with an estimated population of 35.06 million[1]. It accounts for most outpatient consultations (43%) and affects all age groups, particularly children under five and pregnant women, with the entire population at risk[2]. According to the 2024 World Health Organization (WHO) World Malaria Report, Ghana recorded over 6.5 million malaria cases and 146 deaths in 2023 alone, representing 5.3% of malaria cases in West Africa and contributing 2.5% of global cases and 1.9% of global deaths. Malaria transmission is generally stable in Ghana with varying endemicity across the regions. The Ghana Demographic and Health Survey (DHS) 2022 showed a reduction in national prevalence from 14.1% in 2019 to 8.6% in 2022, with the Greater Accra Region still having the lowest prevalence of 2.0%, and the Oti Region the highest (15.0%).

Malaria transmission in Ghana varies geographically and follows rainfall patterns. In the central and southern regions, two rainy seasons—April to June and September to November—drive transmission for nine months or more, with a smaller peak in May to July and a larger one in October to November. The northern region has a single season, starting in May, peaking in August, and extending into September or October. *Plasmodium falciparum* accounts for over 90 percent of infections, and *An. gambiae* and *An. funestus* are the primary vector species.

Historically, Ghana's malaria response has been underpinned by strong donor support from the U.S. President's Malaria Initiative (PMI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). Recent budget reductions and altered investment preferences by PMI, however, are creating urgent gaps in 2025–2026, particularly for entomological monitoring, insecticide treated net (ITN) procurement and distribution, social behavior change programming, routine intervention planning, and surveillance. PMI has cut most of the funding for system strengthening as it has prioritized immediately life-saving interventions. Although GF has maintained its core allocations, it has massively cut its budget for ITN procurement and distribution for 2026. The combined effect of declining external resources and deprioritization of key investment areas threatens to reverse years of hard-won progress. To respond, the BTG Initiative, launched in early 2025, is working with Ghana's National Malaria Elimination Program (NMEP) and partners to map and prioritize these shortfalls. The resulting Ghana Malaria Gaps Inventory (Attachment B) highlights the most critical areas for immediate financing with Table 1 describing the major opportunities for investment in 2025 and 2026.

The BTG initiative has identified the most urgent investment opportunities for 2025–2026, structured around two complementary objectives:

1) In the immediate timeframe, the priority is to prevent sickness and death during the upcoming peak malaria seasons by ensuring mass access to vector control, prompt diagnosis, and effective treatment.

2) In the medium to long term, the focus should incorporate resuming and sustaining progress toward elimination by staying ahead of emerging threats, investing in data-driven systems, and adopting new tools and innovations.

In the short term, Ghana requires bridging finance of $19.34 million to avert a rebound in malaria morbidity and mortality (Table 1). The most acute needs include $8.42 million to procure and distribute ITNs to fill gaps left by GF reductions for 2026, and $5.33 million to strengthen case management implementation at both facility and community levels (Table 1). Finally, $5.59 million is urgently needed to rebuild both epidemiological and

[1] Macrotrends 2025
[2] PMI/ Ghana, *FY 2024 Malaria Operational Plan*

entomological surveillance, resume therapeutic efficacy studies (TES) to monitor anti-malarial drug resistance, and restore the information systems that are essential for both immediate response and long-term planning.

Without urgent bridging finance, Ghana risks recording more malaria morbidity and mortality, particularly among children and other vulnerable groups in high-burden rural districts. Sustaining Ghana's malaria gains is both a public health and a development imperative. Closing immediate gaps will prevent avoidable deaths and maintain momentum, while longer-term investments in systems and innovation will enable the country to accelerate toward elimination. We call on government, donors, private sector partners, and philanthropies to act decisively to close these financing gaps. Protecting Ghana's malaria progress is not only a matter of saving lives but also a strategic investment in national resilience, equity, economic prosperity and stability.

It is hoped that this summary format might encourage potential new partners to identify areas that suit their technical portfolios and budget availability. The need is great, the chance to save lives is compelling, and the opportunities to build resilient systems are tremendous.

How to use this document

Widespread funding disruptions have further complicated an already complex environment for international malaria control. This report intends to carefully document resulting gaps and opportunities in Ghana, providing guidance to prospective donors, malariologists and, most importantly, the Ghana Health Service (GHS) and the NMEP team. By necessity, it is lengthy and detailed. Our team has attempted to structure it in a way to ensure accessibility by technicians and laypeople alike. Readers will find increasing detail by reading further into the document; those interested in high-level overviews may read the glossy primer, available at malaria.akros.com (resources), while those looking for detailed information about specific vector control interventions, for example, would look towards later chapters.

This document begins with a brief overview of the current funding crisis, an introduction to the BTG team and analysis methods, closing with a commentary on the historical structure of international aid. While there is much to praise in the generosity and velocity of past efforts, there have been weaknesses worth considering during this restructuring phase. Following this, we provide a targeted list of priority interventions which will be required, in our opinion, for Ghanaians to avoid unnecessary sickness and death in the short-term. Last, and longest, in the "Results" section we provide detail on those high priority investments and lower priority or longer-term investments in Ghana's malaria control portfolio.

Introduction

Malaria Control at a Critical Juncture

The recent contraction in funding from the PMI has posed significant challenges to malaria control and elimination efforts in Africa, creating potential risks for national programs. In the case of PMI, abrupt stop work-orders, project terminations, and the dismantling of U.S. Agency for International Development (USAID) largely halted PMI funding flows and implementation support during the first half of 2025. This was followed by slow and still-uncertain resumption of partial implementation support under the US Department of State from mid-2025. Neither the GF nor the Ministry of Health (MOH) were in a position to make up for the large gaps created, while Bill Gates pointed out that even large foundations such as the Gates Foundation did not have the resources to step in to support intervention access at scale[3]. Modeling from the Malaria Atlas Project (MAP) (February 2025) for Ghana estimated that sustained PMI funding disruptions could lead to an additional 250,000 malaria cases and over 600 deaths in 2025 alone[4]. (Of note: while the modelling was useful for highlighting the stakes, it is fortunate that this worst-case scenario has not come to pass.) In response to this fluid and uncertain situation, the BTG Incubator[5]—a collaborative initiative launched by Akros and Population Explorer—was established to support country-led efforts to rapidly identify and address critical implementation and financing gaps in malaria programs across five high-burden countries.

BTG initiative - our team and goals

BTG supports national malaria programs by facilitating expedited, detailed assessment of funding shortfalls, producing targeted investment cases, engaging with donors, and coordinating the deployment of local implementation partners. Its approach is aligned with global strategies developed by the WHO, Roll Back Malaria, the GF, African Leaders Malaria Alliance, and the former PMI. Target countries were selected based on high malaria burden and strategic need, and currently include Zambia, Ghana, Ethiopia, Nigeria, and the Democratic Republic of Congo.

The initiative was launched shortly after the February 2025 announcement of the USAID shutdown and is led by a core Executive Leadership Team (ELT) composed of former USAID, CDC and global malaria experts. This team works in close partnership with national malaria programs, technical agencies, and implementation partners in each country. BTG also receives strategic guidance from a Board of Advisors, comprising global leaders in malaria control and international development. As a lean, country-focused incubator, BTG has moved quickly, earning enthusiastic support from all participating countries and rapidly generating operational momentum.

The central aim of BTG is to mobilize the resources necessary to protect and sustain progress toward malaria control in the face of funding volatility. This white paper focuses specifically on Ghana, detailing the immediate resource needs created by the withdrawal of United States government (USG) support and outlining a locally led response to preserve gains and protect lives. Although the development of this white paper benefitted

[3] Rogelberg, S. (2025, March 18). *Bill Gates reportedly warned Trump his foundation won't be able to fund global health gaps if the administration keeps making major cuts. Fortune*. Retrieved from https://fortune.com/2025/03/18/bill-gates-warned-trump-administration-foundation-usaid-foreign-aid-funding/

[4] Symons et al 2025. Estimating the potential malaria morbidity and mortality avertable by the PMI in 2025: a geospatial modelling analysis. The Lancet. 405: 2231- 2240

[5] BTG website is found at www.malaria.akros.com

greatly from the collaboration of the MOH and partners, the findings and recommendations represent BTG opinions.

BTG methods

Using the PMI Malaria Operational Plan (MOP) and GF allocation documents as primary sources, BTG catalogued key interventions—such as vector control, case management, surveillance, and entomological monitoring—historically supported by these donors. We then collaborated closely with Ghana's NMEP (Attachment A, Letter of Support and Engagement, Ghana), GF stakeholders, and PMI implementing partners to assess which activities were likely to be cut, partially maintained, or remain unfunded in calendar years (CY) 2025 and 2026.

This painstaking process, which was initiated in February 2025 and was conducted during a period of rapid change to October 2025, enabled us to map expected funding shortfalls by intervention and to prioritize activities for alternate resource mobilization. For PMI, the assessment aimed to capture the *de facto* budget revisions resulting from the Foreign Assistance Review (FAR) which played out in the first half of 2025 while most PMI-funded activities were paused or cancelled outright. For the GF grant, the assessment captured the formal budget revisions resulting from the reprioritization exercise in June-July which had been mandated by GF-Geneva. This approach permitted up-to-date estimations of *Original* versus *Revised* expected spending, by malaria intervention area, during the August 2025 to December 2026 period.

The result of this effort is the Ghana Malaria Gaps Inventory and Prioritization ("Inventory"), a live working document that provides a detailed, activity-level assessment of malaria control interventions across Ghana for the remaining months of 2025 and all of 2026, including budgets, implementing partners, current status, and mitigation options. Further, the gaps inventory outlines each activity's financial gap, potential mitigation pathways, and priority level for replacement funding.

International aid - where do we stand?

Strengthening local capacity

For over two decades now, malaria control and elimination stakeholders have invested heavily in two parallel objectives: providing technical and financial support to malaria interventions and strengthening the country-led systems to deliver those interventions. The overarching goal, whether directly stated or not, was to interrupt the unnecessary deaths of millions, while simultaneously empowering vulnerable countries to lead this fight without external assistance. We have seen remarkable progress on both objectives, but the recent, drastic cuts to foreign aid have exposed apparent weaknesses in our historical approach: malaria continues to rise, and many countries remain ill-equipped to counter this deadly threat on their own.

Our gap analysis should be read against this global history. Where systems remain under-capacitated, simply restoring budgetary line-items (if that were possible) would not, on its own, deliver on these ideals. The approach to aid must change, but the exact method is unclear. Finding and executing an effective solution will require patience, iteration, and close collaboration with governments.

Resources are shrinking

The rapid reductions in foreign aid in early 2025 compounded an already ominous global challenge: malaria resources are inadequate to meet the rising rate of infections and deaths. Our instinct is to meet this crisis head-on, identifying the most vulnerable populations and bringing to them life-saving resources as quickly as possible. We recognize the clear tension this brings to the patient, capacity-building objectives detailed above.

Our position

Our stance is twofold. First, we will emphasize efficiency and precision in deploying interventions that prevent unnecessary deaths now. With a shrinking pool of resources, we cannot tolerate excess—large consultant footprints, sloppy targeting, or lax coverage indicators.

Second, every near-term efficiency gain should also harden country systems wherever feasible. In practice: default to the Ghanaian government's platforms and routines when risk is manageable; where risk is high, use time-bound parallel channels with a clear plan—and date—for re-entry to country systems. The destination remains country leadership; the route must be pragmatic and sequenced.

Pushing for rapid deployment of efficient interventions can feel at odds with the slower, patient work of country ownership. We must hold both truths. Protect children and other vulnerable groups now and ensure that each immediate gain is somehow paired with new methods for government engagement so it persists beyond the current funding cycle.

Immediate priorities for Ghana's malaria control

At the time of this writing November 2025, the funding picture remains fluid. Although revised donor commitments by PMI and GF for the remainder of CY 2025 have largely come into focus, much uncertainty remains regarding PMI support in CY2026 and beyond, and regarding GF support in CY2027 and beyond. What is clear, is that the combination of funding cuts and shifts in donor priorities have created several alarming gaps in support for malaria control. These gaps place vulnerable populations at increased risk of malaria infection and death in the immediate term while threatening to undermine progress in the longer term.

In this context, based on its inventory and gap analyses, the BTG team has identified a set of major opportunities for new partners to make impactful investments in Ghana. During this time of budgetary constraints in global health, it is the BTG teams' informed opinion that a targeted set of interventions warrant urgent support: These are summarized in Table 1. More in-depth analysis is provided in the next chapter of this report.

The team prioritized activities based on **two main criteria**:

(1) They are significantly underfunded, with expected spending in 2025-2026 much reduced from their original budgets for 2025-2026

(2) They contribute centrally to one or more high-level malaria control objectives in Ghana:

- **Prevent sickness and death** during the upcoming peak malaria seasons (April/May - Oct/Nov 2025, April/May -Oct/Nov 2026) by ensuring access to core, life-saving interventions.
- **Stay ahead of threats** and make evidence-based investments.
- **Resume and sustain progress** in malaria burden reduction by strengthening national systems and human resources.

Table 1 (below) and related commentary comprise what BTG believes to be the most immediate and urgent requirements for Ghana to stave off malaria resurgence and protect vital health systems. The chapters following, beginning with an overview of Ghana's malaria environment, provide a more detailed analysis of both short-term and longer-term gaps, opportunities and risks.

Table 1. Bridging Gaps in the Malaria Fight in Ghana - Major Opportunities for Investment in 2025-2026

Intervention	Acute needs	Gap (in Millions USD)	Rationale
ITN Distribution	• Procure ITNs for 2026. continuous distribution channels • Warehouse and distribute these ITNs.	$8.42M	• Prevent infected mosquito bites to reduce malaria cases and save lives. • Continuous ITN distribution through ANC and Expanded Programme on Immunization (EPI) clinics to cover high-risk populations of pregnant women and children under 5 in all but the lowest-burden districts. • GF has reduced the funding to procure ITNs. Therefore, the planned coverage targets for the upcoming continuous distributions may not be met, potentially leaving vulnerable populations at increased risk of malaria.
Case Management Implementation	• Train, supervise, and provide quality assurance for healthcare facilities and community health workers (CHWs). • Sustain activity levels of CHW volunteers through provision of enabler packages.	$5.33M	• Provide prompt and effective diagnosis and treatment of malaria infections to avert severe complications and save lives. • Commodity needs (medicines, tests) are relatively well catered for in 2025-26, but implementation budgets have been slashed. • Leverage the volunteer labor and zeal of Ghana's "army" of community health volunteers.
Data for Decision Making	• Entomologic surveillance: Track insecticide resistance, invasive vectors. • Epidemiologic surveillance: Track malaria cases and deaths; track anti-malarial drug resistance. • Program monitoring and evaluation (M&E): Use household surveys, geospatial tools, data analysis tools to guide investments.	$5.59M	• Data visibility to protect malaria investments. • Threat detection and mitigation, especially for insecticide resistance in the mosquito, anti-malaria drug resistance in the parasite, and the dangerous, invasive *An. stephensi* mosquito. • Leverage Ghana's proven track record in data capture and use • Limit the damage of severe, abrupt funding cuts in this area.
Total		$19.34M	

Malaria in Ghana

Overview

In spite of significant progress, malaria remains a major public health concern in Ghana, accounting for most outpatient department consultations. It is endemic and affects all ages, with the majority of infections observed in children under the age of five and pregnant women (MOP FY2024). The entire population is at risk of malaria infection in Ghana, although transmission intensity varies by geographic region and is closely linked to rainfall patterns[6]. Ghana is among the countries with the highest malaria burden globally and in the African region. According to data from the 2024 WHO World Malaria Report, Ghana recorded over 6.5 million cases of malaria and 146 reported deaths due to malaria in 2023 alone[7]. Although Ghana has sustained its malaria prevention and control interventions for years, making steady progress according to global indicators, 2.5% of global malaria cases and 1.9% of global malaria deaths still occur in the country[8]. Malaria cases and deaths trend analysis from 2015 to 2023 show that, although there was no major shift in terms of case numbers, impressive results were achieved in reducing deaths due to malaria (Fig 1 below).

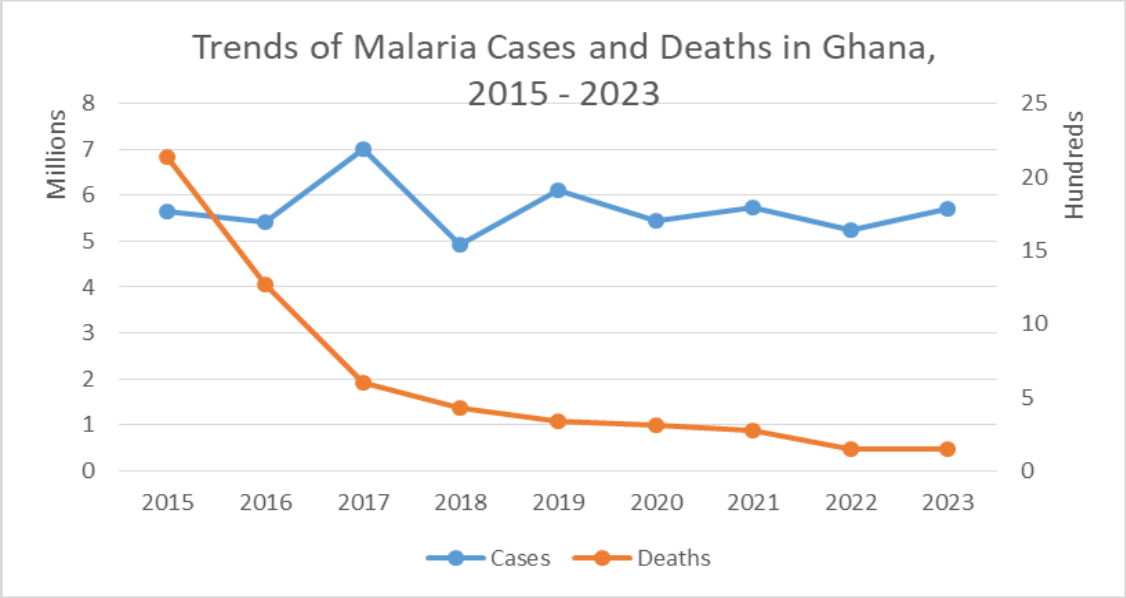


Figure 1. Trends of Malaria Cases and Deaths in Ghana, 2015-2023. Extracted from World Malaria Report 2024.

Plasmodium falciparum is the major parasite accounting for over 90 percent of malaria infections, while *An. gambiae* and *An. funestus* are the main vector species contributing to transmission in Ghana.

Ghana's NMEP is internationally recognized for its adroit implementation of WHO's recommended sub-national tailoring (SNT) approach to deploying interventions. The NMEP conducted stratification exercises in 2023 based on malaria prevalence and incidence metrics, as well as all-cause mortality among children under five years of age to develop a composite score for each district. The epidemiological data were combined with district-level measures of entomology, insecticide resistance, seasonality, urbanization, and access to care to identify core interventions to be implemented in each district, including case management, intermittent preventative

[6] World Malaria Report 2024

[7] https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2024

[8] https://www.severemalaria.org/countries/ghana

treatment (IPTp), indoor residual spraying (IRS), seasonal malaria chemoprevention (SMC), post-discharge malaria chemoprevention (PDMC), ITNs, larval source management (LSM), and malaria vaccine (MV)[9]. Accordingly, a district-level stratification with intervention mix was produced (Fig 2), representing the estimated optimal deployment from a technical point of view. The NMEP's planning map for actual deployment was appropriately modified based on operational and funding considerations, consistent with international best practice.

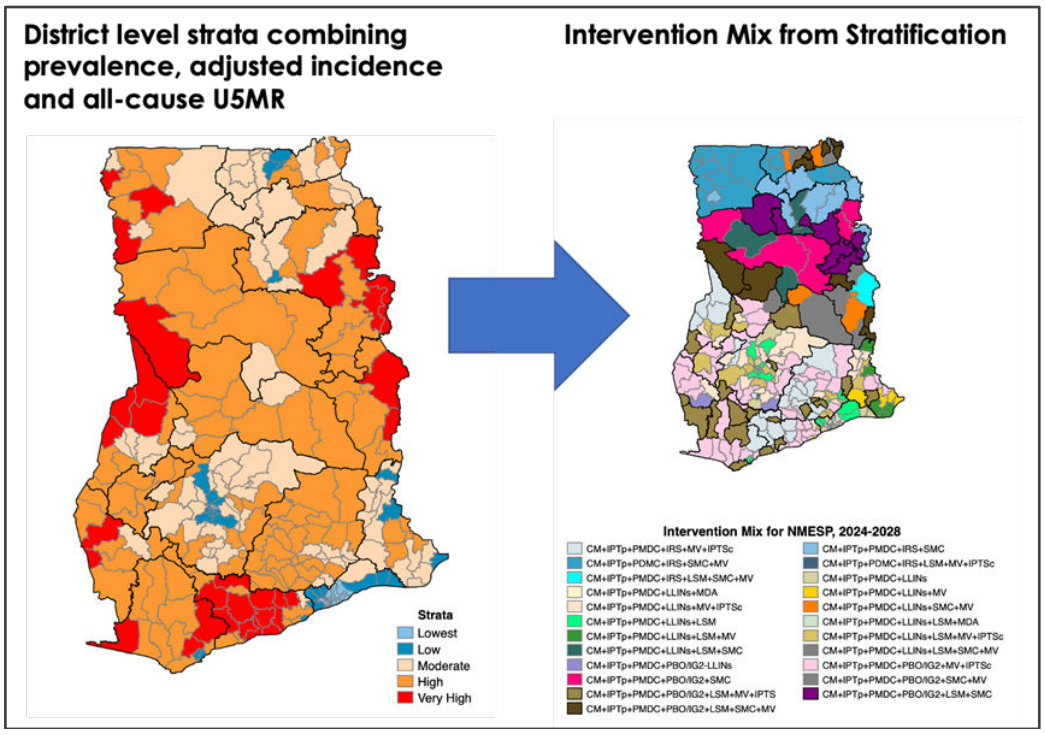


Figure 2. Ghana districts stratified into five strata based on a combination of malaria prevalence, adjusted incidence, and all-cause under five mortality rate (U5MR). On the right, the interventions recommended by the National Malaria Elimination Strategic Plan).

Regional Heterogeneity

Ghana spans 238,535 square kilometers, with elevations ranging from sea level to about 883 meters and average temperatures between 23°C and 30°C, conditions that are highly conducive to malaria transmission. Although transmission is generally stable throughout the country, the intensity varies across its three ecological zones: the coastal savannah in the south, the forest zone in the center, and the Sahel savannah in the north.

In the coastal savannah and forest zones, two rainy seasons—March to June and September to November—produce two corresponding peaks in malaria transmission. In these southern areas, transmission can occur for nearly ten months of the year, with the heaviest burden during the rains. The northern Sahel savannah experiences a single rainy season from June to October, which results in one highly intense transmission peak.

Topographically, Ghana is predominantly low-lying, with more elevated terrain concentrated in the east. The regions with the highest malaria burden tend to be those with prolonged rainy seasons, dense forest vegetation,

[9] US Presidents Malaria Initiative. Malaria Operational Plan FY 24, Ghana Country Profile

warm temperatures, and abundant, efficient malaria vector species. These environmental conditions, combined with human behaviors, livelihood patterns, and socio-economic factors, create a landscape where malaria transmission remains consistently high.

The National Malaria Strategy and Progress to Date

Ghana has made significant progress regarding malaria control over the years. For instance, deaths due to malaria have reduced from 2,799 in 2012 to 151 in 2022. Malaria prevalence has also declined from 27.5% in 2011 to 8.6% in 2022 while confirmed malaria cases per 1,000 population has reduced from 192 in 2019 to 159 per 1,000 in 2020[10]. Despite these achievements, malaria remains a significant public health problem in Ghana.

Ghana launched its National Malaria Elimination Strategic Plan (NMSP) 2024–2028 in January 2024, marking a shift in focus toward achieving malaria elimination in a select number of districts. The introduction of this new strategy officially brought an end to the 2021–2025 National Malaria Strategic Plan. The NMSP builds upon the progress achieved in recent years and incorporates contributions from a broad range of stakeholders—including health partners, community representatives, the research community, academia, and non-governmental organizations. It provides a framework to guide stakeholders in aligning their efforts with Ghana's accelerated malaria control and pre-elimination agenda.

The NMSP 2024–2028 is guided by three overarching goals and eight strategic objectives. These are summarized below.

The three goals include:

1. Reduce malaria mortality by 90% by 2028, using 2022 as the baseline.
2. Reduce malaria case incidence by 50% by 2028, using 2022 as the baseline.
3. Eliminate malaria in 21 districts with a very low malaria burden by 2028

The NMSP 2024–2028 eight strategic objectives include:

1. Ensure that 100% of the population has adequate knowledge, attitudes, practices, and skills for malaria elimination.
2. Ensure that 100% of the population uses at least one malaria prevention measure.
3. Ensure that 100% of suspected malaria cases are tested.
4. Ensure that 100% of confirmed malaria cases are appropriately, effectively, and completely treated.
5. Strengthen malaria surveillance, monitoring, and evaluation systems.
6. Ensure timely and adequate supply of quality-assured malaria commodities to all service delivery points.
7. Strengthen and maintain governance and program management capacity at all levels of the health system to achieve malaria elimination objectives.
8. Improve resource mobilization and ensure efficient use of available resources toward malaria elimination.

[10] Ghana National Malaria Strategic Plan 2024 - 2028

Elimination Focus and Case Management Strategy

Ghana has identified 21 districts in the Greater Accra Region as targets for malaria elimination by 2028. Key interventions in these districts, as outlined in the NMSP, include mass drug administration (MDA), single low-dose primaquine, enhanced epidemiological surveillance and enhanced entomological surveillance. The NMSP 2024–2028 also underscores the central role of diagnosis and treatment in achieving elimination goals.

- Diagnostics: Strategies include improving access to parasitological testing, strengthening laboratory technician capacity through pre-service and in-service training, expanding diagnostic quality assurance systems, and ensuring adequate staffing of laboratory personnel nationwide.
- Treatment: Efforts focus on capacity building for community health officers (CHOs) and community health volunteers and students through in-service and pre-service training, developing and distributing job aids, treatment guidelines, and social and behavior change (SBC) materials, enhancing data collection and management, and monitoring antimalarial efficacy through TES.

Prevention Strategy

The NMSP's prevention component integrates vector control, SBC, and drug-based interventions:

- Vector Control: Routine and targeted ITN campaigns, IRS, LSM, and strengthened monitoring, surveillance, and data utilization.
- SBC: Increased focus on risk communication and community engagement at regional and district levels; continued use of mass and social media for public engagement; and intensified community sensitization through platforms such as community durbars.
- Drug-Based Prevention: Includes intermittent preventive treatment in pregnancy (IPTp), seasonal malaria chemoprevention (SMC), MDA, intermittent preventive treatment in schoolchildren, PDMC, and the MV.

While Perennial Malaria Chemoprevention (PMC) is not currently part of the NMSP 2024–2028, the MOH continues to closely monitor ongoing studies on combining PMC and MV deployment in Ghana to inform future malaria prevention strategies.

Table 2. MOH Summary of NMSP Goals and the Key Approaches (NMSP 2024–2028). For full details, please refer to the NMSP document.

Strategic Area/ Focus Investment Area	NMSP Goals (2024/25–2026/27)	NMSP Key Approaches
Vector Control	To ensure 100% of the population use at least one malaria preventive measure by 2028.	- Universal ITN coverage - Targeted IRS, LSM, and - Deployment of new-generation ITNs
Case Management	Ensure 100% of suspected malaria cases are tested by 2028. Ensure 100% of confirmed malaria cases are appropriately and completely treated by 2028.	- Universal access to quality diagnostics and treatment - Rapid case detection - IPTp integration - Strengthen case detection, adherence, and quality of care at all levels of care
Supply Chain	Ensure timely and adequate supply of quality-assured malaria commodities to all service delivery points by 2028.	- Improved forecasting, procurement, warehousing, and last-mile distribution - Focus on uninterrupted commodity flow data-driven supply planning, and capacity-building for logistics staff
Surveillance, Monitoring, Evaluation (SMEOR)	Strengthen surveillance, monitoring and evaluation systems by 2028.	- Emphasis on digital platforms (DHIS2, eCHIS). - Routine data quality assessments, and operational research (OR) — consistent with NMSP - Ensure data-driven decision-making and program adaptability
Social Behavior Change (SBC)	Ensure 100% of the population have adequate knowledge, attitudes, practices, and requisite skills for malaria elimination by 2028.	- Update communication plan. - Mass media campaigns, and community engagement - Prioritize ownership, awareness, and sustained use of preventive measures

The total estimated cost of implementing Ghana's NMSP from 2024 to 2028 is approximately USD 3.0 billion, based on the NMEP's cost projections shown in Table 3. Vector control accounts for the largest share of planned expenditures, representing the single highest spending area across the 2024–2028 period, with particularly large allocations in 2024 and 2027 driven by nationwide ITN distribution campaigns.

Other major investment areas include case management and procurement and supply chain management (PSCM), which together constitute a significant portion of the overall budget. Additional spending is planned for SMEOR, as well as specific prevention interventions, such as IPT and social and behaviour change communication (SBCC). While these areas represent noteworthy priorities, their funding levels remain markedly lower than those allocated to vector control and case management.

Focusing specifically on 2025 and 2026, the projected resource requirements are approximately USD 585 million for 2025 and USD 623 million for 2026. Expenditure during these years remains heavily concentrated in vector control, which accounts for roughly 57% of annual costs, largely due to ITN procurement and distribution. Other major spending areas include PSCM for medicines and diagnostics at about 16% and case management implementation at around 15%. Together, these three modules—vector control, PSCM, and case management implementation—absorb nearly 90% of total planned spending in both 2025 and 2026.

The Ghana NMSP 2024–2028 does not specify how much each funding partner, including the Government of Ghana (GOG), the GF, PMI/USAID, or others, will contribute to the total resource envelope. As a result, although the NMSP provides a detailed financial projection by technical module, the distribution of financing across domestic and external sources remains undefined. This lack of clarity highlights the need for further partner engagement and resource mapping to determine the degree of reliance on major external partners versus domestic financing, and to identify potential funding gaps that may threaten sustained progress toward malaria elimination.

Table 3. Ministry of Health Costing Summary for Implementation of the National Strategy by Module (NMSP 2024–2028) (Amounts in USD).

Module	2024	2025	2026	2027	2028
Vector Control	426,251,314	36,784,060	41,485,435	491,439,835	49,283,087
IPT	8,581,062	7,890,828	11,017,106	9,808,299	12,911,431
SBCC	36,294,347	37,824,950	42,742,194	47,016,413	50,783,699
Other	1,766,021	2,745,287	3,120,337	3,409,318	3,688,335
Case Management Implementation	113,316,480	129,448,763	146,030,408	160,633,448	173,683,125
PSCM	118,931,890	126,434,268	137,979,480	148,445,872	158,571,340
SMEOR	13,468,582	15,586,927	17,623,070	19,351,833	20,911,673
Programme Management	2,310,072	99,484	113,089	123,659	134,350
Total	746,239,070	381,260,264	438,305,734	909,775,397	511,312,350

Malaria Elimination Challenges

While the aspiration of a malaria-free Ghana remains intact, the country's ambitions are at a crossroads. The resurgence of malaria in the wake of sustained progress is a stark reminder of the fragility of public health gains in the face of climate change, vector adaptation, *Plasmodium falciparum* histidine-rich protein 2/3 (HRP2/3) deletions, drug and insecticide resistance, and funding volatility. Ghana's malaria program has demonstrated the capacity for both innovation and resilience. However, closing the implementation and funding gaps will be essential for restoring progress toward elimination.

Health System and Implementation Bottlenecks

Ghana's malaria elimination aspirations—anchored in the NMSP 2024–2028—face a complex array of implementation bottlenecks. The NMEP has demonstrated innovation and resilience, yet persistent challenges in surveillance, financing, and workforce distribution continue to impede full implementation. Reporting completeness and timeliness vary widely, with gaps in private sector and community-level data. The NMSP therefore prioritizes strengthening SMEOR to enhance data quality and responsiveness.

Human resource shortages, especially in rural and high-transmission areas limit service delivery despite the strong foundation of the Community-based Health Planning and Services (CHPS) system. To overcome these constraints, Ghana is pursuing a progressive, subnational elimination approach grounded in stronger community engagement, inter-sectoral collaboration, and use of data-driven interventions. This strategy seeks to sustain recent gains, adapt to emerging threats, and accelerate the country's transition from malaria control to elimination.

Surveillance and Reporting Gaps

Ghana has made notable advances in data management through the District Health Information System (DHIS2), yet inconsistencies in completeness and timeliness persist, particularly in remote and underserved districts. The NMSP emphasizes that while the national reporting completeness rate has improved, data quality and integration from private health facilities, community pharmacies, and over-the-counter medicine sellers remain sub-optimal.

Weak feedback loops, limited interoperability between digital platforms, and periodic stock-outs of diagnostic supplies constrain real-time case tracking and response. To close these gaps, the NMSP prioritizes strengthening the SMEOR system, expanding electronic reporting, and improving verification through sentinel sites and laboratory networks. Enhanced training, supervision, and data quality audits are planned to improve accuracy, while efforts are underway to institutionalize case classification and rapid investigation in elimination-targeted districts.

Diagnostic, Drug Resistance, and Socio-Cultural Barriers

Rising insecticide and potential drug resistance pose increasing risks to Ghana's elimination agenda. The emergence of *Anopheles stephensi* in Accra in 2023 has introduced a new urban vector with known multi-insecticide resistance. Similarly, monitoring reports cite widespread pyrethroid resistance, prompting a transition toward dual-active-ingredient (dual-AI) long-lasting insecticide treated nets (LLINs). The NMSP also highlights concerns about HRP2/3 gene deletions, which threaten the reliability of HRP-based rapid diagnostic tests (RDTs).

Socio-cultural factors continue to affect uptake of malaria interventions. Net misuse, refusal of IRS in certain localities, and inconsistent adherence to treatment regimens undermine community-level effectiveness. The NMEP's response focuses on Social and Behaviour Change (SBC) interventions, community dialogue, and gender-sensitive messaging to increase acceptance and sustained use of preventive tools.

Population Mobility, Displacement, and Cross-Border Transmission

Population mobility and cross-border movements remain important drivers of malaria transmission in Ghana. Migrant labor patterns, particularly seasonal migration from northern to southern regions facilitate parasite re-

introduction into areas of declining transmission. Border districts adjoining Côte d'Ivoire, Togo, and Burkina Faso face persistent risks of re-importation.

The NMSP promotes cross-border collaboration under Economic Community of West African States and West African Health Organization frameworks and prioritizes enhanced surveillance at points of entry, transport corridors, and migrant settlements. The plan also integrates malaria control within humanitarian response mechanisms to address health service gaps among mobile and displaced populations.

Vector Control Challenges

Ghana continues to rely on a combination of LLIN distribution, IRS, and entomological surveillance as its core vector control package. However, maintaining universal LLIN coverage and sustaining IRS operations remain costly and logistically demanding. Entomological monitoring indicates widespread resistance to pyrethroids and partial resistance to carbamates, reducing the efficacy of conventional LLINs and insecticides.

To address these challenges, the NMSP endorses phased deployment of next-generation dual-AI LLINs, expansion of IRS in high- and moderate-burden districts, and integrated vector surveillance to guide insecticide rotation strategies. Limited funding, however, constrains large-scale LSM implementation and routine entomological assessments. The plan therefore calls for stronger multisectoral collaboration, particularly with environmental, agricultural, and local government sectors to improve cost-efficiency and sustainability of vector control interventions.

Funding Landscape

Ghana's malaria elimination trajectory was facing mounting financing pressures, even prior to the disruptions of 2025. Although the GOG has demonstrated sustained political commitment, the NMEP remains heavily dependent on external financing, principally from the GF and PMI. According to the NMSP 2024–2028, the cost of implementing the plan is estimated at nearly USD 3 billion over five years, yet available resources fall far short of this requirement. Annual program financing needs range from USD 381 million in 2025 to USD 909 million in 2027, underscoring a widening resource gap[11].

Domestic funding allocations, though improving through mechanisms such as the District Assembly Common Fund and the National Health Insurance Scheme, remain insufficient to ensure sustained coverage of key interventions. Funding volatility threatens continuity of IRS, LLINs, LSM, IRS, and surveillance and M&E activities. The NMSP calls for diversification of funding sources, enhanced private-sector engagement, and stronger alignment between national and donor investment frameworks to safeguard progress toward elimination.

In 2025, associated with the new US administration's FAR, PMI and the GF signaled reductions in planned allocations for the 2025–2026 period and beyond (Figure 4). For PMI, this includes significant cuts to activities not deemed lifesaving in the short term, including IRS (even though it is lifesaving), entomological monitoring (within the vector control category), surveillance, M&E, OR, surveys, SBC and malaria elimination activities, among others. Meanwhile, the GF's funding realignment exercise has led to the reduction or cancellation of activities totaling nearly US $12.3 million for Ghana over the current two-year period (2025 – 2026). At the same time, the Grant Cycle 7 2023-2025 allocation has shifted some funds away from longer-term investments—such as data system strengthening, public education, and innovation—toward short-term commodity needs,

[11] Ghana National Malaria Strategic Plan 2024 - 2028, pXIII

including RDTs and ACTs. Although the GOG is expected to increase its allocation to health overall, and to malaria specifically, its fiscal space remains severely constrained.

The sudden contraction in financing and the uncertainty in future support poses a risk to the gains made so far. Like nearly all non-island countries across sub-Saharan Africa, gains in reducing case incidence had already stagnated by 2016, although malaria deaths in many countries continued to improve through at least 2022. From 2025-26 onward, the anticipated reduction in mass access to prevention and treatment services, particularly in high-burden or hard-to-reach districts could reverse trends in declining mortality as well. The loss of funding for IRS and ITN campaigns in high-burden areas, two major vector control interventions in selected high malaria burden districts, together with cuts to entomological monitoring, including surveillance for *An. stephensi* in urban cities, is likely to fuel the ongoing malaria upsurge. In addition, reductions in support for surveillance and data systems further weaken Ghana's ability to identify and mitigate threats such as antimalarial drug resistance and invasive vectors such as *An. stephensi*, detect outbreaks, and measure impact in real time. Given that ITN use in Ghana is already low (49% among children under 5 according to the DHS 2022), the loss of SBC funding, which plays a critical role in raising household awareness, promoting intervention uptake, and engaging communities, will further exacerbate the country's malaria situation.

While Ghana's government is increasingly engaged in health financing, its current fiscal space limits the ability to immediately absorb donor withdrawal. This creates an urgent need for bridging strategies, including catalytic donor engagement, reallocation and sustained domestic resources, and enhanced coordination across implementing partners.

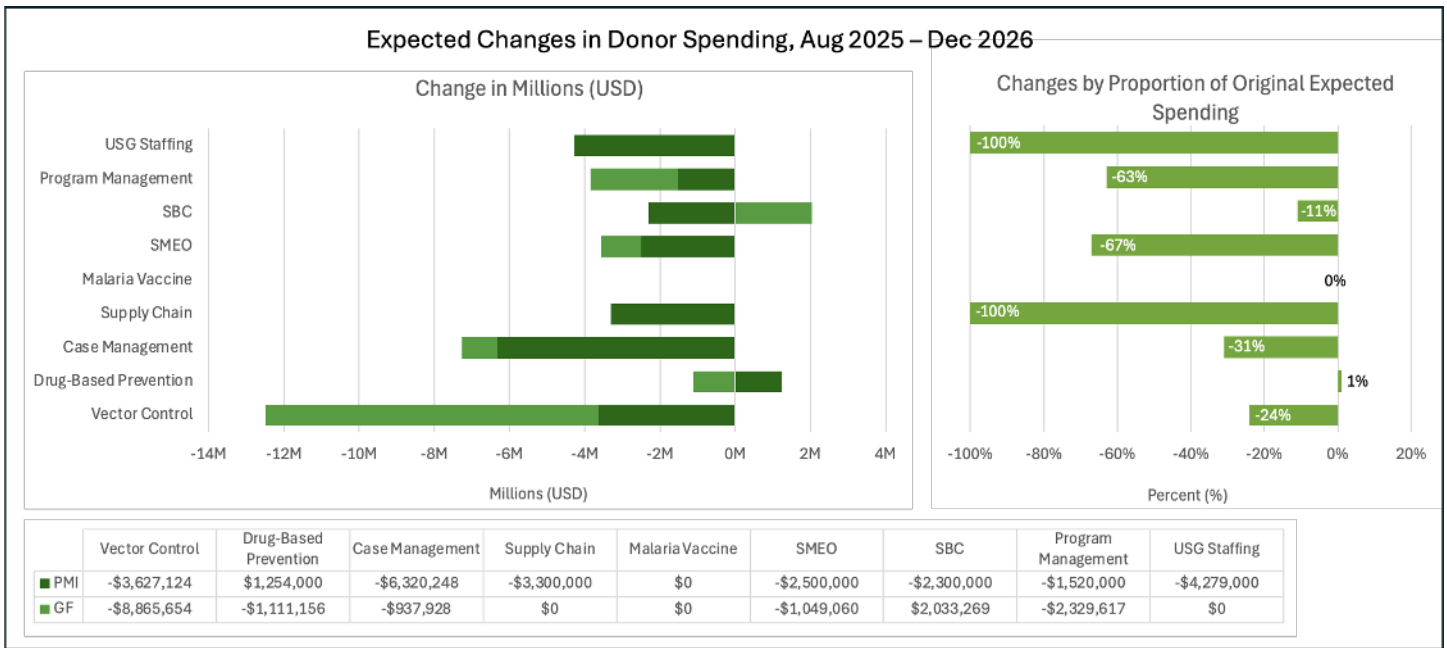
Results: Ghana Malaria Gaps Inventory and Prioritization

The Ghana Malaria Gaps Inventory ("Inventory") is structured using the same intervention areas (aka "categories" or "focus investment areas") as found within the former USAID PMI MOP documents. MOPs are detailed implementation plans previously developed by PMI to guide malaria control and elimination efforts in specific countries. MOPs outline the strategies, activities, and funding allocations for PMI's support by fiscal year, aligning with NMCPs and global goals. These plans were previously developed in close collaboration with NMCPs and other key stakeholders.

A summary of inventory results is provided in Attachment B, organized by MOP 'focus investment areas' and capturing both PMI funding reductions and GF-MOH grant reprioritization. The full inventory has been shared with the Ghanaian NMEP.

In Ghana, for 2025–2026, PMI's originally planned allocation of $54 million (USD $27 million per year) has been revised downward by $31.4 million, leaving $22.6 million. Similarly, the GF-FMOH budget for years 2 and 3, initially set at $57.2 million, has been reduced to $44.9 million following reprioritization (a $12.3 million reduction).

Overall, the combined net change across PMI and GF funding for 2025–2026 amounts to a reduction of $34.9 million (Figure 3 and 4). The following sections detail and disaggregate these funding modifications by focus area.



	Vector Control	Drug-Based Prevention	Case Management	Supply Chain	Malaria Vaccine	SMEO	SBC	Program Management	USG Staffing
PMI	-$3,627,124	$1,254,000	-$6,320,248	-$3,300,000	$0	-$2,500,000	-$2,300,000	-$1,520,000	-$4,279,000
GF	-$8,865,654	-$1,111,156	-$937,928	$0	$0	-$1,049,060	$2,033,269	-$2,329,617	$0

Figure 3. Changes in Expected Donor Spending, August 2025-Dec 2026, by Intervention Area. The left-hand graph depicts the estimated difference between the original and revised spending levels, for each donor. The right-hand graph depicts the combined change for PMI and GF, expressed as a percentage of original expected spending.

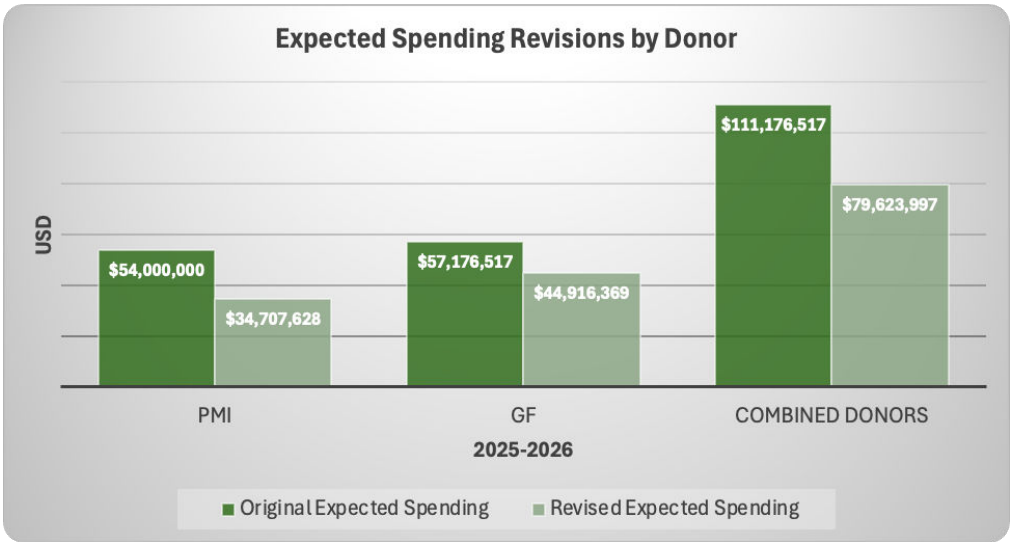


Figure 4. Funding was revised downward for PMI, GF by a total of -$34.9 million across 2025 and 2026 (combined).

Vector Control

Ghana's vector control strategy relies on a comprehensive, multi-pronged approach that includes entomological monitoring, ITNs, IRS, and LSM. The following sub-sections detail the original and revised donor allocations from PMI and GF for each of these core interventions for 2025–2026, highlighting the specific funding shortfalls that pose operational and malaria risks.

Table 4. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026 by PMI and GF.

Expected Spending Revision, Vector Control (2025-2026)			
	PMI	**GF**	**Totals**
Original Expected Spending	$22,973,752	$28,953,242	$51,926,994
Revised Expected Spending	$19,346,628	$20,087,587	$39,434,215
Net Change	-$3,627,124	-$8,865,654	-$12,492,779

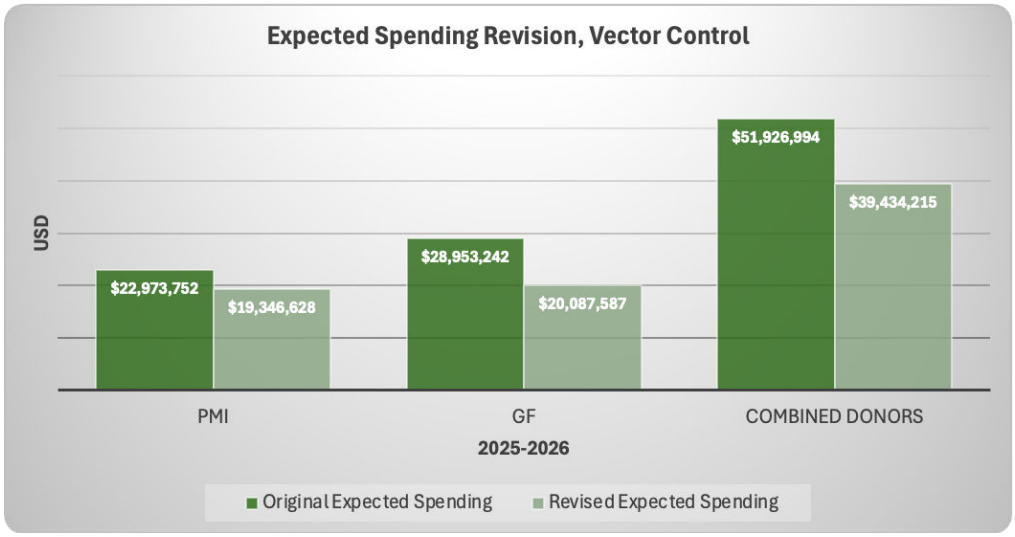


Figure 5. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026, by donor.

To summarize, PMI reduced its expected spending on vector control by $3.6 million, falling from $23 million to $19.3 million (Table 4, Figure 5). GF (MOH) contributions also declined, with a reduction of approximately $8.9 million—from $29 million to $20.1 million. Taken together, across both funding streams, Ghana is projected to face a net reduction of $12.5 million in vector control resources over the 2025–2026 period.

	Entomological Monitoring	Procurement of ITNs for Mass Campaign	ITNs Mass Campaign: Storage and in-country distribution	ITNs: Micro-planning, supervsion and post campaign review meetings	IRS Insecticide & PPE procurement and Distribution	IRS Operations	LSM	CDC STTA
PMI	-$1,069,296	$0	$0	$0	$603,522	-$3,161,350	$0	$0
GF	$226,131	-$8,260,139	-$163,621	$0	-$535,181	-$132,844	$0	$0

Figure 6. Expected spending revisions in vector control, for the period Aug 2025-Dec 2026, by donor and intervention area.

The following sections describe the funding modifications for each intervention associated with vector control which are depicted in Figure 6.

Entomological Monitoring

Ghana's entomological monitoring system operates through a collaborative approach supported by PMI, GF, and the NMEP. The program's core activities encompass comprehensive insecticide resistance monitoring, which is conducted at 30 sentinel sites across the country to ensure coverage of all ecological zones. In addition, monthly vector bionomics studies are carried out at six of the 20 designated national entomological sites, providing vital

information on mosquito population dynamics and behavior. To guarantee the quality of IRS, cone bioassays and wall bioassays are routinely performed in IRS districts. Surveillance efforts are further strengthened by targeted monitoring for *Anopheles stephensi,* focusing on nine peri-urban port and border locations, including Accra, Kumasi, Tamale, and other high-risk points of entry. Capacity building forms an integral part of the system, with ongoing training for entomology technicians, provision of microscopes, and specialized instruction in morphological identification. All data generated from these activities are systematically integrated into the NMSP's stratification framework, guiding the selection of insecticides for IRS and ITNs and informing national decision-making processes.

PMI Funding

- PMI originally budgeted **$1.2 million** for the 2025-2026 period (**$550,000 for 2025** and **$600,000 for 2026**) to support IRS quality control at 14 sentinel sites, insecticide susceptibility testing at 14 sites, and *An. stephensi* surveillance in selected sites.
- During budget reductions, this allocation was cut by **$1.1 million**, leaving **$80,704**.
- As a result, coverage has been reduced to a fraction of sites — IRS quality control and insecticide resistance testing are now limited to a handful of priority districts only, with *An. stephensi* surveillance largely unfunded.

GF/MOH Funding

- The GF allocated **$393,490** for entomological monitoring across 2025 (**$208,735**) and 2026 (**$184,755**). This funding was intended to support insecticide resistance monitoring in 15 sites and vector bionomics monitoring in 14 national sentinel sites. Funding also supports insecticide resistance, vector bionomics, and supports national entomological surveillance sites including surveillance for *An. stephensi* including field work, laboratory analysis of specimens, data management, and reporting.
- Following the re-prioritization exercise, the GF budgets for entomological monitoring in 2025 and 2026 **increased** by **$226,131 (**by **$224,143 in 2025** and **$1,988 in 2026)**.

Combined Reduction for 2025-2026

- The combined projected funding between PMI and GF does result in a decrease for entomological monitoring over this period of **~$843,165**.
- This represents a 55% cut relative to the original combined allocation.

Risk Statement:

The funding shortfall presents significant programmatic risks, most notably creating gaps in resistance detection due to the reduced number of operational sentinel sites. This limitation increases the risk that emerging resistance to insecticides such as clothianidin and chlorfenapyr will go unnoticed, potentially undermining the effectiveness of IRS and ITN interventions. Additionally, the reduction in cone bioassays compromises the quality assurance of IRS operations, diminishing confidence in spray efficacy and raising the likelihood of inefficient insecticide use. The threat of urban malaria is also heightened, as limited surveillance for *An. stephensi* could result in its undetected establishment and spread within Ghana's cities, thereby jeopardizing recent progress in malaria control. Moreover, incomplete entomological data caused by these constraints will weaken the NMEPs ability to stratify risk and target interventions effectively, undermining evidence-based decision-making. Finally, the reduction in funding threatens the retention of trained entomology staff and the continuity of vital laboratory systems, which are essential for sustained program performance.

Vector Control: Entomological monitoring

Priority level for seeking alternative funding: HIGH.

Expected Impact: IMMEDIATE.

Total net change (2025 - 2026) = -$843,165, an approximate 55% reduction

Risk (brief):

- The significant funding shortfall for entomological monitoring of 55% will severely limit resistance detection and quality assurance activities.
- Fewer operational sentinel sites and reduced surveillance for *An. stephensi* increase the risk of undetected insecticide resistance and urban malaria outbreaks.
- These gaps undermine evidence-based decision-making, threaten retention of trained staff, and jeopardize the effectiveness of IRS and ITN interventions, potentially reversing recent gains in malaria control.

Insecticide Treated Nets

Ghana's ITN strategy combines mass campaigns every three years with continuous distribution through ANC, the Expanded Programme on Immunization (EPI), schools, and targeted channels for special populations (e.g., prisons, orphanages, "kayayei," and security personnel). The NMSP 2024–2028 emphasizes universal coverage, with ITNs as the backbone of vector control in all 261 districts except those covered by IRS. ITN campaigns are complemented by durability monitoring, post-distribution surveys, and social SBC activities to improve net use. The next ITN mass campaign is scheduled for March-November 2027, complemented for the foreseeable future by continuous distribution through health facilities every year.

PMI Funding

- The original PMI budget for 2025 and 2026 remains unchanged at **$5.7 million** and **$4.9 million**, respectively, allocated for the procurement, storage, and in-country distribution of ITNs for the 2026 mass campaign, as well as continuous distribution through ANC, EPI, and schools. Through this support, approximately 3.8 to 4.0 million ITNs were expected to be procured and delivered to priority regions.

GF/MOH Funding

- GF originally budgeted **$12.7 million** for 2026 continuous ITN distribution in 2026 (**$870,287 for 2025** and **$11.8 million for 2026**) to support procurement, storage, in-country distribution, micro-planning, supervision, and review meetings.
- During budget reductions, allocation was cut by a dramatic **$8.4 million for 2025-2026**, leaving **$4.3 million**.

- The significant reduction in funding resulted in sharp cuts to ITN procurement, micro-planning, supervision, and review activities.

Combined Reduction for 2025-2026

- The total reduction in funding from PMI and GF for ITN distributions in 2025 and 2026 amounts to **~$8.4 million**.
- This shortfall threatens Ghana's ability to sustain universal ITN coverage, especially in high-burden areas, and may reduce the effectiveness of distribution campaigns.

Risk Statement:

The shortfall in ITN funding presents both immediate and medium-term threats to Ghana's malaria control efforts. With nearly half of operational funding lost, there is a significant risk that the 2026 ITN continuous distribution will fall short of achieving universal coverage, potentially leaving millions of people unprotected. Vulnerable populations, such as pregnant women, young children, and the urban poor, are particularly at risk of reduced access, especially if logistical operations and supervision are inadequately funded. Furthermore, cuts to warehousing, transport, and micro-planning threaten the timely and effective delivery of campaign activities, while reduced support for SBC interventions undermines efforts to increase ITN use, which remains low despite reasonable access. Collectively, these operational gaps not only jeopardize the immediate success of the campaign but also pose strategic risks by potentially diminishing donor confidence and reversing recent progress in reducing malaria prevalence.

Vector Control: ITN Continuous Distribution
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$8.4 million, an approximate 48% reduction** **Risk (brief):** ● This major funding shortfall for ITN activities poses immediate and medium-term risks to Ghana's malaria control, threatening coverage targets and leaving vulnerable groups at higher risk. ● Operational gaps from reduced funding may undermine ITN delivery and donor confidence, potentially reversing gains in malaria reduction.

Indoor Residual Spraying

IRS remains a cornerstone of Ghana's vector control strategy, especially in the northern savannah regions where malaria transmission is highly seasonal and intense. Supported by PMI and GF, IRS operations are conducted

across 28 districts. PMI covers 10 districts, GF supports 16, and the GOG contributes in 2 districts. In total, there are 261 districts in Ghana. Core activities encompass the procurement and distribution of insecticides, personal protective equipment (PPE), and spray supplies, alongside the training and deployment of spray operators, supervisors, and environmental compliance officers. Community mobilization and SBC activities are undertaken to ensure households are adequately prepared and receptive. Environmental compliance is closely monitored, with safe disposal of insecticide waste prioritized. Following each campaign, post-spray monitoring, which includes cone bioassays and coverage surveys, validates spray quality. These efforts consistently achieve coverage rates exceeding 90% of targeted structures, thereby protecting millions of people each year

PMI Funding

- In both 2025 and 2026, PMI's budget **increased by $301,761** per year for the procurement and distribution of IRS insecticide and PPE from **$1.4 million to $1.7 million**, while IRS operations **decreased by $1.6 million** per year from **$4.2 million to $2.6 million**.
- As part of cost-saving measures, the number of houses sprayed and the number of people protected remained unchanged; however, certain non-core activities, such as SBC interventions and environmental compliance activities, were scaled down to reduce overall expenditure.

GF/MOH Funding

- In 2025, the budget **increased by $995,797** for procurement and distribution of insecticide and PPE as well as operations from **$6.9 million** to **$7.9 million** across activities.
- However, in 2026, the budget **decreased by $1.7 million,** from **$8.9 million** to **$7.3 million** remaining for the year.
- Gains in 2025 allow for near-full coverage of planned districts, but the 2026 reduction risks scaling back operations, potentially leaving high-burden districts partially unsprayed.

Combined Reduction for 2025-2026

- The overall combined reduction in PMI and GF funding for IRS in 2025 and 2026 amounts to **~$3.2 million** (a decrease of $3.3 million for IRS operations and an additional $68,341 of funds for procurement and distribution).

Risk Statement:

The funding shortfall for IRS poses important medium-term risks to malaria control efforts. While current resource levels have not affected the number of structures sprayed or the population protected, they have significantly reduced support for environmental compliance, social and behaviour change (SBC), and critical trainings for spray personnel. These gaps may compromise operational quality and safety standards, potentially weakening the effectiveness of IRS over time. Although these constraints do not warrant IRS being prioritized above other interventions, they could, if unaddressed, gradually erode program performance and community trust, thereby affecting Ghana's longer-term progress toward malaria elimination.

Vector Control: IRS
Priority level for seeking alternative funding: LOW. **Expected Impact: MEDIUM TERM .** **Total net change (2025 - 2026) = -$3.2 million, an approximate 18% reduction** **Risk (brief):** ● Although funding for IRS in 2025–2026 has been reduced, the number of houses sprayed and the population protected is expected to remain unchanged in Ghana. However, the decrease in resources has led to scaling back of supporting activities, such as reduced number of days for training of IRS personnel, SBC outreach and environmental compliance, which may weaken programme effectiveness over time. These reductions could heighten the risk of under coverage, limit operational quality in high-risk areas, and potentially undermine both malaria control efforts and community trust.

Larval Source Management

LSM serves as a supplementary vector control approach targeting mosquito breeding sites, particularly in urban and peri-urban settings where aquatic habitats are "few, fixed, and findable." Core activities include environmental management, such as draining, filling, and clearing breeding areas, alongside larviciding with biological or chemical agents in selected locations. These efforts are supported by community mobilization and school-based campaigns to reduce standing water and foster environmental hygiene, as well as OR to evaluate LSM's impact on malaria transmission and mosquito populations. While LSM is recognized in Ghana's NMSP 2024–2028 as a potential intervention for urban areas, large-scale implementation has not been prioritized due to persistent funding limitations

PMI Funding

- No PMI funding was allocated for LSM activities during the 2025-2026 period.

GF/MOH Funding

- No GF funding was allocated for LSM activities during the 2025-2026 period.

Other Funding Sources

- GOG (MOH/GHS): Limited resources may support small-scale environmental management through municipal health departments.
- Local authorities and community initiatives: Some districts implement ad hoc drainage and sanitation campaigns, often supported by NGOs or private sector partners.

- Research institutions: Universities and partners occasionally pilot larviciding or environmental management projects, but these remain small-scale and not sustained.

Combined Reduction for 2025-2026

- With no PMI or GF allocations, Ghana's LSM activities rely entirely on government, local authority, and research-driven initiatives, which are fragmented and underfunded.

Risk Statement:

The absence of donor funding for LSM exposes Ghana to sustained urban malaria risks, as the country cannot effectively address *Anopheles stephensi* or complement ITNs and IRS in densely populated areas.

Vector Control: LSM
Priority level for seeking alternative funding: NOT APPLICABLE. **Expected Impact: LONGER TERM** **Total net change (2025 - 2026) =** No PMI or GF allocations **Risk (brief):** ● Ghana remains at risk of urban malaria due to a lack of donor funding for LSM, limiting the ability to control *Anopheles stephensi* in densely populated areas.

Drug-based Prevention

Prevention of Malaria in Pregnancy (MiP)

In Ghana, the MiP is anchored on the provision of IPTp with sulfadoxine-pyrimethamine (SP) through antenatal care (ANC) services. The NMSP 2024–2028 targets at least 80% of pregnant women to receive three or more doses of IPTp. To achieve this, activities focus on procuring and distributing SP nationwide, training ANC providers and CHOs at CHPS compounds and fostering community engagement and social and behaviour change initiatives to boost ANC attendance and IPTp uptake. Additionally, efforts include monitoring SP stock levels, conducting post-market surveillance to maintain drug quality, and integrating these interventions with broader maternal health services, such as ensuring ITNs are distributed at the first ANC visit and reinforcing adherence to IPTp guidelines.

PMI Funding

- In both 2025 and 2026, PMI's budget for prevention of MiP was reduced by **$380,000** per year, decreasing from **$500,000** to **$120,000** annually. This allocation had been designated to support the procurement and distribution of SP for ITPp, training of ANC and CHPS staff, community engagement to boost ANC attendance and IPTp uptake and monitoring drug stocks and quality.
- Overall, PMI's budget reduction for prevention of MiP across 2025 and 2026 amounts to **-$760,000** (see Figure 7).
- The reduction in funding has severely limited the procurement of SP and the delivery of IPTp through ANC services. As a result, training, supervision, and social and SBC activities have also been significantly scaled back, undermining efforts to address barriers to IPTp uptake.

GF/MOH Funding

- GF originally budgeted **$449,609 for the 2025-2026** period (**$334,257 for 2025** and **$105,352 for 2026**) to support the procurement and distribution of SP, training of ANC and CHPS staff, community engagement to enhance ANC attendance and IPTp uptake and monitoring drug stocks and quality.
- GF increased their budget for prevention of MiP by **$83,939** over both 2025 and 2026.
- The additional resources provide some support for SP procurement, training, and supervision, but the increase falls short of compensating for PMI's substantial funding cuts. As a result, major gaps remain in commodity security and the delivery of essential services.

Combined Reduction for 2025-2026

- Although GF's budget for MiP saw a marginal increase, the overall budget between PMI and GF funding decreased by **$676,061**.

Risk Statement:

The funding shortfall for prevention of MiP poses significant risks. Reduced resources threaten the consistent availability of SP commodities, raising the likelihood of stock-outs at ANC facilities and jeopardizing the coverage of IPTp. Without sufficient support for training, supervision, and SBC activities, uptake of three or more IPTp doses may stagnate or decline, directly undermining maternal and neonatal health outcomes. These challenges are particularly acute in rural and hard-to-reach areas, where CHPS compounds are vital for ANC service delivery, potentially widening equity gaps and leading to increased rates of maternal anemia, low birth weight, and neonatal mortality. Furthermore, the inability to sustain IPTp scale-up risks eroding donor confidence and may compromise Ghana's progress toward achieving NMSP 2028 targets.

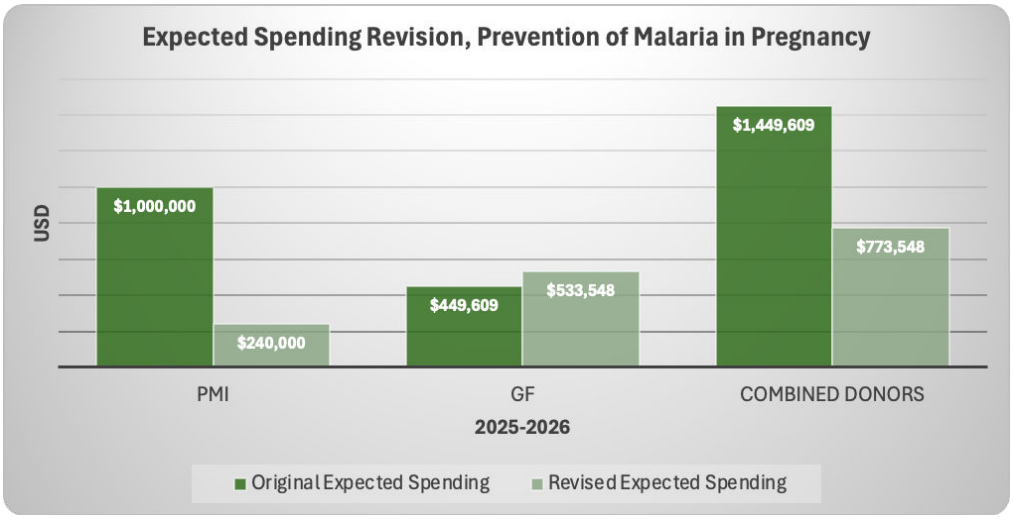


Figure 7. Revision to expected donor spending on MiP. A substantial net funding decrease of $676,061 (47%) for 2025-2026 primarily resulted from reductions in PMI allocations, whereas GF experienced a slight increase.

Drug-Based: Prevention of Malaria in Pregnancy
Priority level for seeking alternative funding: MODERATE **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$676,061, an approximate 47% reduction** **Risk (brief):** • Nearly half of MiP prevention funding has been lost, threatening SP commodity security and ANC service delivery. • Stock-outs, reduced supervision, and weakened SBC will lower IPTp coverage, increasing risks of maternal anemia, low birth weight, and neonatal mortality.

Seasonal Malaria Chemoprevention

SMC is implemented across Ghana's seven northern regions, namely, Bono East, North East, Northern, Savannah, Oti, Upper East, and Upper West, where malaria transmission peaks during the rainy season. The initiative targets children aged 3 to 59 months, delivering four to five monthly cycles of sulfadoxine-pyrimethamine plus amodiaquine (SPAQ) to protect them throughout the high-risk period. Core activities include procuring and distributing SPAQ, training and deploying community distributors and supervisors, and conducting microplanning and social mobilization to maximize coverage, even in hard-to-reach areas. Real-time

campaign monitoring is enabled through the digitization of data through the use of mobile tools. Additionally, cross-border coordination ensures harmonized SMC delivery in border districts, while pharmacovigilance and drug efficacy monitoring safeguard the intervention's safety and effectiveness.

PMI Funding

- PMI originally budgeted **$4.8 million for 2025-2026** for SMC and the budget saw an increase of **$2 million**, to **$6.8 million**, for the 2025-2026 period.
- The increased funding has enabled broader support for both the procurement and implementation of SPAQ, strengthening the program's capacity to reach all eligible children across the seven northern regions. This financial boost has also enhanced operational capabilities, allowing for more effective training, supervision, and digital monitoring of campaign activities.

GF/MOH Funding

- GF funding remained unchanged for 2025, with the budgeted amount at **$3.3 million**. In 2026, the original amount of **$4.6 million** decreased by **$1.2 million** to a revised amount of **$3.4 million**.
- Stable funding in 2025 allows the program to maintain its intended coverage, while the reduction in 2026 places pressure on operational budgets and may restrict supervision, SBC activities, and last-mile delivery in certain districts

Combined Revision for 2025-2026

- The combined projected **increase** in funding from both PMI and GF for SMC over this period is **~$818,905** (Figure 8).

Risk Statement:

Despite an overall increase in SMC funding, significant risks persist. The reduction in GF operational support for 2026 may strain supervision, SBC activities, and last-mile delivery, particularly in hard-to-reach and border districts, raising concerns about equity of coverage. These operational challenges could lead to incomplete campaign cycles, undermining caregiver trust and adherence in future campaigns. Furthermore, inconsistent or insufficient coverage may heighten the risk of drug resistance by increasing selective pressure on malaria parasites.

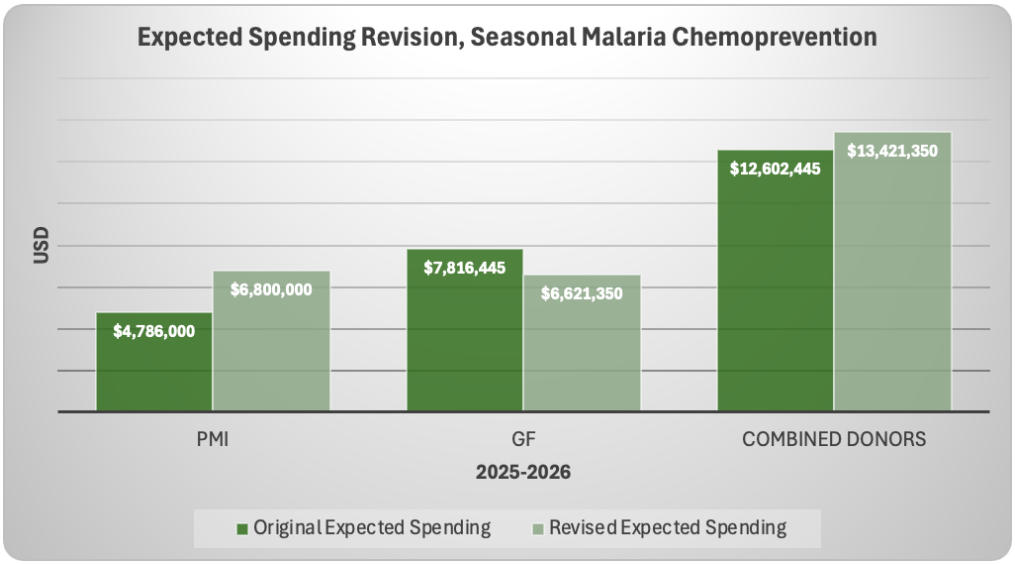


Figure 8. Revision to expected donor spending on SMC. A net increase of $818,905 was recorded, driven by a substantial rise in PMI allocations, while GF funding remained relatively stable.

Drug-Based: Seasonal Malaria Chemoprevention
Priority level for seeking alternative funding: LOW **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026/27) = $818,905, an approximate 10% increase** **Risk (brief):** • The planned net increase in total funding makes this area a lesser priority for seeking alternative new resources. • However, reductions in GF operational support for 2026 may weaken supervision and last-mile delivery. This could result in uneven coverage, particularly in hard-to-reach districts, undermining the effectiveness of SMC and risking drug resistance.

Case Management Activities

Commodity Procurement and Distribution (Tests and Medicines)

Commodity procurement and distribution form the foundation of Ghana's malaria case management strategy, ensuring uninterrupted access to RDTs, artemisinin-based combination therapies (ACTs), injectable artesunate, and rectal artesunate (RAS). Through the national supply chain, these life-saving commodities reach health facilities, CHPS compounds, and providers at the community level. Essential activities include sourcing diagnostics and medicines to meet national needs, distributing supplies via central and regional medical stores for timely delivery, and closely monitoring stocks to prevent shortages and wastage. The program also integrates private sector outlets such as pharmacies and over the counter (OTC) medicine sellers to broaden access, while ongoing supervision and quality assurance efforts reinforce rational medicine use and strict adherence to treatment guidelines

PMI Funding

- In 2025, PMI maintained its budget of **$1.5 million** to support the procurement and distribution of RDTs, and ACTs. This ensured continuity of commodity availability across public facilities.
- In 2026, however, PMI's budget was reduced by **~$600,000**, decreasing from **$2.1 million** to **$1.5 million**.
- The reduction in funding will directly constrain the procurement of key malaria commodities, notably RDTs and ACTs resulting in increased risk of stock-outs—particularly in high-burden districts during peak transmission periods. This diminished budget also reduces the program's capacity to adapt to unexpected spikes in demand or disruptions within the supply chain, thereby compromising the ability to maintain consistent access to life-saving treatments.

GF/MOH Funding

- The GF budget allocations have been **protected from recent deprioritization cuts.**
- As a result, the original allocations for 2025 (**$4.8 million**) and 2026 (**$5.2 million**) remain fully preserved.
- While GF's stable funding provides a critical baseline of commodity security, the absence of increased allocations restricts the program's capacity to expand coverage, accommodate a growing population, or enhance engagement with the private sector.

Combined Reduction for 2025-2026

- The overall funding gap for commodity procurement in 2025 and 2026– arising mainly from the PMI cut in 2026– amounts to **-$600,248** (Figure 9).

Risk Statement:

Although the funding shortfall for ACT procurement is minimal, it still warrants attention, the funding shortfall for commodity procurement and distribution poses immediate and significant risks. Reduced procurement volumes may result in stock-outs of ACTs and RDTs, leading to treatment delays and undermining effective case management. Rural and underserved districts face heightened vulnerability to these supply disruptions, further exacerbating existing disparities in access to essential care. The absence of buffer stocks also leaves the health system ill-equipped to respond to seasonal surges or unexpected epidemics, increasing overall system fragility. Moreover, frequent stock-outs risk eroding public trust in health facilities, potentially driving patients to seek care from unregulated private markets.

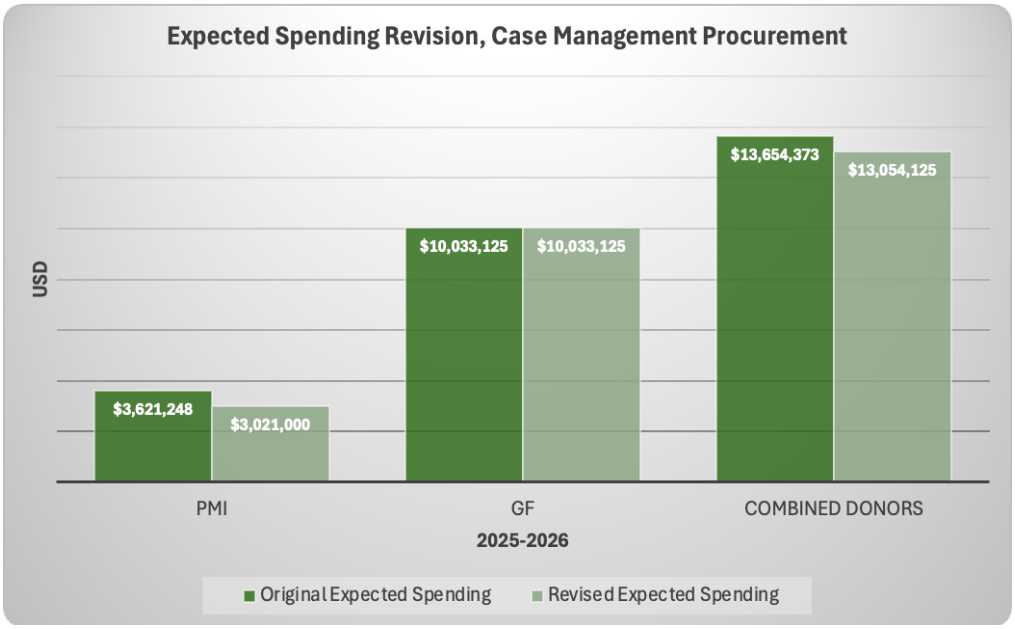


Figure 9. Combined funding reductions for case management commodities procurement for 2025-26 is $600,248.

Case Management Activities: Procure Case Management-Related Commodities
Priority level for seeking alternative funding MODERATE **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$600,248, an approximate 4% decrease** **Risk (brief):** • Even a modest cut in procurement funding risks stock-outs of essential diagnostics and medicines. • This threatens timely diagnosis and treatment, particularly in rural and high-burden districts, undermining Ghana's malaria control and elimination goals.

Case Management Implementation

Case management implementation is vital to ensuring effective malaria diagnosis and treatment at both health facility and community levels. This involves training and supervising health workers to adhere to national guidelines, provide quality diagnoses, and administer appropriate treatments. Community-based activities extend these services through CHPS compounds and CHOs, reaching populations situated more than five kilometers

from health facilities. In 1999, Ghana adopted the CHPS policy to expand health access at the community level, where a trained Community Health Nurse and midwife provide integrated community case management (iCCM) and ANC services in a facility constructed by the community and coordinated through a Community Health Committee. These services are further supported by Community Health Volunteers, who assist CHPS staff in delivering community-level health interventions. The program also focuses on engaging the private sector by training pharmacies and OTC medicine sellers to follow diagnostic and treatment protocols. To maintain high standards of care, supportive supervision and quality assurance are conducted through outreach training, integrated supervision, and clinical audits. In addition, TES and HRP2/3 gene deletion monitoring are carried out to track drug resistance and ensure the reliability of diagnostic tools. Capacity building is further strengthened by regularly updating guidelines, developing job aids, and training health workers at all levels of the health system. Figures 10 and 11 summarize PMI and GF funding modifications.

PMI Funding

- Overall, PMI's budget reduction for case management implementation across 2025 and 2026 amounts to **-$4.4 million**.
- In 2025, PMI's budget for case management implementation was reduced by **$2 million**, decreasing from **$3 million** to **$1 million**. This allocation was designed to fund training, supervision and support malaria diagnosis and treatment at health facilities and in the community.
- In 2026, PMI's budget was further reduced by **$2.4 million** (from **$3.4 million** to **$1 million)**.
- In addition, PMI withdrew its previously planned allocation of **$600,000** for TES in 2025 and another **$600,000 in 2026**. The **$10,000 per year** CDC short-term technical assistance (STTA) allocation for case management for 2025 and 2026 was also withdrawn from both years of funding.
- The funding reductions will result in a severe decrease in supervision and training activities of case management activities, the suspension of support for TES and HRP2/3 gene deletion monitoring, and the loss of technical assistance essential for strengthening case management systems.

GF Funding

- In 2025, the GF budget for case management implementation was cut by **$600,000**, decreasing from **$1.9 million to $1.3 million**.
- In 2026, the budget faced an additional reduction of **$337,385**, from **$473,910 to $136,525**.
- Altogether, these adjustments result in a total budget **decrease of $937,928 across 2025 and 2026**.
- The funding reductions have significantly undermined the ability to sustain iCCM, private sector engagement, and supportive supervision. With limited resources now available for updating guidelines, conducting training, and maintaining effective monitoring, the program faces mounting challenges in delivering consistent and high-quality malaria care across all levels.

Combined Reduction for 2025-2026

- The combined reduction in funding from PMI and GF for case management implementation during 2025-2026 amounts to **-$5.3 million**.

Risk Statement:

The funding shortfall for case management implementation poses both immediate and medium-term threats to the malaria program. Reduced training and supervision compromise adherence to treatment guidelines, limit diagnostic accuracy, and increase the risk of irrational drug use, ultimately undermining the quality of care. Rural

and underserved communities, especially those dependent on iCCM, are likely to experience diminished access to timely diagnosis and treatment, exacerbating inequities in health service delivery. The suspension of TES further delays the detection of drug resistance, jeopardizing the effectiveness of existing treatment regimens. In the absence of adequate supportive supervision, data quality and reporting through DHIS2 may also decline, weakening accountability and the overall resilience of the health system. Collectively, these challenges threaten to erode patient trust in public health facilities and malaria interventions, undermining the program's credibility and its progress towards malaria elimination.

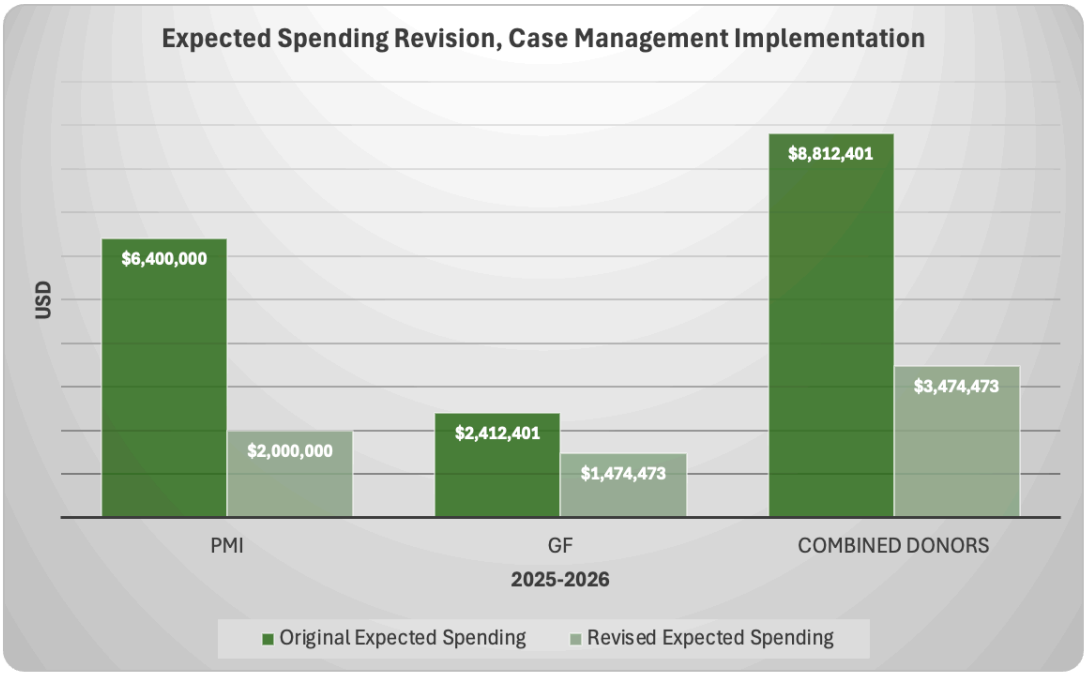


Figure 10. Revision to expected donor spending on case management implementation. The combined funding reduction for 2025-2026 is $5.3 million.

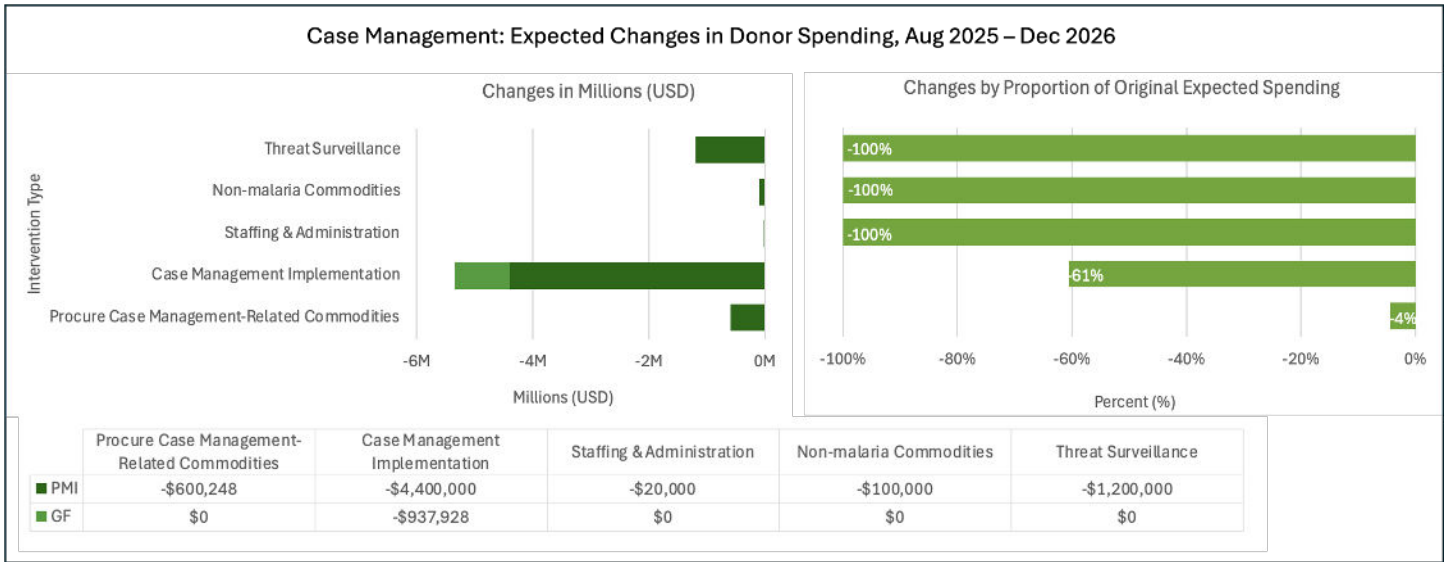


Figure 11. Expected spending revisions in case management for the period August 2025 - December 2026, by donor and intervention area.

Case Management Activities: Implementation
Priority level for seeking alternative funding: HIGH. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = -$5.3 million, an approximate 61% decrease** **Risk (brief):** ● Severe cuts to case management implementation are expected to undermine supervision, training, and surveillance. ● This threatens service quality, equitable access, and timely detection of drug resistance, jeopardizing Ghana's malaria elimination goals.

Supply Chain Strengthening Activities

In-Country Supply Chain

A robust in-country supply chain is essential to ensure the continuous availability of malaria commodities such as ITNs, RDTs, ACTs, injectable and rectal artesunate, and SPAQ at service delivery points. Key activities encompass warehousing and distribution from central and regional medical stores to health facilities, with dedicated efforts to ensure last-mile delivery reaching CHPS compounds and peripheral sites. These operations are bolstered by capacity building for logistics officers, focusing on skills in forecasting, quantification, and inventory management. The rollout and use of the Ghana Integrated Logistics Management Information System (GhiLMIS) further strengthens data systems, enabling effective monitoring of stock availability and consumption at facilities through end-use verification (EUV) surveys. Additionally, ongoing coordination with partners supports the alignment of procurement efforts, helping to reduce duplication and prevent stock-outs across the supply chain.

PMI Funding

- The PMI's supply chain budget remained unchanged, allocating $1.6 million for 2025 and $1.7 million for 2026. These funds are dedicated to supporting warehousing, distribution, and last-mile delivery of malaria commodities, enhancing the GhiLMIS logistics management system, conducting EUV surveys, and providing training for logistics personnel.

GF/MOH Funding

- GF 2025 and 2026 support for supply chain management continues as integrated funding under Case Management commodity procurement and RSSH – Health Products Management.

Combined Reduction for 2025-2026

- There is no net change in PMI and GF funding for the 2025-2026 period (Figure 12).

Risk Statement:

Although funding for supply chain activities remains stable, there is a minimal risk given that all funds were retained.

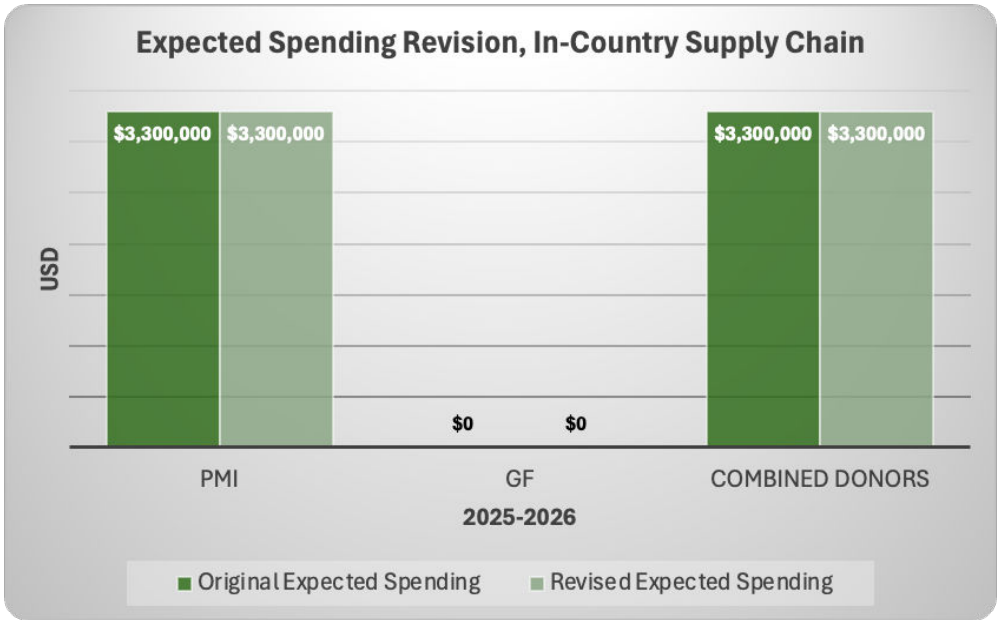


Figure 12. Revision to expected donor spending on supply chain. The GF contributions to in-country supply chain management are incorporated into the budgets for Case Management commodity procurement and RSSH- health products management budgets.

Supply Chain Strengthening Activities: In-Country Supply Chain
Priority level for seeking alternative funding: LOW. **Expected Impact: IMMEDIATE.** **Total net change (2025 - 2026) = Nil** **Risk (brief):** • Despite stable funding, the supply chain faces only minimal risk of disruptions given all funds were retained.

Malaria Vaccine Introduction

Ghana is one of the first countries globally to introduce malaria vaccination, beginning with the RTS,S/AS01 pilot in 2019 across 42 districts. By 2023, the program expanded to 93 districts, and in 2024, began reaching an additional 43, totaling 136 districts covered. The vaccine is administered via the routine EPI, with scheduled doses at 6, 7, 9, and 24 months of age. Guided by the NMSP 2024–2028, the goal is to achieve nationwide coverage and ultimately transition from the RTS,S to the R21 vaccine as supplies allow. The implementation involves coordinated procurement and distribution through Gavi and United Nations International Children's Emergency Fund (UNICEF), integration with routine immunization services at ANC and child welfare clinics, and comprehensive training for health workers on vaccine delivery, safety monitoring, and record management. In addition, the program prioritises ongoing pharmacovigilance to monitor adverse events following immunization and robust community engagement to foster caregiver trust and sustain vaccine demand.

PMI Funding

- No PMI funding was allocated for MV activities during the 2025–2026 period.

GF Funding

- No GF funding was allocated for MV activities during the 2025–2026 period.

Other Funding Sources

- Gavi, the Vaccine Alliance: primary financier of vaccine procurement and delivery support.
- GOG (MOH/GHS): Provides co-financing, logistics, and integration into the national immunization program.
- UNICEF and WHO: Support cold chain, technical assistance, and monitoring.

Combined Impact for 2025-2026

- Ghana's MV program depends entirely on Gavi and MOH resources, as no funding has been allocated from PMI or GF. Although Gavi ensures vaccine procurement, there are ongoing risks of funding gaps for crucial activities such as training, SBC, and pharmacovigilance. As a result, the expansion of the program beyond the current 136 districts may be delayed, potentially hindering progress toward achieving nationwide coverage.

Risk Statement:

Ghana's MV rollout relies predominantly on support from Gavi and the GOG, with supplementary input from UNICEF and WHO. The absence of prior or current involvement from PMI and the GF means the initiative is dependent on a limited group of partners. Although established vaccine partners are well-positioned to address potential funding gaps, this concentrated support structure exposes the program to heightened risk should there be changes in priorities or resource availability among the main contributors.

Malaria Vaccine Activities
Priority level for seeking alternative funding: NOT APPLICABLE. **Expected Impact: LONGER TERM.** **Total net change (2025 - 2026) = No PMI or GF allocations (full reliance on Gavi/MOH)** **Risk (brief):** ● Ghana's MV initiative is primarily supported by Gavi and the GOG, with additional contributions from UNICEF and WHO. There has been no prior support from PMI or GF for this rollout. Consequently, the lack of PMI and GF involvement is not expected to significantly affect the program, as established vaccine partners are we-positioned to mitigate any potential gaps.

Surveillance, Monitoring and Evaluation and Operations Research (SMEO) Activities

SMEO are essential components underpinning Ghana's malaria elimination efforts. These activities provide the evidence base for interventions, support efficient resource allocation, and drive ongoing improvements in program implementation. Core SMEO functions include routine surveillance and reporting through DHIMS2 and the Ghana Malaria Information System, ensuring timely and accurate data collection. Data quality audits and supportive supervision activities help strengthen the reliability and completeness of reporting across the health system. Regular household and facility-based surveys, such as the Malaria Indicator Survey and DHS, are conducted to assess intervention coverage and overall impact. OR evaluates new tools, strategies, and delivery models to enhance program outcomes. Finally, ongoing capacity building for health information officers, entomology staff, and program managers ensures that data analysis and evidence use remain central to Ghana's malaria response.

PMI Funding

- In 2025, PMI had initially planned to allocate $1.45 million—$1.05 million for surveillance, monitoring, and evaluation, and $0.40 million for surveys—but this funding was entirely eliminated. Similarly, for 2026, the original allocation of $1.05 million for surveillance and monitoring was also reduced to zero.

GF Funding

- In 2025, GF originally allocated $1.82 million, but this was reduced to $869,845, a cut of $948,731.
- In 2026, GF originally allocated $957,513, but this was reduced to $857,183, a cut of $100,330.
- The remaining GF support can only maintain a minimal level of SMEO activities, limited to routine reporting and occasional supervision. This funding falls short of enabling critical efforts such as the execution of large-scale surveys.

Combined Reduction for 2025-2026

- The combined projected decrease in funding from both PMI and GF for surveillance, monitoring, and evaluation over this period is **~$3.55 million**.

Risk Statement:

The drastic withdrawal of donor funding for SMEO (see Figures 13 and 14) poses critical risks to Ghana's malaria control efforts. Reduced funding leads to fewer data audits and supervisory visits, resulting in compromised accuracy of DHIS2 reporting and weakening evidence-based decision-making. National surveys are likely to be postponed or scaled back, limiting visibility on intervention coverage and impact. The reliability of data for tracking progress diminishes, eroding donor and policymaker confidence in Ghana's progress toward malaria elimination. Finally, without OR, opportunities to introduce and evaluate new tools and strategies are lost, stalling innovation and further jeopardizing elimination goals.

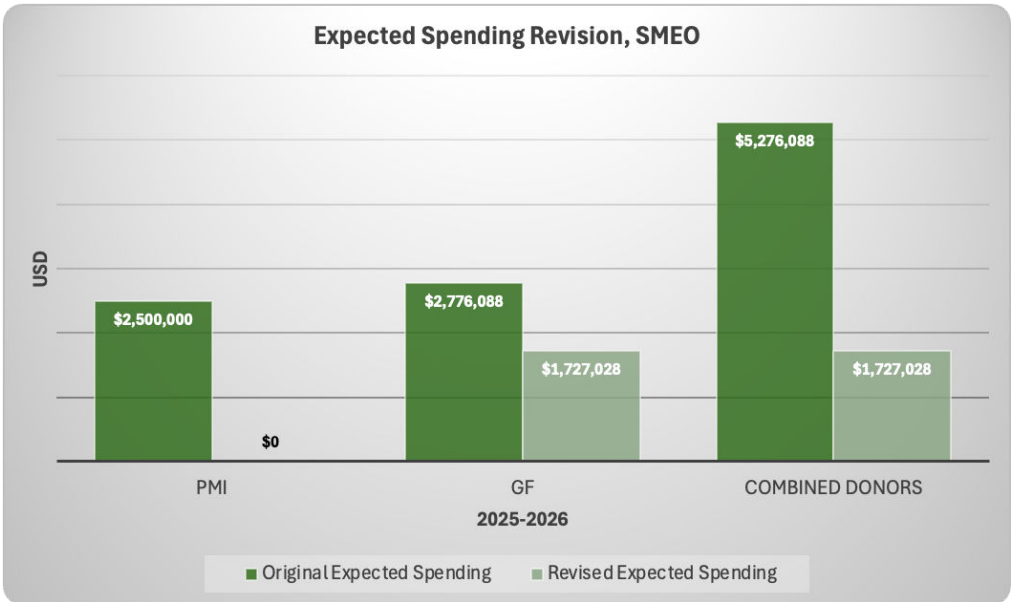


Figure 13. Revision to expected donor spending on SMEO. A substantial net funding reduction of $3.55 million was made, mostly from complete withdrawal of PMI support and additional funding cuts from GF.

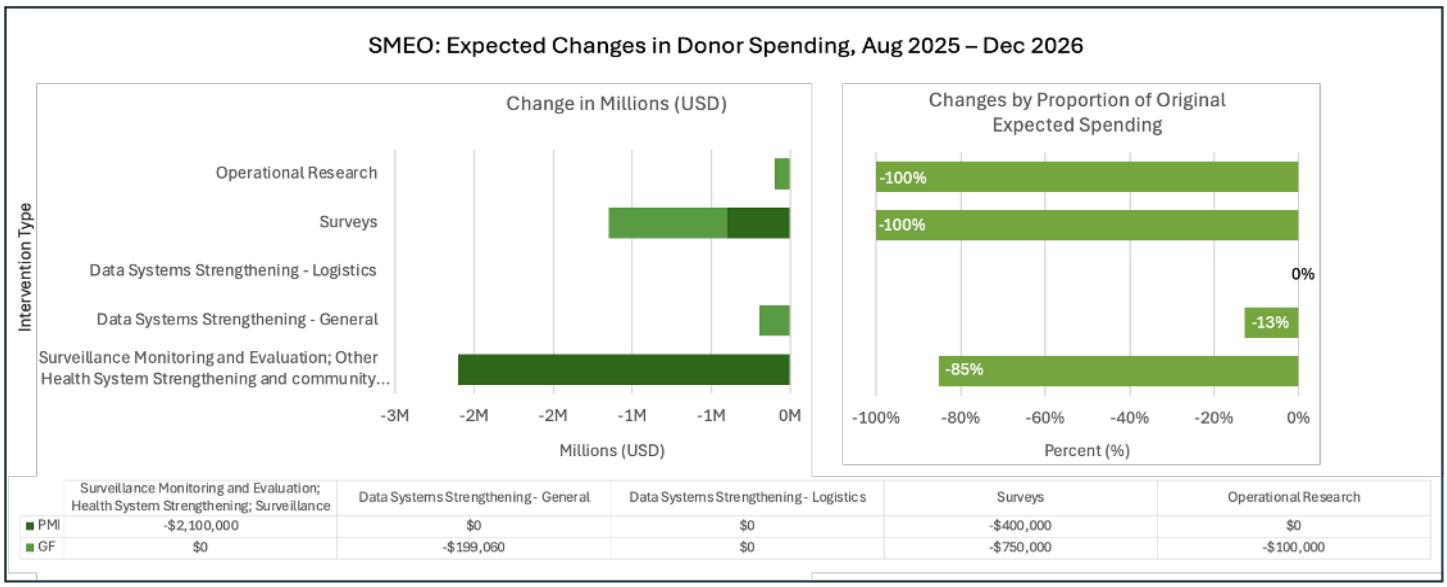


Figure 14. Expected spending revisions in SMEO for the period August 2025 to December 2026, by donor and intervention area.

Surveillance, Monitoring and Evaluation, and Operational Research (SMEO) Activities: Surveillance, Monitoring, and Evaluation

Priority level for seeking alternative funding: HIGH.

Expected Impact: IMMEDIATE.

Total net change (2025 - 2026) = -$3.55, an approximate 67% reduction

Risk (brief):

- The drastic loss of SMEO funding undermines Ghana's ability to detect resistance, monitor intervention coverage, and ensure data quality.
- Without reliable surveillance and operational research, decision-making is weakened, accountability is compromised, and elimination goals are jeopardized.

Social and Behavioral Change Communications

SBC interventions are fundamental to increasing the uptake and sustained use of malaria prevention and treatment services in Ghana. These efforts include mass media campaigns—across radio, television, and social media—to encourage the use of ITNs, promote prompt care-seeking for fever, and support adherence to malaria treatment. Community engagement activities such as durbars, drama performances, and peer education

specifically target misconceptions and cultural barriers, ensuring messages resonate at the local level. The SBC strategy also delivers tailored messaging for vulnerable groups, including pregnant women, caregivers of children under five, and urban poor communities. Capacity building initiatives for health promotion officers and community volunteers strengthen their ability to provide consistent, evidence-based communication. Importantly, SBC messaging is integrated with service delivery points, such as ANC, child welfare clinics, IRS campaigns, and SMC rounds, to reinforce positive behaviors and maximize the reach of malaria interventions.

PMI Funding

- In 2025 and 2026 combined, PMI initially allocated **$2.3 million** for SBC and related health systems strengthening, but this was **zeroed out**, leaving a **$2.3 million** gap.
- These funds were designated to support a robust set of activities, including mass media campaigns aimed at promoting the use of ITNs, encouraging timely care-seeking for fever, and fostering adherence to malaria treatment. Additional initiatives encompassed community engagement to address misconceptions and cultural barriers, as well as capacity building for health promotion officers and community volunteers to deliver consistent, evidence-based health messages. SBC messaging was also intended to be integrated with malaria service delivery points—such as ANC, child welfare clinics, IRS campaigns, and SMC rounds—to reinforce positive behaviors and maximize the uptake of interventions.
- The withdrawal of PMI support has resulted in the absence of national and regional SBC campaigns, along with the loss of funding for essential training, supervision, and community-level activities. Consequently, the program's ability to counteract declining ITN usage and effectively address barriers to IPTp and SMC uptake has been significantly reduced.
- The reduction reflects a deprioritization of SBC within U.S. foreign assistance (see Figure 15).

GF Funding

- In 2025, GF funding for SBC **increased by $1.3 million** from **~$69,000 to $1.4 million**. The 2026 budget also **increased by ~$700,000**, from **~$69,000** to **~$766,000**.
- While the increase in GF allocations has helped to partially mitigate the impact of PMI's withdrawal, enabling some continuation of SBC activities at both national and district levels, the available funding remains inadequate to fully replace the scale and reach of PMI's previous large-scale campaigns and robust community engagement.

Combined Reduction for 2025-2026

- Overall, for 2025-2026, the budget for SBC was **reduced, marginally, by $266,731**.

Risk Statement:

The shortfall in SBC funding poses significant medium-term risks to malaria control efforts. Reduced investment is likely to accelerate the decline in ITN utilization, already evidenced by only 40% of the population sleeping under a net despite 61% having access. A diminished SBC presence also threatens to weaken demand generation for key interventions—including care-seeking for fever, uptake of IPTp, and adherence to SMC cycles. These impacts are expected to be most pronounced among rural and underserved communities, which are highly dependent on community-based SBC initiatives. Furthermore, inconsistent messaging increases the risk of misinformation and misconceptions, undermining public trust and the credibility of malaria interventions.

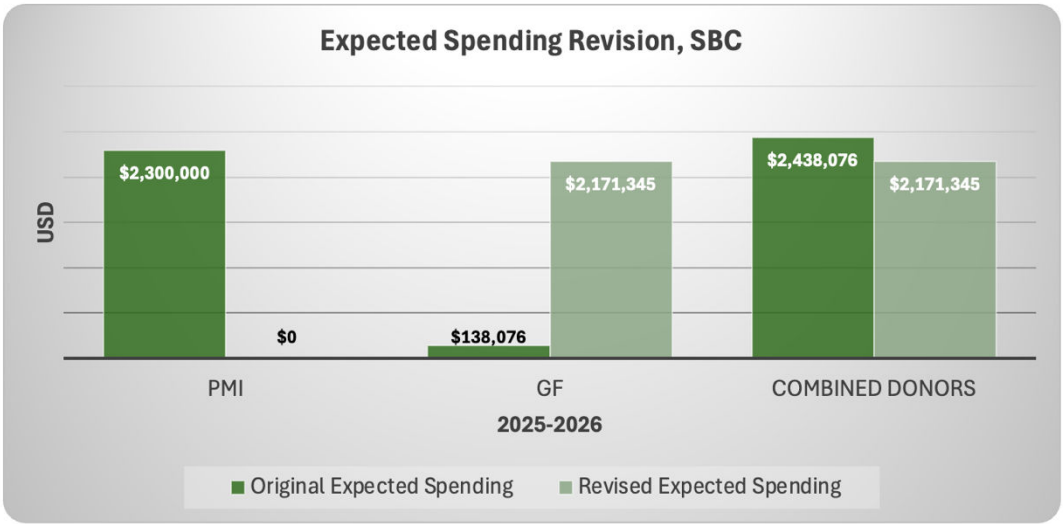


Figure 15. Revision to expected donor spending on SBC. A modest net funding reduction of $266,731 was made during the 2025-2026 period, mostly from complete withdrawal of PMI support, while GF funding increased but did not fully offset the loss.

Social and Behavioral Change Communications
Priority level for seeking alternative funding: MODERATE **Expected Impact: MEDIUM TERM** **Total net change (2025 - 2026) = -$266,731, an approximate 11% reduction** **Risk (brief):** • SBC funding cuts reduce the ability to sustain ITN use, IPTp uptake, and care-seeking behaviors. • Without consistent messaging, utilization of malaria interventions may decline, undermining Ghana's progress toward elimination.

Program Management

Program management funding is essential for the effective coordination, oversight, and accountability of Ghana's malaria response. These resources enable robust grant management and financial oversight, ensuring donor compliance, while also supporting the planning, supervision, and coordination of malaria interventions at all administrative levels. Additionally, they contribute to capacity building for program managers and administrative staff, help monitor partner performance, and promote the alignment of donor and government resources.

Operational support is further extended to governance structures such as the NMEP, technical working groups, and oversight committees, ensuring comprehensive and integrated program delivery.

PMI Funding

- In 2025, PMI's budget for program management was **reduced by $920,000**, decreasing from **$920,000 to $0**. This allocation had been designated to support Ghana's NMEP core functions by funding staff, technical advisors, planning meetings, and working groups. It also supported supervision, partner oversight, financial systems, office operations, logistics, and governance structures like the Malaria Steering Committee. These efforts formed the institutional backbone for effective malaria intervention coordination and oversight.
- In 2026, PMI's budget was **further reduced by $600,000**, from **$600,000 to $0**.
- Overall, PMI's budget reduction for program management across 2025 and 2026 amounts to **-$1.5 million** (see Figure 16).
- PMI's complete withdrawal from funding has resulted in the elimination of support for program management functions, creating significant gaps in coordination, supervision, and financial accountability. This reduction undermines the ability to effectively oversee malaria interventions, manage resources, and ensure compliance with donor requirements, leaving the program vulnerable and less capable of sustaining its critical operations.

GF Funding

- In 2025, the GF budget for program management was **cut by $1.2 million**, **decreasing from $2.3 million to $1.1 million**.
- In 2026, the budget faced an additional **reduction of $1.2 million, from $2.3 million to $1.2 million.**
- Altogether, these adjustments resulted in a total budget **decrease of -$2.3 million across 2025 and 2026** (see Figure 16)
- The funding cuts directly diminish the NMEP's capacity to retain program management staff, carry out regular planning and supervision activities, and uphold effective oversight of sub-recipients.

Combined Reduction for 2025-2026

- The combined reduction in funding from PMI and GF for program management during 2025-2026 amounts to **-$3.8 million**.
- These cuts significantly weaken Ghana's ability to coordinate malaria elimination activities, manage grants effectively, and sustain oversight functions.

Risk Statement:

The sharp reduction in program management funding poses immediate and medium-term risks to the effectiveness of Ghana's malaria elimination efforts. With diminished resources, the NMEP could face significant challenges in convening stakeholders, aligning donor contributions, and coordinating interventions across districts. Oversight and financial management capacities are weakened, heightening the risk of inefficiencies, delays, and compliance issues. Furthermore, limited funding for planning and supervision undermines accountability for intervention quality and coverage. The cuts threaten the retention of skilled program management staff, eroding institutional memory and leadership. Ultimately, without robust program management, Ghana's progress towards achieving the NMSP 2024–2028 targets is jeopardized, even if essential

commodities and interventions remain funded. The risk is assessed as moderate (not high) because of NMEP's demonstrated ability to maintain operations even under constrained budgets.

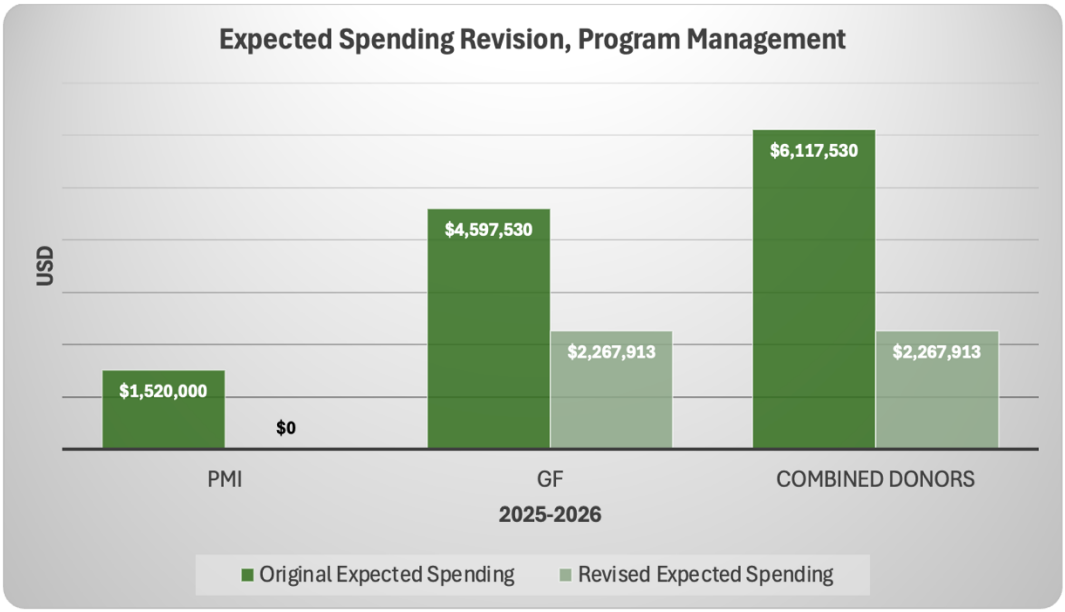


Figure 16. Revision to expected donor spending on program management. A significant net funding reduction of $3.8 million occurred during 2025-2026, primarily due to the complete withdrawal of PMI support, with additional reductions resulting from further cuts by GF.

Program Management Activities
Priority level for seeking alternative funding: MODERATE **Expected Impact: MEDIUM TERM** **Total net change (2025 - 2026) = -$3.8, an approximate 63% reduction** **Risk (brief):** • Significant cuts to program management funding undermine coordination, oversight, and accountability. • Without adequate management capacity, Ghana risks inefficiencies, reduced intervention quality, and slower progress toward malaria elimination. • The risk is assessed as moderate because of NMEP's demonstrated ability to maintain operations even under constrained budgets.

Short-Term Technical Assistance from CDC (STTA CDC)

Ghana has long benefited from the technical expertise provided by the United States Centers for Disease Control and Prevention (CDC), which is recognised as one of the leading global institutions in malaria research and control. Through the CDC Interagency Agreement (IAA) with USAID, Ghana received short-term, high-level technical assistance in areas such as vector control and case management (as detailed in their respective sections). These expert visits provided a cost-effective mechanism for technical quality control, program oversight, and specialized support to the national malaria program.

With the termination of the CDC IAA, all PMI funding for short-term CDC technical assistance has been cancelled. This has meant cancellation of planned expert visits (budgeted at $20,000 for 2025-2026) for technical assistance in vector control and case management activities. This decision eliminates a long-standing source of specialized expertise and leaves Ghana without a critical layer of external technical support.

Risk Statement

The cancellation of CDC technical assistance funding deprives Ghana of a cost-effective, long-standing source of specialized support. Without CDC engagement, the national malaria program loses access to high-level expertise in vector control, surveillance, monitoring and evaluation, and operational research. This gap reduces the program's ability to ensure technical quality, adapt to emerging challenges, and maintain rigorous oversight. Although the funding required to restore this support is relatively modest, the absence of CDC technical assistance poses a longer-term risk to the effectiveness and sustainability of Ghana's malaria elimination efforts. Addressing this gap would require only modest additional resources, but the loss of CDC engagement represents a significant setback for program quality assurance and innovation.

Short-Term Technical Assistance from the CDC
Priority level for seeking alternative funding: MODERATE **Expected Impact: MEDIUM TERM** **Total net change (2025 - 2026) = -$20,000 (100% reduction)** **Risk (brief):** Cancellation of CDC technical assistance funding removes a cost-effective, long-standing source of specialized expertise, weakening technical oversight and program quality.

USG Staffing and Administration

Funding for direct USG staffing and administrative support for the PMI program has been eliminated. This is due to the termination of the CDC IAA and the dismantling of USAID in the country. These budget lines covered the salaries, benefits, travel, and other support costs for in-country USG staff from both CDC and USAID who provided direct management and oversight of the malaria portfolio. While these functions are essential for

program continuity, the associated costs are internal to the USG and are not considered funding gaps to be filled by external partners.

Priority level for seeking alternative funding: Not Applicable (These are internal USG operational costs).

Funding Gap: The total eliminated budget for these internal USG costs for 2025-2026 is $4.3 million (Attachment B).

Attachment A. Letter of Support and Engagement, Ghana MOH

In case of the reply the number and the date of this letter should be quoted.

NATIONAL MALARIA ELIMINATION PROG.
GHANA HEALTH SERVICE
ACCRA
Telephone: 0302-664387

GPS Address: GA-107-5451

My Ref No./NMEP/ADMIN/017/25
Your Ref .....

16th June 2025

To Whom It May Concern

Subject: Letter of Support – Bridge the Gap Malaria Incubator Initiative

The National Malaria Elimination Programme of Ghana Health Service is pleased to express its strong support for the **Bridge the Gap Malaria Incubator**, an initiative led by **Akros**, in collaboration with **Population Explorer**. This initiative comes at a critical juncture, as shifting global donor priorities present growing challenges to the sustainability of malaria programs, particularly in high-burden countries such as Ghana.

Akros has a well-established history of supporting national malaria programs across sub-Saharan Africa through data-driven, precision public health approaches. Their experience working alongside ministries of health in countries such as Zambia, Nigeria, and Tanzania demonstrates their commitment to strengthening country-led systems through strategic, evidence-based solutions.

The **Bridge the Gap Incubator** is well aligned with Ghana's malaria control and elimination agenda. Its approach—rapid identification of operational gaps, use of structured prioritization frameworks, and mobilization of alternative financing—offers a valuable and timely complement to ongoing national efforts.

The National Malaria Elimination Programme of Ghana Health Service recognizes this initiative as a strategic mechanism to help sustain malaria programming and ensure the uninterrupted delivery of essential interventions. We fully endorse Akros in its engagement with partners and potential donors to bridge current funding gaps and accelerate progress toward malaria elimination.

We look forward to continued collaboration with Akros and its partners as we work collectively toward a malaria-free Ghana.

Sincerely,

DR HILARIUS A. K. ABIWU
PROGRAMME MANAGER
NATIONAL MALARIA ELIMINATION PROGRAMME
GHANA HEALTH SERVICE

Attachment B. Ghana Gaps and Inventory Table

Table 1: 2025 Expected Spending, PMI and GF Ghana								
		PMI			GF Ghana			Net Difference (PMI & GF-MOH) [5]
	Intervention	Original [1]	Revised after FAR (Aug-Dec) [2]	Difference [3]	Original	Revised [4]	Difference After GF Prioritization	
Vector Control	Entomological Monitoring	$550,000	$40,352	-$509,648	$208,735	$432,878	$224,143	-$285,505
	Procurement of ITNs for Mass Campaign and other Handling Fees	$4,782,500	$4,782,500	$0	$0	$0	$0	$0
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$900,000	$900,000	$0	$109,660	$0	-$109,660	-$109,660
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels	$0	$0	$0	$760,627	$760,627	$0	$0
	IRS Insecticide & PPE procurement and Distribution	$1,400,000	$1,701,761	$301,761	$3,314,163	$3,743,720	$429,557	$731,318
	IRS operations	$4,200,000	$2,641,825	-$1,558,175	$3,613,581	$4,179,821	$566,240	-$991,935
	LSM procurement and implementation	$0	$0	$0	$0	$0	$0	$0
	CDC STTA (ento)	$0	$0	$0	$0	$0	$0	$0
	Subtotal Vector Control	**$11,832,500**	**$10,066,438**	**-$1,766,062**	**$8,006,767**	**$9,117,047**	**$1,110,280**	**-$655,782**
Drug Based Prevention	Prevention of Malaria in Pregnancy.	$500,000	$120,000	-$380,000	$344,257	$411,021	$66,764	-$313,236
	Procure SMC-Related Commodities	$1,600,000	$1,600,000	$0	$71,309	$71,309	$0	$0
	SMC Implementation	$800,000	$1,800,000	$1,000,000	$3,183,340	$3,183,340	$0	$1,000,000
	Subtotal Drug Based Prevention	**$2,900,000**	**$3,520,000**	**$620,000**	**$3,598,906**	**$3,665,670**	**$66,764**	**$686,764**
Case Management	Procure Case Management-Related Commodities (ACTs, RDTs, inj artesunate and RAS)	$1,510,500	$1,510,500	$0	$4,842,497	$4,842,497	$0	$0
	Case Management Implementation (community and facility case management)	$3,000,000	$1,000,000	-$2,000,000	$1,938,491	$1,337,948	-$600,543	-$2,600,543
	CDC STTA (case mgmt)	$10,000	$0	-$10,000	$0	$0	$0	-$10,000

	Non-malaria Commodities	$0	$0	$0	$0	$0	$0	$0
	Threat Surveillance (TES)	$600,000	$0	-$600,000	$0	$0	$0	-$600,000
	Subtotal Case Manage	**$5,120,500**	**$2,510,500**	**-$2,610,000**	**$6,780,988**	**$6,180,445**	**-$600,543**	**-$3,210,543**
Supply Chain	In-Country Supply Chain	$1,600,000	$1,600,000	$0	$0	$0	$0	$0
	Subtotal Supply Chain	**$1,600,000**	**$1,600,000**	**$0**	**$0**	**$0**	**$0**	**$0**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening and community malaria surveillance	$1,050,000	$0	-$1,050,000	$183,223	$183,223	$0	-$1,050,000
	Data Systems Strengthening - General	$0	$0	$0	$785,353	$686,622	-$98,731	-$98,731
	Data Systems Strengthening - Logistics	$0	$0	$0	$0	$0	$0	$0
	Surveys	$400,000	$0	-$400,000	$750,000	$0	-$750,000	-$1,150,000
	Operational Research	$0	$0	$0	$100,000	$0	-$100,000	-$100,000
	Subtotal SMEO	**$1,450,000**	**$0**	**-$1,450,000**	**$1,818,576**	**$869,845**	**-$948,731**	**-$2,398,731**
SBCC [8]	SBC for ITN LSM and case management	$1,200,000	$0	-$1,200,000	$69,038	$1,404,878	$1,335,840	$135,840
	Subtotal SBCC	**$1,200,000**	**$0**	**-$1,200,000**	**$69,038**	**$1,404,878**	**$1,335,840**	**$135,840**
Program Management	Capacity building, human resources, operations and planning $ supervision	$720,000	$0	-$720,000	$1,104,051	$0	-$1,104,051	-$1,824,051
	Human Resources	$200,000	$0	-$200,000	$672,492	$672,492	$0	-$200,000
	Operations	$0	$0	$0	$481,020	$433,027	-$47,993	-$47,993
	Planning and Supervision	$0	$0	$0	$10,491	$10,491	$0	$0
	Subtotal Program Manage	**$920,000**	**$0**	**-$920,000**	**$2,268,054**	**$1,116,010**	**-$1,152,044**	**-$2,072,044**
USG Staffing	CDC	$666,000	$0	-$666,000	$0	$0	$0	-$666,000
	USAID	$1,311,000	$0	-$1,311,000	$0	$0	$0	-$1,311,000
	Subtotal USG Staffing	**$1,977,000**	**$0**	**-$1,977,000**	**$0**	**$0**	**$0**	**-$1,977,000**
Total		$27,000,000	$17,696,938	-$9,303,062	$22,542,329	$22,353,894	-$188,435	-$9,491,497

Table 2: 2026 Expected Spending, PMI and GF Ghana								
		PMI			GF Ghana			Net Difference (PMI & GF-MOH)
	Intervention	Original [1]	Revised after FAR (Aug-Dec) [2]	Difference [3]	Original	Revised [4]	Difference After GF Prioritization	
Vector Control	Entomological Monitoring	$600,000	$40,352	-$559,648	$184,755	$186,743	$1,988	-$557,660
	Procurement of ITNs for Mass Campaign and other Handling Fees	$3,796,252	$3,796,252	$0	$11,551,774	$3,291,635	-$8,260,139	-$8,260,139
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$1,100,000	$1,100,000	$0	$269,805	$215,844	-$53,961	-$53,961
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels	$0	$0	$0	$0	$0	$0	$0
	IRS Insecticide & PPE procurement and Distribution	$1,400,000	$1,701,761	$301,761	$3,786,856	$2,822,118	-$964,737	-$662,976
	IRS Operations	$4,245,000	$2,641,825	-$1,603,175	$5,153,285	$4,454,201	-$699,085	-$2,302,260
	LSM	$0	$0	$0	$0	$0	$0	$0
	CDC STTA (ento)	$0	$0	$0	$0	$0	$0	$0
	Subtotal Vector Control	**$11,141,252**	**$9,280,190**	**-$1,861,062**	**$20,946,475**	**$10,970,541**	**-$9,975,934**	**-$11,836,997**
Drug Based Prevention	Prevention of Malaria in Pregnancy.	$500,000	$120,000	-$380,000	$105,352	$122,528	$17,176	-$362,824
	Procure SMC-Related Commodities	$1,536,000	$1,600,000	$64,000	$238,906	$238,906	$0	$64,000
	SMC Implementation	$850,000	$1,800,000	$950,000	$4,322,890	$3,127,795	-$1,195,095	-$245,095
	Subtotal Drug Based	**$2,886,000**	**$3,520,000**	**$634,000**	$4,667,148	$3,489,228	**-$1,177,920**	**-$543,920**
Case Management	Procure Case Management-Related Commodities (ACTs, RDTs, inj artesunate and RAS)	$2,110,748	$1,510,500	-$600,248	$5,190,628	$5,190,628	$0	-$600,248
	Case Management Implementation (community and facility case management)	$3,400,000	$1,000,000	-$2,400,000	$473,910	$136,525	-$337,385	-$2,737,385
	STTA CDC (case mgmt)	$10,000	$0	-$10,000	$0	$0	$0	-$10,000
	Non-malaria Commodities	$100,000	$0	-$100,000	$0	$0	$0	-$100,000

	Threat Surveillance (TES)	$600,000	$0	-$600,000	$0	$0	$0	-$600,000
	Subtotal Case Manage	**$6,220,748**	**$2,510,500**	**-$3,710,248**	**$5,664,538**	**$5,327,153**	**-$337,385**	**-$4,047,633**
Supply Chain	In-Country Supply Chain	$1,700,000	$1,700,000	$0	$0	$0	$0	$0
	Subtotal Supply Chain	**$1,700,000**	**$1,700,000**	**$0**	**$0**	**$0**	**$0**	**$0**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**	$0	**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening and community malaria surveillance	$1,050,000	$0	-$1,050,000	$183,223	$183,223	$0	-$1,050,000
	Data Systems Strengthening - General	$0	$0	$0	$774,290	$673,960	-$100,330	-$100,330
	Data Systems Strengthening - Logistics	$0	$0	$0	$0	$0	$0	$0
	Surveys	$0	$0	$0	$0	$0	$0	$0
	Operational Research	$0	$0	$0	$0	$0	$0	$0
	Subtotal SMEO	**$1,050,000**	**$0**	**-$1,050,000**	**$957,513**	**$857,183**	**-$100,330**	**-$1,150,330**
SBCC	SBC; Other HSS	$1,100,000	$0	-$1,100,000	$69,038	$766,467	$697,429	-$402,571
	Subtotal SBCC	**$1,100,000**	**$0**	**-$1,100,000**	**$69,038**	**$766,467**	**$697,429**	**-$402,571**
Program Manage	Capacity building, human resources, operations and planning $ supervision	$600,000	$0	-$600,000	$1,134,762	$0	-$1,134,762	-$1,734,762
	Human Resources	$0	$0	$0	$672,492	$672,492	$0	$0
	Operations	$0	$0	$0	$511,731	$468,921	-$42,810	-$42,810
	Planning and Supervision	$0	$0	$0	$10,491	$10,491	$0	$0
	Subtotal Program Manage	**$600,000**	**$0**	**-$600,000**	**$2,329,476**	**$1,151,903**	**-$1,177,573**	**-$1,777,573**
USG Staffing	CDC	$991,000	$0	-$991,000	$0	$0	$0	-$991,000
	USAID	$1,311,000	$0	-$1,311,000	$0	$0	$0	-$1,311,000
	Subtotal USG Staffing	**$2,302,000**	**$0**	**-$2,302,000**	**$0**	**$0**	**$0**	**-$2,302,000**
Total		**$27,000,000**	**$17,010,690**	**-$9,989,310**	**$34,634,188**	**$22,562,475**	**-$12,071,713**	**-$22,061,023**

Table 3: 2025 2026 Combined Expected Spending, PMI and GF Ghana								
		PMI			GF			
	Intervention	**Original**	**Revised**	**Difference [3]**	**Original**	**Revised**	**Difference After GF Prioritization**	**Net Difference (PMI & GF-MOH)**
Vector Control	Entomological Monitoring	$1,150,000	$80,704	-$1,069,296	$393,490	$619,622	$226,131	-$843,165
	Procurement of ITNs for Mass Campaign and other Handling Fees	$8,578,752	$8,578,752	$0	$11,551,774	$3,291,635	-$8,260,139	-$8,260,139
	ITNs Mass Campaign: Storage and in-country distribution and other costs	$2,000,000	$2,000,000	$0	$379,465	$215,844	-$163,621	-$163,621
	ITNs: Micro-planning, supervision and post campaign review meetings at national, regional and district levels	$0	$0	$0	$760,627	$760,627	$0	$0
	IRS Insecticide & PPE procurement and Distribution	$2,800,000	$3,403,522	$603,522	$7,101,019	$6,565,838	-$535,181	$68,341
	IRS Operations	$8,445,000	$5,283,650	-$3,161,350	$8,766,866	$8,634,021	-$132,844	-$3,294,195
	LSM	$0	$0	$0	$0	$0	$0	$0
	CDC STTA	$0	$0	$0	$0	$0	$0	$0
	Subtotal Vector Control	**$22,973,752**	**$19,346,628**	**-$3,627,124**	**$28,953,242**	**$20,087,587**	**-$8,865,654**	**-$12,492,779**
Drug Based Prevention	Prevention of Malaria in Pregnancy	$1,000,000	$240,000	-$760,000	$449,609	$533,548	$83,939	-$676,061
	Procure SMC-Related Commodities	$3,136,000	$3,200,000	$64,000	$310,215	$310,215	$0	$64,000
	SMC Implementation	$1,650,000	$3,600,000	$1,950,000	$7,506,230	$6,311,135	-$1,195,095	$754,905
	Subtotal Drug Based	**$5,786,000**	**$7,040,000**	**$1,254,000**	**$8,266,054**	**$7,154,898**	**-$1,111,156**	**$142,844**
Case Management	Procure Case Management-Related Commodities	$3,621,248	$3,021,000	-$600,248	$10,033,125	$10,033,125	$0	-$600,248

	Case Management Implementation (community and facility case management)	$6,400,000	$2,000,000	-$4,400,000	$2,412,401	$1,474,473	-$937,928	-$5,337,928
	Staffing and Administration	$20,000	$0	-$20,000	$0	$0	$0	-$20,000
	Non-malaria Commodities	$100,000	$0	-$100,000	$0	$0	$0	-$100,000
	Threat Surveillance	$1,200,000	$0	-$1,200,000	$0	$0	$0	-$1,200,000
	Subtotal Case Manage	**$11,341,248**	**$5,021,000**	**-$6,320,248**	**$12,445,526**	**$11,507,598**	**-$937,928**	**-$7,258,176**
Supply Chain	In-Country Supply Chain	$3,300,000	$3,300,000	$0	$0	$0	$0	$0
	Subtotal Supply Chain	**$3,300,000**	**$3,300,000**	**$0**	**$0**	**$0**	**$0**	**$0**
Malaria Vaccine	Vaccine	$0	$0	$0	$0	$0	$0	$0
	Subtotal Malaria Vaccine	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
SMEO	Surveillance Monitoring and Evaluation; Other Health System Strengthening; Staffing and Administration,	$2,100,000	$0	-$2,100,000	$366,445	$366,445	$0	-$2,100,000
	Data Systems Strengthening - General	$0	$0	$0	$1,559,643	$1,360,583	-$199,060	-$199,060
	Data Systems Strengthening - Logistics	$0	$0	$0	$0	$0	$0	$0
	Surveys	$400,000	$0	-$400,000	$750,000	$0	-$750,000	-$1,150,000
	Operational Research	$0	$0	$0	$100,000	$0	-$100,000	-$100,000
	Subtotal SMEO	**$2,500,000**	**$0**	**-$2,500,000**	**$2,776,088**	**$1,727,028**	**-$1,049,060**	**-$3,549,060**
SBCC	SBC; Other HSS	$2,300,000	$0	-$2,300,000	$138,076	$2,171,345	$2,033,269	-$266,731
	Subtotal SBCC	**$2,300,000**	**$0**	**-$2,300,000**	**$138,076**	**$2,171,345**	**$2,033,269**	**-$266,731**
Program Management	Capacity building, human resources, operations and planning $ supervision	$1,320,000	$0	-$1,320,000	$2,238,814	$0	-$2,238,814	-$3,558,814
	Human Resources	$200,000	$0	-$200,000	$1,344,984	$1,344,984	$0	-$200,000
	Operations	$0	$0	$0	$992,751	$901,948	-$90,803	-$90,803
	Planning and Supervision	$0	$0	$0	$20,982	$20,982	$0	$0
	Subtotal Program Manage	**$1,520,000**	**$0**	**-$1,520,000**	**$4,597,530**	**$2,267,913**	**-$2,329,617**	**-$3,849,617**

USG Staffing	CDC	$1,657,000	$0	-$1,657,000	$0	$0	$0	-$1,657,000
	USAID	$2,622,000	$0	-$2,622,000	$0	$0	$0	-$2,622,000
	Subtotal USG Staffing	**$4,279,000**	**$0**	**-$4,279,000**	**$0**	**$0**	**$0**	**-$4,279,000**
Total		**$54,000,000**	**$34,707,628**	**-$19,292,372**	**$57,176,517**	**$44,916,369**	**-$12,260,147**	**-$31,552,520**