

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

- Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.**
- Section 2: Information on the national funding landscape and sustainability.**
- Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.**
- Section 4: Implementation arrangements and risk assessment.**

IMPORTANT NOTE: Applicants should refer to the Standard Concept Note Instructions to complete this template.

SUMMARY INFORMATION

Applicant Information

Country	UGANDA	Component	Malaria
Funding Request Start Date	01/01/2015	Funding Request End Date	31/12/2016
Principal Recipient(s)	1. Ministry of Finance, Planning and Economic Development (MoFPED) 2. The AIDS Support Organisation (TASO)		

Funding Request Summary Table



A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

Summary of the funding request by modular in US Dollars

Module	Allocated/Above	2015	2016	Total
Case management	Allocated	41,592,874	23,425,856	65,018,730
	Above	9,431,186	19,790,710	29,221,896
Health information systems and M&E	Allocated	898,674	1,392,956	2,291,630
	Above	0	0	0
Program management	Allocated	2,529,680	1,123,309	3,652,989
	Above	0	0	0
Vector control	Allocated	3,290,178	39,261,128	42,551,306
	Above	822,543	48,214,365	49,036,908
Total	Allocated	48,311,406	65,203,249	113,514,655
	Above	10,253,729	68,005,075	78,258,804

Summary of the funding request by Principal Receipt in US Dollars

PR Name	Allocated/Above	2015	2016	Total
AIDS Support Organization, Uganda	Allocated	13,962,028	9,777,179	23,739,207
	Above	0	0	0
Ministry of Finance, Planning and Economic Development of Uganda	Allocated	34,349,378	55,426,070	89,775,448
	Above	10,253,729	68,005,075	78,258,804
Total	Allocated	48,311,406	65,203,249	113,514,655
	Above	10,253,729	68,005,075	78,258,804

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

- The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.
- Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.
- Key human rights barriers and gender inequalities that may impede access to health services.
- The health systems and community systems context in the country, including any constraints.

1.1.a - Disease Epidemiology

Burden: Malaria is endemic in 95% of Uganda, affecting approximately 90% of 35 million people. The remaining 5% of the country consists of unstable and epidemic-prone transmission areas in the highlands of the South and Mid-West Uganda, along the Eastern border with Kenya and the North-East border with Sudan (UMRSP 2014 page 22). Figure 1 shows the pattern of distribution of malaria prevalence in Uganda between 2001 (Map A) and 2010 (Map B). Over this period, there was a more than 20% reduction in malaria prevalence in 25 out of the 112 districts as highlighted by the lighter shade of green. The reduction was more prominent in the mid-western and northern part of the country (arrowed). However, since 2010, there has been further scale up of interventions with expansion of IRS and LLINs and therefore it is anticipated that the current picture will have improved further. The updated strategic plan focuses on further scale up of proven interventions.

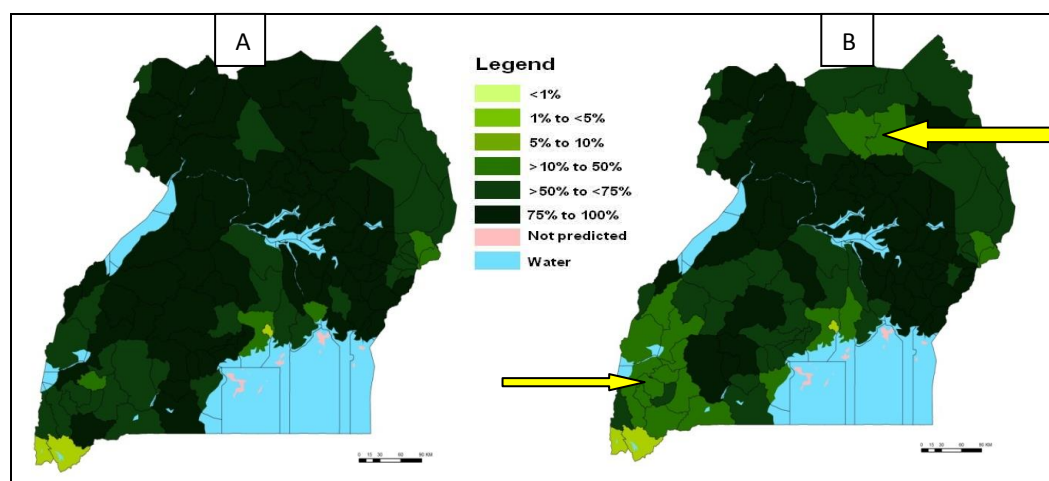


Figure 1. Geographical variation and trend in malaria prevalence in Uganda

Aetiology and vector: Four of the five human Plasmodia species exist in Uganda. However, *P. falciparum* is by far the most common; responsible for 90-98% of diagnosed cases of uncomplicated malaria, and the most common cause of severe malaria. *P. malariae* contributes 2%, *P. vivax* (2%) and *P. Ovale* (<1%); all of which however tend to occur in the context of mixed infection with *P. falciparum*. (MIS 2009, page 62, UMSP 2010 page 52). The main vectors responsible for malaria transmission are *A. gambiae* and *A. funestus*. *A. gambiae* is the dominant species in most places, while *A. funestus* is generally found at higher altitudes and during the short dry seasons of September to November. Permanent water bodies which are the major geographical feature of Uganda across the country are the most common breeding sites (UMRSP, 2014 page 10). In some areas of northern Uganda, the entomological inoculation rates were among the highest recorded in the world (EIR range from 397 to about 1586) (Okello et al, 2006, page 223).

Mortality trend: Although there are no malaria specific mortality rates data, Uganda has achieved a significant reduction in under 5 mortality from 137 to 90 per 1000 live births and infant mortality rate (IMR) from 76 to 54 per 1000 live births (UDHS 2009 and 2011). For malaria deaths, Uganda has moved from the third (2010) to the sixth (2012) highest number of annual deaths from malaria in Africa and contributes about 5% of the estimated 627,000 global malaria deaths (World Malaria Report 2013, page 65). Case fatality in children under 5 malaria admissions decreased from 3.5% in 2011 to 0.72% in 2013, well below the targeted

1% set for 2015.

Morbidity trend: From HMIS data, the proportion of OPD attendance attributed to malaria in children under 5 declined from 48% in 2011 to 14% in 2013. The proportion of OPD attendance in children above 5 years declined from 40% in 2011 to 29% (MTR 2014, page 8-9). This presumably reflects the effect of control measures and greater reductions in the under-fives is mostly likely due to the additional emphasis on this age group in targeting malaria control interventions.

Economic impact: Malaria has an indirect impact on the economy and development in general. The socio-economic impact of malaria includes out-of-pocket expenditure for consultation fees, drugs and transport. In 2003, in sub-Saharan Africa, these costs were estimated to be between USD 0.41 and USD 3.88 per person per month (equivalent to USD 1.88 and USD 26 per household) (UMRSP page 9).

1.1.b Key populations that have disproportionately low access to malaria control interventions.

While everyone in Uganda is at risk for malaria, children <5 years and pregnant women are the most at risk and vulnerable due to their reduced immunity status. In order to ensure that everyone is protected, universal coverage of key malaria control interventions is Uganda's target. In addition pregnant women and infants continue to be prioritized for routine distribution of LLINs, and iCCM also targets the under five. In order to ensure equitable access during the distribution of all malaria control commodities, micro-planning exercises are conducted to stratify the country and ensure that the entire population is covered. However, it is recognised additional efforts are required to reach the following key affected populations:

- (i) Refugees and internally displaced persons are a key population that may experience barriers to access. Based on a study done by Anderson et al (2011) on the burden of malaria in post-emergency refugee sites, annual malaria mortality rates were highest in sites in Sudan (0.9 deaths per 1,000 refugees), Uganda and Tanzania (0.7 deaths per 1000 refugees each). During the planning of the 2014 LLIN mass campaign, it was noted that access to services are coordinated and provided for by the Office of the Prime Minister and partners such as International Red Cross Society (IRCS) and Internally Displaced Persons (IDPs)/refugees were fully covered. LLIN campaign quantifications will continue to include refugee and IDPs.
- (ii) People living in rural areas and economically disadvantaged even though they have been targeted by several malaria prevention and control interventions, still have limited access to services.
- (iii) Nomadic people especially the Karamoja region and fishing communities are also hard to reach because of their mobile habit and difficulty in capturing them in the stratification of the communities.

In the UMRSP, these various groups have been prioritised for improved access particularly through the community delivery systems and focused BCC. (UMRSP 2014, pages 55)

1.1.c - Key human rights barriers and gender inequalities

Generally, Uganda has no major human right barriers influencing access to malaria control services. Although Uganda recently passed an Anti-Homosexuality Act, there is no indication of this limiting access to any of the antimalarial interventions since sexual orientation is not implicit or explicit in malaria care seeking data tools. Gender differences in social customs and occupations may affect equality of access to malaria control services. For instance, health seeking behaviour decisions are largely domiciled with male heads of family and could lead to delays in seeking treatment. There could also be misuse of some of the services, such as only men sleeping under LLINs at the expense of pregnant women or children. This is being addressed through the drive for universal coverage. Uganda will continue to identify the occurrence of any social behaviour barriers while communication strategies will aim at addressing such barriers wherever they occur.

1.1.d - Health Care System

1.1. d (i) Governance Structure: The Government of Uganda is structured with a central government and 112 districts as the local government. The central structure interacts directly with local government at the district level. Below the districts and for administrative convenience, there are counties, sub counties, parishes and villages. Health governance in Uganda is spearheaded by the MoH and shared with other ministries, health development partners, district leadership, providers (public and private), and representatives of civil society organizations (CSOs). The MoH is tasked with the role and responsibility of ensuring the delivery of the health goals and objectives of government as expressed in the Health Sector Strategic and Investment Plan (HSSIP). Given the inter-relationships needed to implement programs, to coordinate players, and to mobilize financial and other resources, the Ministries of Education and Sports; Finance, Planning and Economic Development; Public Service; Local Government; and Gender, Labour and Community Development are also key players. Parastatals such as National Drug Authority (NDA), National Medical Stores (NMS), Joint Medical Stores (JMS), Health Services Commission (HSC), Uganda AIDS Commission (UAC), National Blood Bank, and national insurance providers are also key actors in the health system.

1.1 d (ii) Service Delivery Arrangement: In Uganda, health services are provided by the public (44%) and private sub-sectors (56%) (Uganda National Household Survey 2012/13, MIS 2009 page 39).

Public Sector: The public sector is organised and stratified into the following categories: hospitals (national

referral, regional referral, and general) and a tiered system of health centres comprising health centre IV (Health Sub-district), health centre III (Sub-county), health centre II (Parish) and I (village level) respectively.

Table 1. Uganda Health System Structure

Governance Coordination	Levels of Health Services	Main Category of Health Worker	Roles and estimated service population
Parliament TMC HIPAC	Ministry of Health and other National Level Health Institutions	High level Administrative Technocrats	Stewardship, supervision, policies and quality control & assurance
National and Regional Level Hospital Boards	National Referral Hospitals	Super Specialist and Specialist Medical Personnel	Specialized care-whole population
	Regional Referral Hospitals	Specialist Medical Personnel and Medical Officers	13 in number and each serving a population of approximately 3,000,000 people
District Health Teams	General Hospitals (District Health Services)	Medical Officers, Clinical Officers	District level-approximately 500,000 population
	HC IV level (Health Sub-District)	Medical Officers and Clinical Officers	Referral function for basic general and obstetric surgical care, approximately 100,000 population
	Health Centre III level	Clinical Officers, Registered Nurses, Midwives, Lab assistants	Offers maternity and laboratory services, diagnosis and first level of referral cover for sub county, serves about 20,000 population
Health Sub-Districts	Health Centre II level	Enrolled Nurse, Midwives	Offers the basic preventive and curative services, maternity, and outreach, serves about 5,000 population
	Health Centre I (Village Health Team)	Community Health Workers	Mainly preventive care and home based management, 1,000 population, 5 VHT members/village

Private sector: This comprises the private not-for-profit organizations (PNFPs), private for-profit health care providers (PFPs), and traditional and complementary medicine practitioners (TCMPs). Nearly 70% of facility-based PNFP organizations exist under the umbrella organizations: the Uganda Catholic Medical Bureau (UCMB) and the Uganda Protestant Medical Bureau (UPMB). More than 5% are represented by the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB).

1.1 d (iii) Health System Coordination

National level: At the national level, MoH is responsible for policy, coordination, resource mobilization, quality assurance and supervision. The MoH provides leadership role and responsibility for delivering the outputs of all strategic plans of the health sector. Other stakeholders have defined roles to play in the implementation of the strategic plans. The MoH has defined the functions and responsibilities of each level of health care and set the minimum service standards and staffing norms for each level. MoH is also in charge of the national and regional referral hospitals which provide tertiary level of healthcare.

District Level: The district health team headed by District Health Officer (DHO) is responsible for health services in the district. The district health system (DHS) encompasses both public and private general hospitals and health centres and community health programs. The district level government is responsible for the delivery of health services, recruitment and management of personnel. In addition, they are tasked with development and passing of health related bye-laws, planning, budgeting and resource mobilisation. Within the district, health systems is further sub divided into health sub districts (HSDs) that have headquarters at health centres IV or general hospitals. The HSD provides overall day-to-day management and technical oversight of the lower level health facilities (HC level III, II and community level) within its jurisdiction. The HSD also provides leadership in the planning and management of health services including supervision and quality assurance, provision of technical, logistical and capacity development support to the lower health units and communities including procurement and supply of medicines (HSSIP II, 2010 – 2015, page 3 – 7).

1.1 d (iv) Community Health Systems:

Uganda has the National Village Health Team (VHT) strategy which recognises all the preceding health care levels described above. At the community level, this is composed of the VHTs. Each VHT comprises five community health workers that are selected by the community members of the village. The community leaders are responsible for coordination, overseeing and administrative (non-technical) supervision of VHT activities in their areas. The VHTs are accountable to the community leaders. For proper function, VHT members select a team leader, a secretary and treasurer from amongst themselves and coordinator at parish level. A network of VHTs is facilitating community participation and empowerment in the delivery of health services. All five members of the VHT receive basic training that equips them for health promotion activities, community mobilisation to improve health seeking behaviour, disease prevention and adherence to

treatment. In 2010, Uganda adopted the integrated community case management (iCCM) strategy. Towards the iCCM implementation, two of the five VHTs members are trained on diagnosis, treatment and referral of common childhood illnesses including malaria, pneumonia and diarrhoea. (*iCCM Implementation Guidelines*). Currently, the iCCM is being implemented in 34 districts out of the total 112 districts. (*National iCCM Review Report 2014*). The health workers from the nearest health Centres provide technical guidance of the VHTs. VHTs replenish their commodities from and report to the nearest health centres (*The Village Health Team (VHT) Strategy and Operational Guidelines, page 15-18*).

Constraints of the National and Community Health System

National

- **Inadequate numbers and inequitable distribution of health work force.** There are critical shortages in the health work force across the health system and an inadequate professional mix. The few human resources available are skewed to urban areas with a significant dearth in rural areas. *The adoption of the VHT and iCCM strategies has been identified as key approaches to addressing this in the short term.*
- **Absence of a regional structure** sometimes poses a challenge to organisation, coordination and delivery of health services; imposing a need to always deliver all interventions at the same time to the 112 districts. *To address this constraint, GF provided some support for the creation of Regional Performance Monitoring Teams to serve as a bridge between the central and the district health systems.*
- **Health financing:** Budgetary allocation averaging 7.5% to the health sector is below the recommended minimum of 15% by the Abuja Declaration. The lack of a national health insurance scheme is also a key issue. *We are intensifying advocacy for increased allocation to health and strengthening efforts to explore social health insurance. There is also discussion on the possibility of introducing an AIDS Trust Fund.*
- **Health Infrastructure:** There is inadequate health infrastructure at all levels. For instance, only two national referral hospitals for a population of 35 million are inadequate. The percentage of people living within 5km radius of a health facility is 72% suggesting that a significant number are still without geographical access to healthcare. Additionally, there are hard to reach areas with difficult terrain and poor road networks. *The expansion of the VHT and iCCM strategies is key approaches of addressing this in the short term.*
- **Use of data for programmatic decision making.** The HMIS gathers information using a bottom up approach but information/data rarely go downwards for decision making. *This has been identified for prioritization in the UMRSP 2014-2020.*
- **Procurement and supply management challenges:** The National Medical Stores (NMS) is responsible for the procurement and distribution of all essential medicines and health supplies for the public sector in Uganda. However challenges in the NMS in the areas of coordination, storage and inadequate consumption data still exist. *The Quantification and Procurement Planning Unit (QPPU) of the MOH, which does the quantification, pipeline monitoring and procurement planning for the MOH was established in 2012 as a mitigation measure to support this challenge. Additionally, the CCM has identified PSM as a key priority for the country HSS concept note application.*

Community Health Systems

- **Inadequate coverage of the VHT strategy:** VHT structures are yet to be put in place in a number of districts. About 89 out of 112 districts have VHT systems. However, even in the districts where the VHTs have been introduced the level of functionality is still sub-optimal. *There are plans underway to comprehensively map VHTs and the current funding will strengthen the VHTs.*
- **High attrition of the VHT members due to lack of incentives:** Efforts are ongoing to motivate VHTs. *In the short term, support was received from GF to provide bicycles, T shirts, medicine boxes and torches to facilitate their work. In the longer term the Government of Uganda is currently negotiating at Parliament for the introduction of payment of stipends to VHTs.*
- **The challenge of mainstreaming iCCM:** iCCM implementation is largely supported by partners including supply of commodities and reporting and limited in coverage. *In the UMRSP, funding will be mobilised from Government of Uganda and partners to scale up iCCM while improving national ownership of iCCM. Funds are also requested as part of this grant*
- **Weak supervisory system reporting from the VHTs:** There are inadequate supervisory visits with data from VHTs not being adequately captured; other weaknesses are problems of inadequate reporting tools, failure to transmit data and failure to incorporate some of the transmitted data through the HMIS. *Effort has been intensified in the provision of VHT registers and incorporation VHT data into HMIS. There will also be increased supervision to further strengthen the reporting systems.*

Private sector

- **Weak coordination and supervision of the private sector:** There is inadequate supervision of the practices of the private sector. Penetration of diagnosis is still very low and data reporting is generally inadequate. The private sector uses multiple sources for commodity supplies with significant concerns on quality

assurance. *Action is on-going for the formulation of medical devices regulatory framework led by the National Drug Authority and the NMCP. Uganda has demonstrated good success with the AMFm as a means of ensuring the availability of quality assured ACTs. There is also an ongoing initiative to scale up subsidised quality assured RDTs in the private sector.*

1.2 National Disease Strategic Plans

With clear references to the current national disease strategic plan(s) and supporting documentation (include the name of the document and specific page reference), briefly summarize:

- The key goals, objectives and priority program areas.
- Implementation to date, including the main outcomes and impact achieved.
- Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.
- The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.
- For standard HIV or TB funding requests¹, describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.
- Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

Uganda conducted a mid-term review of the 2010-2015 NSP. As a result of the review, strategic actions were identified to enhance on-going programming in the new malaria reduction strategy to be implemented 2014 - 2020. The malaria strategic plan is referred to as the Uganda Malaria Reduction Strategic Plan (UMRSP).

1.2.a - The key goals, objectives and priority program areas.

Goals

- By 2020, reduce annual malaria deaths from 2013 levels to near zero (from 29 per 100,000 to <1 per 100,000)
- By 2020, reduce malaria morbidity to 30 cases per 1000 population (80% reduction from 2013 levels);
- By 2020, reduce the malaria parasite prevalence to less than 7% (>85% from the 2010 levels).

Strategic objectives (UMRSP—Chapter 4, page 42)

The following objectives were identified for the achievement of the above stated goals:

- By 2017, achieve and maintain protection of at least 85% of the population at risk through recommended malaria prevention measures;
 - By 2018, achieve and sustain at least 90% of malaria cases in the public and private sectors and community level receive prompt treatment according to national guidelines;
 - By 2017 at least 85% of the population practices correct malaria prevention and management measures;
 - By 2016, the programme is able to manage and coordinate multi-sectoral malaria reduction efforts at all levels
 - By 2017, all health facilities and District Health Officers report routinely and timely on malaria programme performance;
 - By 2017, all malaria epidemic prone districts have the capacity for epidemic preparedness and response.
- In order to achieve the aforementioned objectives, the following strategic interventions were prioritized in the first two years of the UMRSP 2014 - 2020:

Disease Prevention

- Achieve and maintain Universal Coverage with LLIN through mass campaign and continuous distribution at ANC, EPI Clinics and schools.
- Scale up IRS from 12 to 50 high transmission districts.
- Strengthen prevention of malaria in pregnancy.

Diagnosis and Treatment

- Ensure parasitological diagnosis of all suspected malaria cases before treatment at health facility (public

¹Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

and private) and community levels.

2. Ensure uninterrupted supply of malaria commodities (ACTs, RDTs, Microscopy reagents, rectal artesunate, and Injectable artesunate, SP) in the required amounts for public and private sectors.
3. Implement iCCM in a phased approach starting with high burden, hard to reach and/or regions with high Infant Mortality Rates.

Cross cutting interventions

1. Scale up IEC/BCC to promote the use of the proven malaria control intervention measures to achieve desired impact.
2. Strengthen M&E for routine HMIS data collection, reporting and use; program reviews, surveillance, operational research and surveys.
3. Strengthen partnerships and coordination with private sector, other government sectors, and civil society.

1.2b - Implementation to date, including the main outcomes and impact achieved

The National Program has followed a continuum of core steps towards strategic decision-making and finally developing this CN. A comprehensive mid-term review (MTR) with involvement of internal stakeholders as well as external experts was conducted early 2014. The mid-term review which had a particular focus on synthesis of available data on the Malaria epidemiology in Uganda and the progress toward impact provided critical recommendations to inform revision of the existing national strategies and developing the Uganda Malaria Reduction Strategic Plan.

The current CN aims to invest strategically, to maximize available resources, in achieving and sustaining high coverage of core interventions to achieve the greatest impact. The investment plan is complemented by a monitoring and evaluation plan to not only monitor the progress in achieving higher coverage of core interventions but also to allow measure disease burden over time. Uganda conducted its first MIS in 2009 and after scaling up malaria control measures, a repeat MIS is planned to be implemented in 2014. This MIS will provide comparable evidence on net ownership and utilization, as well as any change in parasite prevalence.

Disease prevention

Long Lasting Insecticidal Nets: Between 2010 and 2013, a total of 20,386,095 LLINs were distributed. Of this number, 7.2 million LLINs were distributed to children under five years and pregnant women with the support from GF in 2010. Another 651,860 LLINs were distributed in 2012 through mass campaign in Eastern Uganda(4 districts) by partners while 12.5 million LLINs (with GF support) have just been distributed in 67 districts across the country, covering 71 of the 112 districts as part of the national universal distribution campaign which will cover the entire country by the middle of 2014. Based on UDHS (2006 and 2011) The proportion of households with at least one ITN increased from 16% to 60% and the current *operational coverage of nets is estimated to be above 79%*. The proportion of pregnant women and children under five who slept under ITN rose from 10 to 43% and the 10 to 47% respectively from 2006 to 2011. (UDHS, 2006 and UDHS 2011). Net use was also noted to be high with 78% of the population with access to a net sleeping under it (Koenker H, Kilian A (2014) - page 3- Table 1. Access, use, and ownership of ITNs by survey).

Indoor Residual Spraying: In the last three years, IRS has been conducted in 10 districts in Northern Uganda supported by President's Malaria Initiative (PMI) and in two districts in Eastern Uganda supported by the government. In the targeted districts, IRS has achieved coverage of 92%; protecting a population of 2.6million people. (MTR 2014, page 25). There has been a remarkable decrease in malaria prevalence in targeted districts from 63% to less than 20% and a marked reduction of indoor resting vector populations. The country is currently using carbamates for IRS but will switch to organophosphates as part of its insecticide resistance management. Insecticide resistance has been detected to DDT and pyrethroids (Okia et al 2013, page 1). Entomological surveillance and insecticide resistance studies will continue to be carried out and an integrated vector management strategy is under development, including insecticide resistance management.

Case management:

Malaria diagnostics: 19 million malaria RDTs were distributed in 2013. The proportion of cases that received parasitological diagnosis with microscopy and RDTs increased from 24% (2008/9) to 59% in 2013. There are plans to conduct a national survey to determine compliance to test results among health care providers in 2015. A pilot is also underway on use of RDTs in the private sector and the NMCP is planning to develop a policy on use of RDTs in the private sector.

Availability of ACTs: 24.3 million ACTs were distributed in 2013 through the National Medical Stores and Joint Medical Stores. Through the AMFm, Uganda procured and distributed 23.5 million ACTs through the private sector in 2013. The proportion of health facilities with reported ACTs stock outs in public health facilities decreased from 50% in 2009/10 to 10% in 2013. (Annual health sector performance reports 2010 and 2012/2013). The proportion of under-five children who received ACTs within 24 hours from onset of fever increased from 29% in 2009 to 43% in 2012. Among children under age 5 with fever in the two weeks

preceding the survey, about two-thirds (65%) took antimalarial drugs (ACTwatch, 2012). Through the full implementation of iCCM in 34 districts 1.8 million under-five children were reported to have received treatment for malaria in 2013. (National iCCM Review Report 2014).

Malaria in Pregnancy. 50% of pregnant women received at least two doses of IPTp in 2013 through ANC. PMI will continue to support strengthening the delivery of malaria in pregnancy services including increasing the uptake of IPTp in both the public and private sectors.

Capacity development of the health workforce (HW): Training of HWs on the use of malaria RDTs was conducted in 54 districts for the public facilities in 2013, 5 districts for the private for profit facilities and in all 112 districts for the PNFPs. A quality assurance system for parasitological (EQA) was rolled out in 34 districts. A total of 18,519 HWs (Public-10,705, PNFP-7,814) were trained on integrated management of malaria (IMM) countrywide. From the time this training occurred, 7,211 health workers have been recruited into health service (Annual Health Sector Performance Report 2012/13) and hence will require to be trained.

Behavioural Change Communication: Communication activities were implemented to support malaria interventions including advocacy meetings with political, civic and religious leaders, social mobilisation and behaviour change communication through various channels including mass media, drama, school competitions and community dialogues. According to the 2009 MIS the proportion of people aware of malaria prevention measures was 75% and the proportion of children under 5 with fever seeking care from a recommended person within 24 hours of recognition of fever was 66.4% in 2009 MIS and increased to 81.6% in 2011 (UDHS data).

Changes in some of the key indicators are presented in the table below.

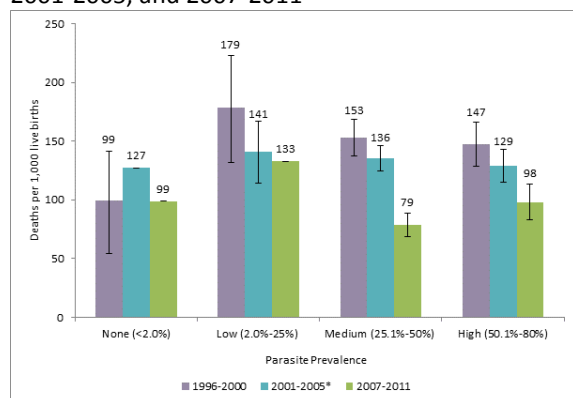
Table 2: Changes in some of the key indicators from routine data.

Key indicators from routine data	2011	2013	Source
OPD visits attributed to malaria in children under 5 (in public and PNFP facilities)	48%	13.7%	MTR, Pg 62
The percentage of OPD visits attributed to malaria in individuals above 5 years	40%	29%	
In-patient malaria mortality	3.5%	0.72%	
Proportion of suspected malaria cases tested	25%	58.8%	
Percentage of women who received 2 or more doses of IPTp	42%	50%	

Overall Impact:

As per UDHS 2011, progress was noted as follows: decline in all cause under-five mortality from 137 in 2006 to 90 deaths per 1000 live births in 2011, in line with the MDG goal 4 to reduce under-five mortality rate by two thirds.

Figure 1.2: Trends in ACCM in very low (none), low, medium and high malaria risk areas, Uganda 1996-2000, 2001-2005, and 2007-2011



A recent Impact Evaluation conducted by Uganda Malaria Impact Evaluation Group-PMI in 2013 highlights that all cause child mortality changed (ACCM) to 99, 133, 79, and 98 by 2007–2011, indicating statistically significant changes from baseline in the medium and higher malaria risk zones but not in the lower risk zones or in areas with <2% parasitemia. Overall, these results indicate malaria control has contributed to declines in ACCM.

A survey was conducted in the northern districts in 2011 to assess the relative impact of IRS on parasitemia prevalence by comparing two districts that have received IRS (Apac and Pader) to one district that has not (Lira). Parasite prevalence amongst children under five year of age in Lira (no IRS) was significantly higher (50% parasite prevalence) than amongst children in Apac and Pader (37% and 17% respectively), and these differences persisted when only rural areas were included in the analysis. Children with anemia followed a similar trend with 5% of children having severe anemia in Lira, compared to 3% in Apac and 1% in Pader.

1.2.c Limitations to implementation and lessons learned that will inform future implementation.

1.2 c (i) Limitations to Implementation of previous NSP

The MTR identified the following limitations that impacted on the implementation of the previous NSP;

Disease prevention:

- **Unpredictable pattern of funding** resulting in failure to synchronise implementation of interventions towards achieving a cumulative impact. For instance, the delay of implementation of the Malaria Round 7

Phase II grant precluded the completion of the initial mass campaign following the distribution of 7.2million nets targeting vulnerable groups. By the time funds were subsequently available; these nets could no longer be counted as part of the universal coverage as they had outlived their effective life, resulting in significant shortages towards the attainment of universal coverage of LLINs. *This GF new funding model helps to address this by ensuring predictable funding and enhanced transparency around funding. Additionally, we expect enhanced government commitment to health be announced in June 2014.*

- **Quantification of LLINs:** Population projections regarding LLIN deployment resulted in significant shortages in the LLIN distribution. The figures obtained during LLIN micro-planning indicated 15% excess household members above the national population figures. It then became necessary to source 3 million additional nets. *Current gap analysis estimates has factored this into the quantification.*

Case management:

- **ACT availability in the private sector:** The public sector contributes 44% of health care delivery suggesting that a significant population receive health care through the private sector. The end of the AMFm posed a threat for the sustained availability of affordable quality assured ACTs in the private sector with a danger of reversing the current gains of access to ACTs. *USD 17 million has been secured from DFID to sustain the private sector co-payment in 2014. This concept note prioritises the continued support of co-payments in both allocation and incentive funding to sustain the significant gains made.*
- **Hard-to-reach areas with low access to health services as indicated in section 1.1.b.** there are population groups with inadequate geographical access/operational access to health services. This was a challenge in the implementation of the previous Malaria Strategic Plan. *These groups will be prioritised through targeted efforts and strengthening community delivery mechanisms particularly ICCM.*
- **Limited integration and supervision of the private health service providers in malaria control interventions** resulting in under reporting of malaria cases and missed opportunities to improve quality of healthcare services. *The implementation approach under the current planned period will seek active engagement of the private section in malaria control and management.*

Cross cutting:

- **Inadequate staffing at NMCP:** Many established positions at NMCP are not filled by substantive staff. Only 40% of the positions are filled leading to sub-optimal performance at NMCP, inadequate follow up and coordination of the program. *In order to support the rapid and integrated scale up of interventions in the UMRSP, the NMCP will require human resource support in the interim through this application, whilst in the long term; the Ministry of Health is expected to recruit for key positions in the NMCP.*
- **Inadequate coordination among malaria implementing partners** with fragmentation in implementation and attendant challenges in tracking of interventions. *There has been improved coordination of the implementation arrangement.*
- **Constraints in the use of existing district structures to implement malaria control intervention.** This has led to low morale among district malaria officials, lack of local ownership and inadequate coordination and audit of activities at district level. *Systems will be put in place to strengthen programme coordination*
- **Weak M & E systems** as evidenced by incomplete and late reporting on routine data and quality concerns have resulted in delays in programmatic reporting necessary for resource mobilisation and accountability. *There is a deliberate effort to strengthen reporting through DHIS2 and the use of Regional Performance Monitoring Teams (RPMTs) to improve data quality (timeliness, completeness and accuracy)*
- **Inadequate engagement of the corporate companies** resulting in missed resource mobilisation opportunities. *It is envisaged that a Business plan will be developed from the current strategic plan and opportunities created for engagement with corporate companies.*
- **Financial management:** Delayed submission of Audit reports by MOH, as well as other financial management issues, often led to delayed disbursements of funds for activities. *The country has put in place a rigorous financial management system in order to ensure funds are used for the intended services and there are no leakages based on the previous risk management assessment done by various donors. The risk mitigation plan also addresses this challenge (see annex1)*

1.2 c (ii) Lessons learnt

- **Mobilization and advocacy:** Involvement of political, civil and religious leaders facilitated implementation of malaria control programmes especially with respect to mass campaigns.
- **Community Systems:** Use of district structures is sustainable and once you build the district capacity, there is greater efficiency, ownership and community accountability. The new NSP will ensure strengthening and use sub national structures.
- **Public awareness on subsidy arrangement:** Implementation of co-payment mechanisms such as the AMFm increases availability, affordability and accessibility of quality assured ACTs both in the private and public sector. However, public awareness about the quality, prices and outlets delivering these medicines

is vital for its success.

- **Use of malaria RDTs by trained VHT members** at community level to diagnose malaria prevents wastage of life saving ACTs as it promoted targeting ACTs to febrile cases that are due to malaria. Additionally, implementation of iCCM reduces congestion and crowding of patients at lower level health Centres.

1.2 c- (iii) In order to apply the above lessons learned and address the limitations highlighted, the following strategic actions were identified to enhance future implementation of the new malaria reduction strategy:

- **NMCP will hold advocacy meetings with all potential funders and key stakeholders to mobilize additional resources for malaria control.** Additionally, the programme will develop concept notes, proposals, and work-plans for resource mobilization from the government, development partners and the corporate private sector for malaria control.
- **To strengthen coordination of malaria control activities, the programme will delineate partners' activities and geographical scope to streamline delivery of a comprehensive package of malaria interventions.** This will minimize fragmented implementation of interventions and duplication of efforts. In-country RBM coordination will be enhanced through regular reviews and planning meetings.
- **To effectively use national and sub-national structures, NMCP will advocate for recruitment both at national and sub-national level.** This process will be preceded by capacity needs assessment to identify human resource and capacity building gaps. In the interim, the GF and other country partners will continue supporting the following TA; two M&E specialists, Program officer, pharmacist/logistician, statistical epidemiologist
- **In order to build on lessons learnt from AMFm, NMCP will establish the private sector co-payment taskforce.** This will address private sector access to subsidized ACTs and malaria RDTs; training and support supervision approaches for private health providers and sub-national structures for data collection from private sector, management and dissemination.
- **In order to improve the role of BCC in malaria control, the NMCP will revitalise the BCC thematic area working groups and update the Malaria Communication Strategy to include more innovative approaches.** In additions to this, through joint planning with the thematic area focal persons, an arrangement will be made to ensure the integrated delivery of BCC message pre-, during and post-implementation.
- **To address the PSM limitations, NMCP plans to train health workers on proper quantification, forecasting and ordering for malaria commodities as part IMM training.** The NMCP will second a procurement logistician to the QPPU unit who will be responsible for quantifying RDTs, ACTs, rectal Artesunate, Artesunate injections and malaria microscopy consumables. The NMCP will coordinate with the Pharmacy division- QPPU units and Central Medical Stores, to ensure that there are fewer stock outs at the service delivery points.

1.2d. Main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

Alignment with National Health Policy

The National Health Policy II prioritises health promotion, disease prevention, early diagnosis and treatment of disease with emphasis on vulnerable populations. Deriving from this, the UMRSP keys into these priorities. The health policy expresses the commitment of the Ugandan government towards achieving health related MDGs and the 2000 Abuja declaration of AIDS, TB and malaria. To this end, the policy specifically calls for scaling up of investments in health promotion, disease prevention and increasing aid effectiveness. The current UMRSP is aligned to this goal through the projected scale up of interventions for the achievement of the revised Abuja targets in relation to malaria control and elimination. In addition the strategic plan has been costed for the planned period and application for the NFM is aimed at increasing Aid effectiveness. The implementation of this strategic plan will contribute to reduction in all-cause mortality and morbidity.

Alignment with National Health Sector Strategic and Investment Plan II (HSSIP)

The HSSIP defines the medium and long term health agenda and operationalize Uganda's operations as outlined in the National development plan. In cluster 2, the NHSSIP 2010/11-2014/15 recognises the need to reduce malaria morbidity and mortality and cluster 4 calls for scale up and sustained high and effective coverage of a priority package of cost effective child survival intervention in order to reduce under- five mortality. The implementation of the current UMRSP with focus on malaria reduction is aimed at addressing a prioritized disease condition of the HSSIP II.

Alignment with the Government agenda

There is a strong political will in Uganda to eliminate malaria. Uganda's National Resistance Movement (NRM) party has stated in its 2010-2016 manifesto that "it is the intension of the NRM to totally eliminate malaria from Uganda" thereby demonstrating strong political will towards malaria control and elimination. The current UMRSP aims at bringing intervention activities to a level that will ensure attainment of pre-

elimination status. In the budget speech of the financial year 2013/2014, the Minister of Finance, Planning and Economic Development re-affirmed the intention of government to commit more resources towards malaria control. *The intended level of scale up of malaria intervention is to reduce the burden of malaria towards pre-elimination levels.*

Alignment with the Uganda's Vision

Uganda's vision 2040 provides development paths and strategies to operationalize Uganda's vision statement which is "a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years" as approved by the Cabinet in 2007. Malaria has both direct and indirect impact on the development and social economic transformation of a nation, from the crippling effect of the disease, the cost of care, loss of productive work force and serving as a dis-incentive to tourism and direct foreign investment. *The UMRSP articulates objectives and strategies to ensure significant reduction in the burden of malaria thereby contributing critically to the expressed intentions of Vision 2040.*

1.2.f. Country process of reviewing NSP

The malaria strategic planning cycle is aligned to the government finance year (July–June). The current UMRSP will run from 2014/15 to 2019/2020. The Uganda malaria strategic plan was running from 2010/11-2014/15. A midterm review was conducted between February and March 2014, by the NMCP and malaria partners. The review was all-inclusive and participatory involving all malaria stakeholders from different sectors, including: government, civil society, academia/research, malaria development partners and the corporate private sector, and outcomes were validated by WHO. The purpose of the MTR was to examine progress to date against the goals and targets, and identifying key issues affecting implementation. SWOT analysis was done per malaria thematic areas. A Peer review of the UMRSP was facilitated by RBM/WHO in a meeting held in Nairobi. The exercise involved assessing the strategic plan against a standard checklist of parameters that measure the overall coherence and technical adequacy of the strategic plan. Feedback from the MTR and peer review of the NSP provided a basis for revising and updating the UMRSP. Several multi stakeholders' meetings were held with technical assistance from WHO and RBM partnership towards the development of the new strategic plan incorporating lessons learnt and updating the technical approaches within the strategy. The draft of the updated strategic plan was thereafter presented to government, Country Coordinating Mechanism and partners for buying in and final approval. In the current plan NMCP together with its partners will carry out a mid-term review in 2017 and in 2020 the end term review will be done to assess the 2014/2020 UMRSP.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALLY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

- The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
- How the proposed Global Fund investment has leveraged other donor resources.
- For program areas that have significant funding gaps, planned actions to address these gaps.

The NMCP is funded through the Ministry of Health budget and assistance from development partners notably GFATM, WHO, UNICEF, PMI, DfID, Clinton Health Access Initiative (CHAI) and Chinese government. Table 2.1(a)-(i) below highlights the funding requirements per thematic areas highlighting the funding per program areas and resources from each partners. No programme area, except MIP is adequately resourced and therefore priority areas are included in the request to the Global Fund.

Table 2.1.a-(i) Table of funding gap per thematic area and contribution by various donors- in US\$ millions

Thematic area.		UMRSP (2015- 2016)	GOU	PARTNERS	FUNDING GAP before allocation to GF	GF-NFM- Allocation
Prevention	IRS	53.55	3.20	27.44	22.91	
	Larval Source Management	0.91			0.91	-
	LLINs	160.55		29.24	131.31	42.55

	Environmental and Entomological Monitoring	1.36		1.36	0.00	
	Specific Prevention Interventions (SPI)- MiP	1.63	0.30	1.31	0.02	
	Commodities (ACTS, RDTs, Artesunate)	108.39	3.50	40.68	161.43	58.78
Case Management	Other case management support (ICCM non commodities ,training HW, clinical audits, QA/QC activities, job aides)	97.21				3.89
	Program management ***	3.96			3.96	2.63
	BCC	43.82		9.80	34.02	2.35
Cross cutting	M& E, Operations research	12.04		6.06	5.98	2.07
	Grant Management- TASO					1.25
Total		483.42	7.2	115.89	360.3	113.52

** This program management includes the NMCP –MoH mandate PM costs, excluding the partners program management costs submitted in their thematic area request.

2.1(a) –ii- Currently submitted Contribution by Partners over the Concept Note period

	2014	2015	2016	Total 2015- 2016
UMRSP NEED	251,821,600	175,160,785	308,263,627	483,424,412
Domestic resources –government**	4,617,443	3,607,450	3,607,450	7,214,900
China	486,541	486,541	486,541	973,082
United States Government (USG)	34,000,000	33,000,000	33,000,000	66,000,000
United Kingdom	37,728,939	19,483,029	19,280,187	38,763,216
International Drug Purchase Facility (UNITAID)	1,407,873	2,551,747	2,551,747	5,103,494
Malaria Consortium	4,846,045	2,267,315	1,215,910	3,483,225
Clinton Foundation	50,000	50,000	50,000	100,000
The United Nations Children's Fund (UNICEF)	1,359,595	743,791	743,791	1,487,582
Total External resources	79,878,993	58,582,423	57,328,176	84,420,017
Existing GF grants	16,391,694			
Funding Gap		112,970,912	247,328,001	360,298,915
Request from Global fund allocation		48,311,406	65,203,248	113,514,655
Request from Global fund - incentive funding		10,253,728	68,005,076	78,258,804

**anticipated Domestic resources from the government totalling to 5.7 in 2015 and 4.7m in 2016 have been included in the table , these are expected to support human resources and laboratories . This has been include in the gap analysis

2.1 (b) How the proposed Global Fund investment has leveraged other donor resources.

A Programmatic and financial gap analysis has been conducted with respect to the UMRSP. Total need for funding the UMRSP from 2015 to 2016 is \$483,424,412. The government commitment over this period is \$7,214,900. While the government contribution has been constant over the recent years, resources have been leveraged from other partners in meeting the programmatic needs. GF Resources (allocated NFM) will supplement the existing resources in order to sustain the gains of program intervention, and prevent disruptions of critical interventions. GF funding has been directed mainly to ACTs, RDTs and training, LLINs for both routine and mass campaign among others. In-country partners support has been directed towards, capacity building, quality assurance and other support activities.

Partner collaboration is coordinated by the NMCP through the RBM partnership and the technical working groups of MOH. The NMCP ensures high standards of transparency and accountability for all the resources for the malaria response by joint work plans implementation and integrated supervisions from the central to the lower levels. The principle of “the three ones”, further promotes broader stakeholders’ complementarity and synergies in program implementation.

2.1 c For program areas that have significant funding gaps, planned actions to address these gaps.

Program areas that have significant funding gaps	Planned actions to address these gaps
Non-funded iccm components	NMCP is exploring avenues to ensure that government of Uganda addresses the gap of equipment and supplies for pneumonia and diarrhoea in under-five children .Additional resources are also expected through UNICEF and the RMNCH trust fund

Vector control –IRS	Engaging in-country partners and government
LLIN mass campaigns	Incentive funding and engagement of in-country partners and government
Private sector co-payment	Incentive funding and continuous advocacy with DFID for more support

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	✓ Yes <input type="checkbox"/> No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	✓ Yes <input type="checkbox"/> No	
iii. Increasing government contribution to disease program	✓ Yes <input type="checkbox"/> No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

2-3 PAGES SUGGESTED

2.2 a Minimum threshold for counterpart financing:

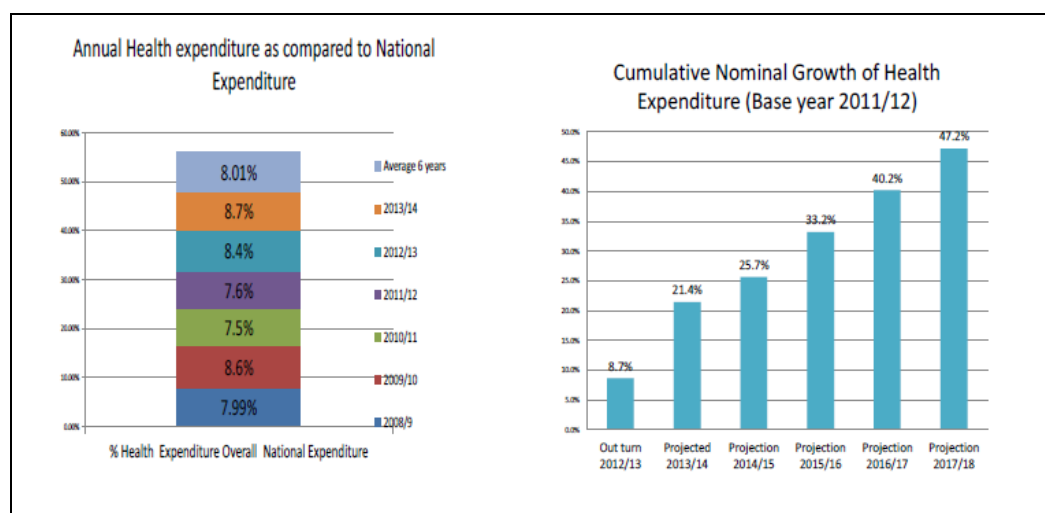
The Gap analysis indicates that the counterpart Financing is 7% which is greater than 5% requirement for a country like Uganda. (The figure is 11% if calculated basing on existing GF funding and country allocation). This is due to government commitment to procure malaria commodities (SP, ACTs, and laboratory consumables for microscopy), contribution to Human resources and implementation of IRS in two districts totaling to approximately \$3.6 million annually.

2.2 b Increasing government contribution to national disease program and increasing government contribution to the overall health sector over the next Phase/Implementation Period.

The Government of Uganda funds the health sector through a mechanism called budget support under the country Medium Term Expenditure Framework (MTEF) of the Ministry of Finance, Planning and Economic Development (MOFPED) established to pool resources to support sectors activities. The Government contributes significantly to the health care delivery in the form of payment of salaries and wages. This contribution has not been captured in the above projections because the basis for prorating/disaggregating the government contribution to different programs cannot be adequately and accurately justified in neither absolute nor relative terms. As a result of economic dynamics in the budget support mechanism, contribution to health financing is based on budget ceilings of MOFPED. If the economy is not performing then the health resource envelope is affected. However, it has been projected that Uganda national budgets have been growing for the past years and this will continue in the future and guarantee additionally in financing of the health sector from government revenue.

Status of Government Funding: Although the share of Government funding allocation to the health sector spending, including the NMCP, appears to remain low as indicated below compared to the expected 15% Abuja minimal requirement for budget support towards Health, in nominal terms, the country's health budget is expected to grow by 47.2% in the year 2017/18 compared to the year 2011/12 health budget (See Figure 2.2). It is projected that as the economy grows, the overall national budget will increase and therefore all sector budgets will increase in nominal terms accordingly.

Figure 2.2: Annual Health Expenditure and cumulative Nominal Growth



Willingness to pay: Of the total allocation of US\$ 420.9 million for Uganda, 15%, equivalent to US\$ 63 million, is accessible based on “willingness to pay”, which refers to additional counterpart financing of the programs supported by the Global Fund in the next phase (FY 2014/15 to FY 2016/17) compared to the previous phase (FY 2011/12 to FY 2013/14). The Uganda Medium Term Expenditure Framework (MTEF) budget projections for 2014/15 to 2016/17 indicate a 16% increase in allocation from the Government of Uganda resources. The Government has already shown willingness to increase on the number of health workers as evidenced by the recent recruitment, illustrated in the graph above

The CCM will work with the GoU and advocate for:

1. An increase in the allocation for ACTs, ARVs, and anti-TB medicines;
2. Absorption of human resources supported by donors over the next three years: Currently over 1,800 health workers in Uganda are supported by PEPFAR (1,200) and the Global Fund (600);
3. Strengthening procurement and supply management systems to improve quality and continuous supply of prevention, treatment and care services to beneficiaries.

Information Requirements related to Government Investments:

For the CCM to track the government investment, the CCM will be obtaining an update on government spending (past two years), budget (current year) and commitments (next three years) to programs supported by the Global Fund as illustrated in figure 2.2 (health expenditure as a percentage of government expenditures). This investment will include interventions/activities currently financed by government investments and additional investments over the next phase for scaling up program activities and/or absorption of existing donor support (including Global Fund).

Information on how actual spending will be verified and reported by the CCM by using Official documents that serve as the basis for verifying government spending . These include :

- Medium Term Expenditure Framework
- National Health Accounts/National Spending Assessments
- Costing of National Strategic Plans for the three diseases
- Budget Execution details of Health Sector

2.2 c (i). Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

Steps to estimate government current and anticipated domestic funding. In coming up with estimates for the current and anticipated government domestic funding, the country took up the following steps;

1. Reviewed the overall landscape of government resources in terms of sources of revenue and expenditures. Got the total government revenue by sources
2. Reviewed the government budget/expenditures and nature of contributions to the health sector.
3. The CCM reviewed documents of Ministry of Finance, Planning and Economic Development (MoFPED) Medium Term Expenditure Framework (MTEF) papers that included; Indicative Revenue and Expenditure Framework from National Budget Framework Paper FY 2013/14 – FY 2017/2018; April 2013; Background to the budget 2013/14 Fiscal year; June 2013; Performance of the Economy Report, June 2013; Reports on overall Fiscal Operations Year July 12- June 2013. Health Ministerial Policy Statement. Got the health budgets by sources

4. Defined government budget on health and separated it from Overseas Development Assistance (ODA) budgets
5. Identified all sources that go through budget support and projects.
6. Identified earmarked budget/expenditures for various sections of the health sector that include the Central Ministry of health, referral hospitals and local government general hospitals and primary health care facilities and disease programs
7. Separated capital development and wage expenditures from recurrent expenditures by source of financing. To get government funding for these components.
8. Identified earmarked funds for Malaria support under government revenue and ODA support in different past years of implementation. Got what is earmarked for Malaria
9. Projected all domestic/government funding by using an assumption that the funding will grow in line with the country projections of the growth in general government expenditures and then factor in an additional reallocation of resources to the health sector using (a) Growth in National budget and (b) annual increase in the health sector budget allocations

2.2 c(ii) Assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

Data sources: The following are three major sources of data used to complete the financial gap analysis;

- 1) Budget framework papers of Ministry of Finance, Planning and Economic Development (MoFPED) for overall national budget and macroeconomic indicators - Indicative Revenue and Expenditure Framework from National Budget Framework Paper FY 2013/14 – FY 2017/2018; April 2013.
- 2) Ministerial budget framework paper; Health budgets; Budget support and health projects under Medium Term Expenditure Framework (MTEF) ; Earmarked funds for Malaria medicines from government commitment obtained from National Medical stores.
- 3) Sources financing the health sector outside the government systems; Off MTEF; Health projects implemented by NGOs funded by donors.(PMI , DFID, CHAI,UNITAID)

Assessment of the completeness and reliability of financial data reported:

The country has not yet carried out a resource tracking study to establish specific disease spending. National health accounts 2010/11 did not capture disease specific spending. Earmarked funds for Malaria are for purchase of commodities committed by the government (obtained from NMS). Accessibility to partner's financing databases was a main challenge. Data submitted from partners implementing Malaria programs outside government systems seem to portray a lower picture of their expenditures. Annual budgetary performance framework reports have been used.

Financing Data system Limitation:

- 1) Insufficient existing mechanisms of sharing finance information between the malaria program and partners implementing malaria programs outside the government funding mechanisms.
- 2) Lack of established database at the NMCP
- 3) Budget support spending is not earmarked by disease area while for the partners, it lacks disaggregation by malaria specific interventions areas.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

Global Fund Programmatic gap analyses tables have been completed for key commodities including LLINs, ACTs and RDTs in the public sector and for iCCM, ACTs for the private sector, and artesunate for treatment of

severe malaria.

Additionally the RBM gap analysis tables include additional modules for BCC, programme management and monitoring and evaluation based on the UMRSP 2014 (see **Table 2(b)_Uganda Gap_Analysis_RBM**). In each of these modules the programmatic need has been quantified but the data on resource commitments from partners and government are still being collected and verified. The CCM has therefore selected priority activities which are not resourced and are considered most essential to support the implementation of the UMRS.

BCC/IEC

There will be an emphasis on interpersonal participatory communication at community level through the following:-

Capacity building and mentoring of CBOs/FBOs, NGOs and DHTs to train the VHTs in 33 districts. VHTs will be with equipped with the skills and tools to spearhead community sensitization through IPC. VHTs will deliver malaria control messages especially on LLIN use, and prompt health care seeking behaviour, availability and cost of subsidized ACTs in the private sector. Resources will be required to support the expansion of this approach to additional districts.

IEC materials will be adapted, developed, produced and disseminated to be used by the CBOs, DHTs and VHTs for the 33 target districts..

Social mobilization activities; Community dialogue, Community and school sports events and drama, Film shows on malaria interventions. Teachers and student leaders will also be trained and equipped with malaria skills. These will be used as change agents in the community.

BCC reporting tools will be adapted and printed and disseminated for use for report on the BCC activities carried in the district.

PMI, UNICEF, Malaria Consortium and DFID are supporting other IEC/BCC components not requested here.

Programme Management

Human resources financed through previous Global Fund grants will be supported through this funding request including two monitoring and evaluation specialists, an epidemiologist and a programme officer. Additionally this application requests support of salaries for a pharmacist (PSM specialist) and a Social and Communication specialist to fill key gaps of human resources at the NMCP.

Supportive Supervision. National and district health teams will be supported to conduct supportive supervision; some of these activities will be integrated with other disease grants to develop implementation efficiencies at the time of implementation.

Quarterly reviews: To strengthen Program management, the UMRSP has proposed quarterly review meetings for the partners to coordinate and ensure they are implementing “The Three Ones” and no duplication is being done. Twice a year, there will be regional and national level meetings to engage the private sector and learn lessons.

CHAI, USAID, WHO and UNICEF are supporting other staff and TA not listed above. The Government of Uganda also contributes to the support supervision component.

Monitoring and Evaluation

Monitoring and Evaluation activities will be carried out through district biostatisticians and HMIS focal persons. This funding application seeks support for the following:

The NMCP will develop a comprehensive M&E plan aligned with the current UMRSP

District Quality Assurance activities

To promote evidence-based decision making and future programming, NMCP in collaboration with Makerere University School of Public Health, WHO, UNHRO, and implementing partners will conduct operational research on the following;

- i) effectiveness of BCC interventions on knowledge, attitude, behaviour and practices of malaria control measures and the most effective BCC delivery channels;
- ii) implementation processes and success indicators for the iCCM strategy during the scale up in the 33 GF supported districts;
- iii) investigate the retention & utilisation of routinely distributed LLINs through ANC and EPI and assess the most efficient model of continuous distribution including school based distribution
- iv) Determine the factors influencing use and non-compliance to malaria RDTs test results among health workers across the country.

Other key areas of monitoring and evaluation such as insecticide resistance monitoring (PMI and government), drug resistance monitoring (PMI), printing of data collection tools (HSS grant), LLIN tracking (previous GF grant, PMI, Government of Uganda – to be integrated into the DHIS2) are ongoing and funded elsewhere. Support to strengthen HMIS and related activities will be requested in the Global Fund HSS application.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

Table 3.2-a Summary of indicative funding allocation for the Malaria concept note:

Component	Malaria	Comments
Total Allocation as of 1 January 2014 (US\$)	\$142,059,768	GF Allocation letter dated 12 March 2014
Less: 2014 Disbursements in the pipeline	\$3,771,098	Procurement of ACTs and Artesunate as per signed PQs 13466 and 13789, discounted by savings of US\$ 1,809,671.31 at PFSCM
Less: Expected budget for period 1/1/2014 to 31/12/2014	\$13,424,858	UGD-011-G11-M IL3-summary budget
Less: Expected budget for period 1/1/2014 to 31/12/2014	\$5,053,545	UGD-011-G12-M: Q6, Q7 & Q8 budgets in IL2 summary budget + Q9 budget in IL4 summary budget
Maximum Available funding 1 Jan 2015	\$119,810,267	Note: Amount available for NFM may be slightly more depending on actual disbursed and/or savings from procurement but this will be communicated by GF.
Less: Adjustment to HSS.	\$6,295,613	11% of 57,232,841-Malaria additional funding Based on CCM decision on grant split
Available Allocation for this Concept Note	\$113,514,654	

Given that the amount allocated for this malaria funding request (\$113,514,654) combined with other currently secured resources from government and in country partners approximately covers 49% of the total Uganda Malaria reduction strategy budget required for 2015-2016 (Table 2.1(a)), there has been a strategic prioritization of the interventions included in the current funding request. The high impact activities included in this funding request have been selected to allow the country to (i) maintain the current gains and avoid interruption of malaria services initiated in GF Round 10 and AMFm grants (ii) sustain and scale up access and use of LLINs distributed in the universal coverage campaign of Round 7-malaria grant and the continuous distribution in Round 10-Malaria (iii) further intensify the scale up effort of iCCM activities in hard to reach areas with high transmission (iv) support tracking of progress in implementation through timely analysis of quality data, reporting and use of data for decision making as well as operational research.

The following are the key areas of the strategic prioritization of the funds included in this funding request:

- i. Sustain Universal Coverage with LLIN through a mass campaign plus continuous distribution at ANC and EPI Clinics **(Vector control Module)**
- ii. Enhancement of the test, treat and track strategy through case management at facility (public and private) and community level by expanding iCCM, confirmation of all suspected malaria cases and giving appropriate treatment **(Case management, Surveillance/M&E module)**
- iii. Ensure availability of malaria case management commodities (ACTs, RDTs, and Injectable artesunate) for public and private sectors, with zero tolerance for malaria commodity stock out. **(Case management, Surveillance/M&E module)**
- iv. Scale up IEC/BCC for increased uptake of all malaria control interventions **(all modules)**
- v. Strengthen M&E for data reporting, data quality and reviews, operations research **(M&E modules)**
- vi. Human resource support to NMCP staff for a pharmacist statistical epidemiologist **(M&E modules)**
- vii. Support the NMCP for effective coordination of partnerships and implementation activities to ensure quality, robust execution of the malaria control strategy to maximize the interventions, sharing of results to track performance and merging complimentary synergies through support supervision, regular stakeholders meetings, Joint annual work-plan and reviews **(program management module)**

This funding request is split to cover the procurement and distribution of essential commodities (80% of the budget request) and key implementation support (20% of the request). The emphasis on commodities and their distribution is necessary given the need to focus on sustaining essential services for case management and vector control previously financed with GF resources, in order to avoid a reversal of the gains to date. In addition to the delivery of ACTs through the public and private sector, the country is expanding the iCCM strategy including training and BCC, and is also strengthening M&E systems for enhanced reporting. In order to ensure effective implementation support, and in reference to some of the previous difficulties in financial

management, the country has put in place a rigorous financial management system in order to ensure funds are used for the intended services (See attached the finance risk mitigation plan).The country will also enhance BCC including IPC at community level to further scale-up demand and utilization of malaria control services.The NMCP has developed a performance improvement plan for BCC (attached). The modules included in this request are shown in the table below.

Table 3.2 b The application amount per module and intervention areas from GF indicative allocation and above allocation (incentive funding).

MODULAR		Allocation	% of total indicative allocation	Above Allocation	% of total of incentive funding
Case management	ICCM: VHT training, ACTs and RDTs for community level, ICCM communication materials, VHT registers, VHT support supervision and quarterly meetings, operational research on ICCM implementation.	\$4,470,064	4%	\$1,555,215	2%
	Procurement of facility based ACTs & RDTs, QA/QC of RDTs	\$36,270,598	33%	\$13,132,925	17%
	Trainings of health workers in IMM, operational research on adherence to RDT test results by service providers.	\$1,484,510		0	
	Severe malaria	Procurement of artesunate	6%	\$2,424,368	3%
		Clinical Audits		0	
	Private sector case management	Private sector price monitoring, training in data collection and reporting, printing of HMIS tools for private sector reporting.	12%	0	15%
		Private sector co-payments		\$12,109,389	
BCC, social mobilisation & community systems strengthening	IEC/BCC- integrated for all malaria control services and community social mobilisation.	\$2,351,862	2%	0	0%
Vector control	Procurements and distribution of LLIN for routine and mass campaign LLINs.	\$42,551,305	37%	\$49,036,908	63%
Program management	Integrated support supervision, quarterly and annual planning and review meetings, quarterly malaria thematic group review, human resources and regional private sector meetings	\$2,626,858	2%	0	0%
HIS & M&E	HIS & M&E: Developing M&E plans (2014/15-2019/20 and Midterm Program review (November 2016), Data quality assessments activities, trainings in data analysis and use for decision making and KAPS-BCC end line survey.	\$2,065,413	2%	0	0%
Grant management	Program costs of PR2-Overhead of TASO	\$1,252,349	1%	0	0%
Total		\$113,514,655		\$78,258,805	

*** M&E cost category overall has taken 5% of the overall budget as it also includes (i) monitoring availability and prices of subsidised ACTs in the private sector (\$331,840), strengthened data collection and reporting from the private sector (\$1,050,662) (currently included in the private sector- case management component) (ii) operational research studies included in their thematic areas including ICCM (\$99,753), LLINs(\$448,402)- and RDTs (\$215,182). Detailed are in Budget summary -

Commodity Allocation in Quantities				
Overall	ACTs (treatments)	RDTs (tests)	Artesunate (Vials)	LLINs
Allocation	40,554,282	32,383,486	3,149,143	10,118,615
Above allocation	28,974,887	10,485,645	1,245,693	11,660,879

1.1 Vector control:

1.1.1 LLINs: In order to consolidate the gains of the 2013/2014 universal coverage, Uganda will focus on

sustaining universal coverage through countrywide routine distribution through ANC and EPI to pregnant women and infants, as well as a mass campaign in 2016/2017. The summary of the LLIN need is shown in table 3.2 c below.

Table 3.2 c: LLIN needs for 2015-2017

Malaria- LLINs	2015	2016	2017
Population of target area	37,916,400	39,228,700	40,578,700
Mass distribution: 1.8 - using WHO recommended calculation plus 15% variance	-	18,797,085	6,265,695
Total LLINs required for distribution through ANC /EPI	3,137,582	3,246,175	3,449,190
Total number of LLINs required (campaign + routine)	3,137,582	22,043,260	9,678,364
Nets funded	2,159,585	2,149,264	1,200,000
Expected annual gap in achieving targets (number of nets required minus number of nets funded)	977,997	19,893,996	8,478,364
Allocation amount	782,398	9,336,217	

Allocation: The GF supported the procurement and distribution of approximately 15 million LLINs in 2013/2014 to contribute to the successful universal coverage campaign. This included the delivery to the country of 11 million LLINs in 2013, which will require replacement in 2016, and approximately 5 million LLINs delivered to the country in early 2014 which will require procurement in 2016 for delivery in early 2017. Thus in order to maintain the scope and scale of what was previously financed by the GF; 10.1 million LLINs have been prioritized for the indicative allocation at a cost of US\$42.5 million.

Above allocation: LLINs are an extremely cost-effective intervention, reducing the malaria burden by 50% in children under five years of age. Uganda has completed its first universal coverage campaign in 2013/2014, with significant support from the GF. It will be essential to replace these LLINs three years after they have been distributed, in order to avoid the reversal of the gains achieved and sustain the impact achieved by the campaign in 2013/2014. This will be particularly important given the reduced immunity in the population as a result of sustained LLIN use, Uganda requests 11.7 million additional LLINs at a cost of \$49 million in the above allocation incentive funding. This includes:

Funds to replace 2 million LLINs distributed to Uganda with GF support in 2013, which will be replaced and delivered in 2016

Funds to procure an additional 4.8 million LLINs in 2016 for delivery in early 2017 to replace the LLINs delivered to the country with GF resources in early 2014.

Funds to procure an additional 4.5 million LLINs to contribute to filling the LLIN gap in 2017.

Uganda is working to mobilise additional resources from partners to fill the rest of the outstanding LLIN gap. In 2013/2014, an additional 5.5 million LLINs were financed through DFID/PMI and World Vision.

1.1.2: IRS, Entomology and insecticide resistance management: IRS is ongoing in 12 districts funded by the Government of Uganda and PMI. Insecticide resistance has been documented to both DDT and carbamates, and ongoing insecticide resistance testing and vector surveillance will be funded outside of this grant through PMI and the Government of Uganda. An integrated vector management strategy is under development, including insecticide resistance management. No funding is requested under this application for IRS, entomological surveillance and insecticide resistance testing.

1.2 Case management: All persons presenting with signs and symptoms of malaria in the public health facilities, private health providers and at community level are targeted through case management. All suspected malaria cases at health facility and community level will be tested parasitologically (microscopy or RDT). Malaria positive cases will be treated according to the national malaria treatment guidelines, whilst negative cases will be further investigated and treated as appropriate. The private sector co-payment mechanism will be sustained. The primary objective of the case management strategy is to shorten morbidity and prevent death thus reducing the overall burden of malaria. By providing universal access to diagnostic testing for all suspected malaria cases this will provide prompt and efficacious treatment to both malaria cases and non-malaria cases.

1.2.1 ICCM strategy: The iCCM strategy is implemented through VHTs to ensure children with poor access to prompt health care services receive appropriate antimalarial treatment at community level within 24 hours of

the onset of symptoms. As per the community health system structure described in 1.1.d (iv), currently 34 out of 112 districts are implementing ICCM with support from various partners including UNICEF and the Malaria Consortium. Based on the lessons learnt to date, in this funding application, the country seeks to scale-up ICCM to 33 additional districts mainly in hard to reach areas through this grant.

Allocation: The specific activities will be funded in the ICCM strategy include:

Training of 22,000 VHTs in 15 districts in 2015 (VHTs in the other 18 roll out districts will be trained using the HSS resources which will only become available in 2016).

ACTs and RDTs for iCCM in 33 districts (procurement and distribution of 795,275 ACTs and 2,073,511 RDTs)

ICCM materials including iCCM communication materials, VHT registers, education materials, job aides and referral cards will be provided for all 33 districts.

Support supervision and quarterly meetings for the 15 districts.

Operational research on iCCM implementation

The total cost of iCCM is \$4,470,064 in indicative funding. VHTs will receive medicines from health facilities in their catchment areas supplied through the established commodity distribution channel. The Global Fund will support malaria commodities while the government and partners including UNICEF, the RMNCH Trust Fund and others will meet costs for non-malaria component supplies. The VHTs will be motivated by the government and supervised by the health workers in their catchment areas where they will be meeting on a quarterly basis. The VHTs will record data in VHT registers provided by the government and report through the HMIS at the health facility in their catchment areas. The CCM recognizes that there some components of the iCCM (respiratory timers, ORS, Zinc) which are not fundable by GF, therefore there will be leverage from the RHCM trust fund and further support from the government to avail these commodities.

ABOVE Allocation: US\$1,555,215 is requested to cover the outstanding commodity cost gaps of 3.4million RDTs and 54,550 ACTs.

1.2.2. Facility based approach. All suspected malaria cases will be tested by microscopy or RDTs and those with malaria will be treated according to national malaria treatment guidelines and those without malaria will be further investigated and treated as appropriate. Health education, follow up and treatment compliance and adherence to test results will be monitored and strengthened through health worker training, support supervision and mentoring. Health facilities will provide reports through the established HMIS systems. Laboratory services will be improved through a focus on improving QA/QC. ACT consumption data will be tracked through mTrac, HMIS, DHIS2, support supervision, annual and quarterly reviews or other appropriate reporting channels. In addition health facilities will be tracking clients referred and supervising the VHT and the private drug shops within their catchment area.

Prompt and appropriate malaria treatment at Health facility public and PNFP:

(i) Procurement, storage and distribution of ACTs, RDTs and Artesunate (PR1/MOH, NMS, PR2, JMS)

All medicines and health commodities will be procured through Pooled Procurement and delivered to the central NMS and JMS for storage and distribution to all public and PNFP facilities respectively.

Allocation: Based on the gap analysis, on average, 35million ACT doses are required annually for the public sector, community level and private sector. Under this application, to ensure an uninterrupted supply of ACTs a request of 17.8 million ACTs are requested for the public sector and 30.3 million RDTs are required to contribute to the target of 80% diagnostic testing in the public sector. Additional diagnosis will be carried out using microscopy, which is not requested in this grant. These quantities are below what was previously funded by the GF (e.g. 24 million ACTs in 2013 for the public sector and 19 million RDTs). 80% of these ACTs and RDTs will be procured by the PR1 and 20% by PR2. This grant is also supporting the roll out of artesunate for the treatment of severe malaria and is procuring 3.1 million vials of artesunate. 75% of the artesunate will be procured by PR1 and 25% by PR2. US\$36.3 million will be allocated to cover the costs of RDT and ACT procurement with an additional \$6, 1 million allocated for artesunate procurement.

Above allocation:-In order to maintain the scope and scale of ACTs and RDTs previously funded through Global Fund, and an additional 7.7 million ACTs and 7 million RDTs are requested for in the above allocation amount. An additional \$2.4 million is also requested for procurement of artesunate to fill the outstanding gap in the treatment of severe malaria.

(ii) Refresher training on case management IMM - (PR2)

38 districts have had their health workers trained in IMM, and under this grant the NMCP will scale up this training to 78 districts to cover the whole country. In total 24,360 health workers will be trained in a phased approach. Part of this training will be contracted out to specialist CSOs under the coordination of the NMCP. This will be done using a cascade format commencing from 2015

(iii) Conduct clinical audits on malaria case management (PR1-MOH)

Clinical audits on malaria case management will be carried out at hospital and health centre IV facilities. Using the lessons learnt from the currently implementing partners in 38 districts, this application will scale up clinical audits to improve management of severe malaria and adhere to clinical guidelines. This scale up will

cover 74 districts. US\$351,224 is budgeted for clinical audits in 2015.

1.2.3 Prompt and appropriate malaria treatment in the Private sector:

(i) Procurement, storage and distribution of ACTs

Based on the lessons learnt from the AMFm, the UMRSP proposes the co-payment scheme to be funded through this application. This co-payment was implemented at large scale in the country in 2013 with approximately 23m ACTs procured and subsidised to the private sector. To ensure no interruption of the private sector co-payment achievements, DFID has supported the continuation of the co-payment in 2014. In order to sustain the gains made, Uganda has prioritised the co-payment in both the allocation and above allocation request.

Allocation: Due to the limited funding allocation under this grant, the country seeks to procure approximately 21million ACTs to cover 100% of the private sector co-payments for 2015 (taking into account a 10% reduction in consumption as a result of universal coverage of vector control)

Above allocation: Uganda seeks above allocation incentive funding to sustain the ACT private sector co-payment into 2016, allowing for the procurement of approximately 21.2 million ACTs. Without this incentive funding, the country will be unable to sustain the significant gains made to date, but will also actively seek alternative resources in the unfortunate event of this request not being successful.

The UMRSP stresses that all suspected cases of malaria are confirmed by either microscopy or RDTs. The Government of Uganda recognizes the importance of engaging with the private sector and the NMCP is working on a policy that will promote the use of RDTs in private sector outlets including drug shops. Additionally, 6 districts are being supported by UNITAID to do a pilot study of private sector co-payment for RDTs. In this application, the CCM is not requesting RDTs for the private sector. The country will document and learn lessons from the experiences from the pilot districts as well as address the policy implications as outlined above. Based on the lessons learnt, the next funding request for the malaria concept note to be submitted in 2016 will include the private sector co-payment for RDTs to meet the UMRSP 90% set target of improved diagnosis and appropriate treatment in public, private and community by 2018.

(ii) Training the private health care providers in IMM

Allocation: This is aimed at increasing the number of patients receiving effective and appropriate malaria treatment in private sector health facilities. In this application, the CCM seeks US\$372,458 to provide IMM training to 2,800 health workers in private sector health facilities across the country.

(iii) Reporting and support supervision of the private sector:

Currently, private sector facilities do not report through the HMIS. With the investment in the private sector, this application seeks to monitor retail prices of the co-payment commodities, train and mentoring 1,750 private sector providers in the HMIS such that the reporting is done and carry out support supervision and mentorship.

Allocation: The cost of \$1,382,502 has been included for support supervision and strengthening private sector data collection and reporting. It should be noted that the BCC/IEC to support this will be integrated in the BCC holistic approach.

1.2.4. Quality assurance and quality control of diagnostics

Allocation: As RDTs are rolled out, there is need for QA/QC to monitor accuracy and quality in the field. This application seeks to; build capacity for malaria microscopy QA/QC and RDT post-shipment lot testing and quality monitoring in the field through training the laboratory technicians at the district hospital laboratories. This activity builds on the achievements realised in 34 districts supported by the USAID/PMI and will utilize the already existing structures of the district laboratory focal persons, Health-sub district (HCIV) and community level systems. This is costed at \$296,360 for approximately 50 districts annually.

IEC/BCC

If correctly implemented, investment in IEC/BCC will contribute to increased knowledge and awareness on appropriate prevention and control measures, improving protection behaviours and adherence to prevention measures. This application seeks funding to:

Using a cascade model, build capacity and mentor CBOs/FBOs, NGOs and DHTs to train the VHTs in 33 districts. The trained VHTs will be equipped with the skills and tools to spearhead community sensitization through IPC. VHTs will deliver malaria control messages especially on LLIN use, prompt health care seeking behaviour (seek treatment within 24 hours, ensure test, treat and compliance to treatment), availability and cost of subsidized ACTs in the private sector.

IEC materials will be adapted, developed, produced and disseminated to be used by the CBOs, DHTs and VHTs.

This grant will also support the implementation of the following social mobilization activities; Community dialogue, Community and school sports events and drama, Film shows on malaria interventions. Teachers and

student leaders will also be trained and equipped with malaria skills. These will be used as change agents in the community.

BCC reporting tools will be adapted and printed and disseminated for use for report on the BCC activities carried in the district.

Allocation: These activities sum up to a total cost of \$2,351,862, which has been requested for in this application. The CCM realises the need to assess the effective BCC methods to be used in Malaria interventions. Based on this, a Knowledge Attitude and Practice (KAP) study has been proposed in line with the UMRSP, which will be integrated into the MIS-2014. Operational research on effectiveness of BCC will be conducted to inform the design of BCC interventions for impact. This is requested under the M&E module. The CCM recognizes that previous grants funded BCC activities that were not fully implemented and a separate document has been provided to explain this (Annex II: BCC improvement Plan)

Program Management

To support smooth implementation of the priority interventions, \$2,626,858 representing 2% of the total budget will cover program management issues, including the following:

Human resources: Human resources financed through previous Global Fund grants will be supported through this funding request including two monitoring and evaluation specialists, an epidemiologist and a programme officer. Additionally this application requests support of salaries for a pharmacist (PSM specialist) and a Social and Communication specialist to fill key gaps of human resources at the NMCP in the interim as the program re-engages the government for more human resource support through the health service commissions.

Supportive Supervision. National and district health teams will be supported to conduct supportive supervision; some of these activities will be integrated with other disease grants to develop implementation efficiencies at the time of implementation. In this application, the CCM is requesting to fund integrated support supervisions where all malaria implementing partners will use an integrated malaria support supervision tool to implement support supervision on a bi-annual basis. Both public and private health facilities will be included in the support supervision. The UMRSP plans for quarterly support supervision to the districts, however, this funding request has considered support for only 2 visits per year, the other two visits will be funded by government and in-country partners such as PMI. These findings will be shared in the quarterly review and planning meetings.

Quarterly reviews: To strengthen Program management, the UMRSP has proposed quarterly review meetings for the partners to coordinate and ensure they are implementing “The Three Ones” and no duplication is being done. Fragmentation of malaria control activities was identified as key elements which deter achievement of malaria control intervention results. It is in this meeting that implementation update will be given and proceeding quarterly plan presented and agreed on. This will enforce accountability by all the stakeholders. Twice a year, there will be regional and national level meetings to engage the private sector and learn lessons.

The cost of \$668,416 has been requested for integrated support supervision and \$193,760 for the quarterly review and planning meetings from this application. The private sector meetings will cost US\$462,067. With this in place, the ministry will have effective oversight of the implementation of malaria control activities in districts and ensure continuous stakeholder engagement. Integrated planning will strengthen coordination and accountability by all players. Once these synergies are maintained the GF support will effectively leverage on existing country support.\$2,626,858

Grant management :To facilitate implementation by PR2 , the costs for the Grant Management Unit(GMU) of TASO has been indicated in this application to bridge the gap between the end of the HSS strengthening grant in 2014 and the next HSS application planned to be in the country in 2016. The proceeding funds for this GMU will be included in the HSS application to be submitted in the October 2014 submission window.

1.5 Monitoring and Evaluation

Monitoring and Evaluation activities will be carried out through district biostatisticians and HMIS focal persons who are charged with overseeing the routine data collection, collation and management. Support to strengthen HMIS and related activities will be requested in the Global Fund HSS application. This funding application seeks support for the following:

1.5.1 The NMCP will develop a comprehensive M&E plan aligned with the current UMRSP

1.5.2 District Quality Assurance activities

1.5.3 To promote evidence-based decision making and future programming, NMCP in collaboration with Makerere University School of Public Health, WHO, UNHRO, and implementing partners will conduct operational research on the following;

i) effectiveness of BCC interventions on knowledge, attitude, behaviour and practices of malaria control measures and the most effective BCC delivery channels;

ii) implementation processes and success indicators for the iCCM strategy during the scale up in the 33 GF

supported districts;

iii) investigate the retention & utilisation of routinely distributed LLINs through ANC and EPI and assess the most efficient model of continuous distribution including school based distribution

iv) Determine the factors influencing use and non-compliance to malaria RDTs test results among health workers across the country.

Other key areas such as insecticide resistance monitoring (PMI and government), drug resistance monitoring (PMI), printing of data collection tools (HSS grant), LLIN tracking (previous GF grant, PMI, Government of Uganda – to be integrated into the DHIS2) are ongoing and funded elsewhere.

The CCM requests for \$2,065,413 to support the above HIS and M&E activities in the allocation funding.

See Annex 3 for the breakdown of interventions by PR and cost summary.

3.3 Modular Template

Complete the modular template (Table3).To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

- Explain the rationale for the selection and prioritization of modules and interventions.
- Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gain expected from the funding requested above the allocation amount.

3.3.a Rationale for the selection and prioritization of modules and interventions

The rationale for the selection and prioritization of modules and interventions for this concept note, took into account the scope and scale of what has been previously funded by the Global fund, guided by the Global Fund (Portfolio Analysis). UMRSP priorities and the guidance of an inclusive group of stakeholders involved in malaria control including technical partners and civil society. In particular emphasis was given to interventions to ensure that the gains achieved with GF support are sustained into 2016, with a key emphasis on avoiding a reversal of these gains. Key lessons learnt to date were also incorporated into the prioritization exercise to ensure that maximum impact will be achieved.

The NMCP has particularly followed a continuum of core steps towards strategic decision-making and finally developing this concept note. A comprehensive mid-term review (MTR) with the involvement of internal stakeholders, as well as external experts was conducted in early 2014. The mid-term review which had a particular focus on synthesis of available data on the malaria epidemiology in Uganda and the progress toward impact provided critical recommendations to inform revision of the existing national strategies and developing the Uganda Malaria Reduction Strategic Plan.

The current Concept Note aims to invest strategically, to maximize available resources, in achieving and sustaining high coverage of core interventions so to achieve the greatest impact. The investment plan is complemented by a monitoring and evaluation plan so as to not only monitor the progress in achieving higher coverage of core interventions but to also allow measurement of the disease burden over time. Uganda conducted its first MIS in 2009 and after a couple of years in scaling up malaria control measures, a repeat MIS is planned to be implemented in 2014. It is expected that the repeat MIS will provide comparable evidence on net ownership and utilization, as well as any change in parasite prevalence.

3.3. b Description the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed.

The malaria control strategy has been designed to be delivered as a comprehensive total package to ensure that each approach contributes holistically to the reduction in malaria morbidity. Parasite prevalence in U5s in 2009 was 42%, with the malaria comprehensive package investment, prevention, prompt diagnosis and treatment and ability to track timely information, is expected to reduce from 42% (2009) to 7% in 2016. Below is the expected outcome for this investment by 2017 if this integrated compressive package is delivered as per the business model in the UMRSP.

Impact /outcome indicator	Baseline	Targets				
	2013	Year 1	Year 2	Year 3	Year 4	Source
		2014	2015	2016	2017	
Inpatient malaria deaths per 100,000 persons per year	29	22	14	6	6	HMIS
Malaria test positivity rate	45%	40	35	30	25	HMIS
Parasite prevalence: Proportion of children aged 6-59 months with malaria infection	42%	9.7%				MIS (Malaria Indicator Survey)
Confirmed malaria cases (microscopy or RDT) per 1000 persons per year.	150	95	82	66		HMIS
Proportion of suspected malaria cases that receive a parasitological test in public sector.	58%	60%	65%	70%	75%	HMIS
Proportion of children under five years old who slept under a net the previous night (baseline MIS 2009)	43	90%			90%	MIS , UDHS
Proportion of pregnant women who slept under a net the previous night (baseline MIS 2009)	47	85%			85%	MIS , UDHS
Proportion of households with at least one insecticide-treated net* for every two people (baseline MIS 2009)	28	85%			85%	MIS , UDHS
Proportion of population using an insecticide-treated net* among the population with access to an insecticide-treated net.(2011)	78%		85%		85%	UDHS

Sustaining the Gains for LLINs

LLINs are an extremely cost-effective intervention, reducing the malaria burden by 50% in children under five years of age. WHO recommends that universal coverage with vector control remains the goal for all people at risk of malaria. Additionally, WHO recommends that in order to maintain universal coverage, countries should apply a combination of mass free LLIN distributions and continuous free distributions through multiple channels, in particular antenatal care and immunisation services. Mass campaigns should be repeated at an interval of no more than three years. As such, Uganda is following international recommendations in seeking to sustain universal coverage of LLINs through this concept note. Universal coverage maximises the protection given by LLIN and with gaps in coverage, an additional and preventable increase is expected in the burden of morbidity and mortality due to malaria. Of particular concern are areas where malaria transmission has been suppressed by effective vector control (such as Uganda, which is currently completing its first universal coverage campaign) leading to reduced immunity to malaria in the local human population. In these areas, failure to maintain transmission control can lead to severe epidemics of resurgent malaria, sometimes involving catastrophic mortality.

Allocation impact: The allocation request will finance support to fill approximately 80% of the LLIN gap required for sustaining routine distribution to pregnant women and children under one year of age. This will ensure a steady flow of LLIN from the routine system, targeting the most vulnerable groups.

Additionally, the allocation amount will fund 8.5 million of the 11 million LLINs required for the 2013 replacement campaign in 2016, sufficient to achieve universal coverage in approximately 77% of the targeted districts. Efforts will be made to target the most highly endemic districts. This will leave the population in 33% of the districts previously protected in 2013 using GF funded nets exposed to malaria.

Above allocation: Uganda requests 11.7 million additional LLINs at a cost of \$49 million in the over allocation amount. This will finance the remaining LLINs (approximately 2 million) required to replace the 2013 distributed LLINs in 2016. This will cover the remaining 33% of districts covered in 2013 and will ensure universal coverage of LLINs is maintained to the end of 2016.

Additional resources are also requested to replace the GF funded LLINs procured in 2013, for distribution in early 2014. These 4.8 million LLINs will need to be procured in 2016, for distribution in early 2017. If these LLINs are not replaced, approximately 8.64 million people previously protected with LLINs procured by the GF will no longer be protected and will be at serious risk of outbreaks and upsurges.

Finally, funds are requested to procure an additional 4.5 million LLINs to contribute to filling the outstanding LLIN gap in 2017, protecting approximately 8.1 million LLINs who are currently being protected through LLINs delivered in 2014.

Case management:

In accordance with the WHO recommendations, all suspected malaria cases in the public sector including health facilities and at community level will be parasitologically tested by microscopy or RDT and those with malaria will be treated according to national malaria treatment guidelines and those without malaria will be further investigated and treated as appropriate. The private sector co-payment mechanism will also contribute to maintaining coverage of quality ACTs in the private sector. The primary objective of this case management component is to shorten morbidity and prevent death thus reducing the overall burden of malaria. The impact will be lower malaria deaths and a decrease in under-five mortality.

The following commodity quantities are requested in the allocation and above allocation for the public sector:

Public Sector	ACT	RDT	Artesunate
Allocation	17,767,016	30,309,975	3,149,143
Above allocation	7,749,553	7,027,494	1,245,693

Allocation: 30.3 million suspected malaria cases will be tested with RDTs and 17.8 million malaria patients will be treated through public health facilities using the allocation provided in this concept note. 780,000 severe malaria cases will be managed with the artesunate, allowing the country to scale up the policy change from quinine.

Above Allocation: If the above allocation resources are secured, an additional 7 million suspected cases will be parasitologically diagnosed and an additional 7.7 million malaria cases treated. An additional 400,000 severe malaria cases will also be treated with artesunate. The above allocation funding will allow the coverage in treatment and diagnosis financed by the Global Fund to be sustained into 2015 and 2016. Otherwise there will be shortfalls in the number of ACTs and RDTs in the public health system, previously sustained by the GF resources.

ICCM increases access to prompt and appropriate treatment in children U5, in the 34 roll out districts 60% of children with fever sought care from VHTs. The following quantities are requested in the allocation and above

allocation for ICCM:

ICCM	ACT	RDT
Allocation	795,275	2,073,511
Above allocation	54,550	3,458,151

Allocation: 2 million suspected malaria cases will be tested with RDTs and 795.275 ACTs will be provided through the iCCM package in 33 districts. None malaria cases will be treated as appropriate using resources from other donors.

Above Allocation: If the above allocation resources are secured, an additional 3.4 million suspected cases will be parasitologically diagnosed and an additional 54,550 million malaria cases treated through iCCM.

Private sector case management and Co-payments for malaria

The private sector delivers 53% of health care in Uganda, a number that underpins the importance of private sector delivery of quality antimalarials to the Uganda population. The AMFm financed by the Global Fund successfully supported the roll out of ACTs in the private sector, and this success has been sustained through an additional one year of bridge funding from DFID. Findings from UMIS 2009 showed that among children under 5 with fever in the two weeks preceding the survey, 54% first seek health care from the private sector. Investing in the private sector will continue to improve the quality of care provided, improving management of malaria. This investment will reduce the ACT prices in the private sector from an average price of UGShs 15000/= to 3000/= hence increasing affordability and equity of malaria control service. Sustaining the supply of quality ACTs will also reduce the likelihood of substandard or counterfeit ACTs, thus also reducing the likelihood of ACT resistance.

The following quantities are requested in the allocation and above allocation for the private sector co-payment:

Private Sector	ACT
Allocation	21,991,991
Above allocation	21,170,784

Allocation: 22 million suspected malaria cases will be treated through the private sector co-payment in 2015 with resources included in this grant, sustaining the level of coverage of the private sector programme.

Above Allocation: If the above allocation resources are secured, the private sector co-payment will be sustained into 2016, delivering an estimated 21.2 million ACTs. Without this incentive funding, the country will be unable to sustain the significant gains made to date, but will also actively seek alternative resources in the unfortunate event of this request not being successful.

IEC/BCC

Investment in IEC/BCC will contribute to increased knowledge of appropriate prevention and control measures, improving health seeking behaviours and health worker adherence to treatment guidelines. Health worker attitudes and adherence to treatment guidelines will be improved leading to appropriate case management, and ultimately reduction in anti-malarial wastages. Improving health seeking behaviours will increase prompt treatment, thus progression to severe malaria will be reduced and use of appropriate drugs will lead to better health outcomes. Based on lesson learnt in child health department inclusion of social mobilisation in the NIDs and Kick Polio Out Campaigns helped raise immunisation coverage from 68% to 87% (NID 2003/2005).

3.4 Focus on Key Populations and/or Highest-impact Interventions
This question is <u>not</u> applicable for low-income countries.
<p>Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:</p> <ol style="list-style-type: none"> If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.
½ PAGE SUGGESTED
NOT APPLICABLE

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT
4.1 Overview of Implementation Arrangements
<p>Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:</p> <ol style="list-style-type: none"> If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s). If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.
1-2 PAGES SUGGESTED
<p>4.1 (b) Dual Track Financing & Coordination between Principal Recipients</p> <p>This grant will be implemented using the recommended dual track financing. PR 1 is the Ministry of Finance Planning and Economic Development (MoFPED) on behalf of Government of Uganda while PR2 is The AIDS Support Organisation (TASO) representing non-government sector.</p> <p>The Ministry of Finance Planning and Economic Development (MoFPED) – PR1</p> <p>The MoFPED is experienced in managing the national budget, estimated at US \$5.36 billion per annum; providing technical guidance on financial matters to the country, managing an array of donor and Poverty Action Fund (PAF) funds using an integrated financial management system; monitoring the implementation of the National Development Plan (NDP) as well as managing the disbursement of Global Funds to priority disease programs. The MoFPED has received and managed 11 previous and current grants from the Global Fund: four malaria grants (Round 2, 4, 7 & 10), three HIV grants (Round 1, 3 & 7), three TB grants (Round 3, 6, 10) and one Health Systems Strengthening grant (Round 10)</p> <p>To further mitigate fiduciary risk and increase absorption of grants, the following measures have been put in place:</p> <ul style="list-style-type: none"> TASO was selected as dual track PR for Global Fund grants on the basis of their track record in grants management, procurement, strong M&E, and Financial management; To optimize harmonization and ensure value for money, representatives of development partners, and the second PR are members of the national steering committee for civil society. To coordinate all these agencies, a Focal Coordination Office (FCO) has been established at the national level. <p>The AIDS Support Organization (TASO) – PR 2</p> <p>TASO is managed by a highly qualified and dedicated management team that has extensive experience and expertise in HIV/AIDS, TB, and malaria programming and management. The management team includes public health, medical, finance management and sociology specialists. They all have vast experience and technical capacity in their respective fields and will not only ensure that this project is well managed and</p>

implemented, but also that their skills are passed on to sub-grantees as part of strategic capacity building. TASO has experience in the management of malaria control including case management and prevention using LLINs as well as sensitization on their proper and consistent use. TASO has provided HIV care, support and treatment services to over 294,358 clients cumulatively since 1987, of which 65% are female. The PR is currently providing ART services to 91,218 clients, 1,000 of whom are children.

TASO has robust financial management systems that are currently managing \$25 million throughput annually. These systems are able to produce monthly and quarterly reports as well as generate 'real time' grants management information. The PR has built systems that operate 16 centers of expenditures and is able to validate, reconcile and consolidate all financial transactions through these centers.

TASO also has a robust M&E system that allows it to track progress of its various projects. The system combines site visits by technical staff as well as computerized data collection, analysis, storage, archiving and feedback mechanisms. Quarterly visits are conducted to all programme sites by technical staff to monitor progress and provide technical support. Data is cleaned regularly, submitted to headquarters for further checking, cleaning and consolidation. The units are required to back up this data weekly while headquarters undertake a full system backup on a monthly basis.

Coordination between PRs

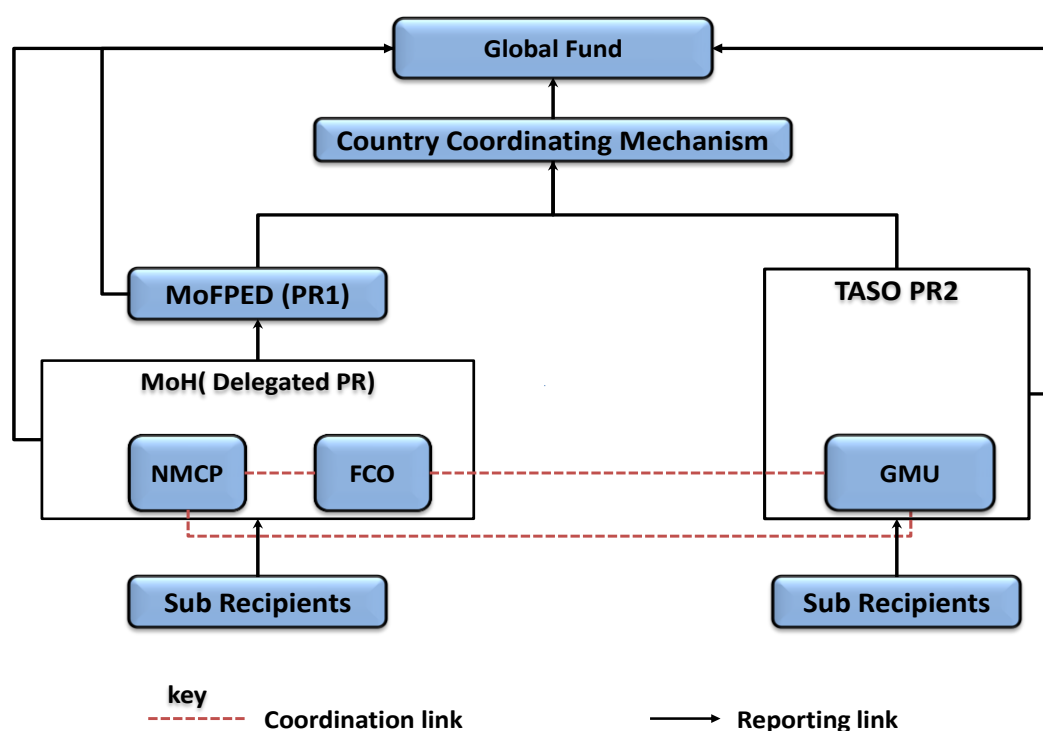
The CCM oversee implementation of GF grants. The 2 Principle Recipients provide the CCM with financial management reports, updates on progress of grant implementation and any challenges as they arise. The coordination structure of the Ministry of Health shall provide oversight to ensure grant implementation is in conformity with the National Health policy. These coordination structures include the Focal Coordination Office (FCO) who provide coordination oversight for GF grants and the NMCP who provide technical oversight on the implementation of malaria grants.

The organogram **below** illustrates the oversight functions of Global Fund Grant.

4.1 c) Sub-recipient management arrangements

Since 2001, the PR has sub-granted Local Governments, CSOs, CBOs and Hospitals. To date, it has managed 32 sub grants for various institutions. The PR undertakes a pre-award assessment to ascertain existing capacity and identify areas of weakness, signs Memoranda of Understanding with qualifying CSOs, undertakes capacity building, disburses grant funds and performs routine monitoring to ensure proper programmatic and financial accountability. The PRs will be responsible for contracting the sub recipients. This will include sub recipient orientation and training on monitoring and reporting requirements as well as capacity strengthening on operational and crosscutting issues. All sub-recipients will then derive their work plans in line with the overall PR work plans

Figure 6: Organogram to represent the reporting and coordination mechanisms



4.1 d) Coordination between Principal Recipients and their respective sub-recipients

The PR shall ensure intensified monitoring, at least twice a quarter, by PR staff to ensure that sub recipients adhere to standard operating procedures set by the Global fund. The PR shall also conduct induction training for all key staff especially those involved in programmatic and financial reporting to ensure that there is common understanding of all reporting indicators and guidelines. The PR shall also facilitate quarterly validation of expenditures by sub recipients and also carry out internal audit as often as is necessary to ensure financial integrity and also external audits as often as is required by the Global Fund.

The PRs will strengthen coordination between priority program implementers and sub recipients. The PRs will ensure that all cross cutting health systems strengthening activities are effectively planned and executed with the relevant stakeholders.

4.1 e) Key Populations

To facilitate and strengthen the evidence-base for human rights and gender mainstreaming, efforts shall always be made to disaggregate health data by age and sex and gender analysis carried out on the results in order to enhance the effectiveness and efficiency of interventions and programs. Every effort will be taken, when involving CSOs, to specifically include women-centered CSOs. Key affected populations that are disproportionately affected by malaria including children under-five years, pregnant women, PLWHA, IDPs, Refugees, PWDs and nomads will be prioritised.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism(CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

1 PAGE SUGGESTED

Link with existing GF funds

The CCM is currently overseeing nine active grants in Malaria, HIV, TB and HSS, most which are ending by December 2014 except for the TB grant which ends in December 2016. The flow of the GF grants is managed by the CCM is shown in the table below.

A Table showing the grants managed by the CCM.

Table showing the grants managed by the GOIN									
No	Existing GF Grants& New Request	Years of Implementation							
		'10	'11	'12	'13	'14	'15	'16	'17
1	Rd7 HIV-UGD-708-G07H, MOFPED	\$127,147,663							
2	Rd7-HIV- UGD-708-G13-H: TASO		\$42,955,439						
3	SST-TB- UGD-T-MOFPED			\$16,173,630					
	SST-TB-2 ^a						\$14,140,122		
4	R10-HSS-UGD-011-G09-S MOFPED			\$4,762,711					
5	R10-HSS-UGD-011-G10-S TASO			\$9,681,757					
6	Rd4^b - Malaria UGD-405-M: MOFPED		\$99,100,046						
7	Rd7 Malaria: UGD-708-G08-M: MOFPED	\$113,727,880							
8	Rd 10 Malaria –UGD-011-G11-M: MOFPED			\$21,054,796					
9	Rd 10 Malaria –UGD-011-G12-M: TASO			20,614,350					
	Malaria GF (CN)						Amount \$ 191,773,460		

^a Requested amount indicated, Approved SST-TB Phase 2 to start 1st July 2014- end Dec 2016; amounts to be communicated.

^b Grant ended in Jan 2014- in closure process .

Complementarity of the overall resource allocation for Program implementation

Round 10 Malaria grants obtained extensions till December 2014. This funding request, links in well with the running malaria GF round 7, 10 grants. It aims at scaling up and/sustaining best experiences and lessons

learned through implementation of current grants, partners and government contributions. This funding would commence around 1 January, 2015.

The CCM also plans to submit a concept note fund request for standalone HSS application focusing on PSM mainly and [combined] HIV/TB by the end of 2014. The CCM has delineated what is to be included in each application to ensure that there is no duplicated activities in the disease specific applications and cross cutting HSS application.

The CCM has ensured that there is no duplication of funded activities across the various partners and funding requests but complementarity has been emphasized. This was done through a stakeholder mapping whereby all stakeholder submitted the funded activities per thematic area (IEC/BCC, human resources, training, monitoring and evaluation, support supervision, vector control and case management) to assess the gap and additional funds to be requested from this application.

Complementarity in program management activities

The concept note will be complimentary to other malaria initiatives and government efforts in the reduction of malaria disease burden through the scale-up of control activities in Uganda. The current proposal will link with the current R7 Phase II & R10 Phase I grants whose effective implementation started in December 2011 & May 2012 respectively. The activities of this application will not duplicate those of the previous rounds. Round 7 Phase 2 activities (universal coverage of LLINs) will end in October 2014. However, it is important to note that Round 7 phase 2 implemented universal coverage of LLINs and its achievements have formed the foundation on which the malaria control efforts for the UMRSP 2014-2020 were based.

Human resource

Under human resource, this grant will support staff directly involved in its management and those positions that are not yet filled at the program level by the government. The following staff under the National Malaria Control Program (NMCP) will be supported; program officer(s), M&E specialists, PSM specialist, and statistical epidemiologist. This is continuity of what the Global Fund accepted to support under Round 10, Phase I grant. In addition, human resource for supported malaria implementation from the Grant management unit of the second PR will be supported in order to ensure continued service delivery by PR 2. Hitherto, the staffs under PR 2 are supported under the HSS grant which is scheduled to end on December 31, 2014. The CCM plans to submit the HSS grant in October 2014 and will only consider the human resource at the GMU for other diseases, thus there will be no duplication.

Trainings

In 2012 and 2013, a total of 18,591 health workers were trained in IMM by both PRs (10,705 in the public sector and 7,814 in the private sector). However, a gap still remains. For instance, as of May 2014, The Allied Health Professional of Uganda inducted 14,491 registered members in the Private sector. A number of these need a comprehensive training in the management of malaria. In this request, more health workers will be trained to bridge the gap. A pool of national trainers trained in the previous phase is available to cascade these trainings at the lower level and these costs have been excluded in the application. TASO (PR2) also did capacity building of LLINs distribution through the ANC/EPI training for health workers in private and public sector thus this funding request for routine LLINs doesn't include any costs of training as this was done in the previous grants. A data base exists to track the health workers trained by sector, district, and health facility. The country is assured that no duplication will exist since every trainee has a unique identifier and invitations will target health workers who have never received the IMM training in the past two years. This will be coordinated at National level and the districts will be required to submit the nominated trainees for verification prior to training.

Integrated support supervision: The NMCP as custodian for malaria control in the country conducts technical support supervision of malaria control activities in regions, Districts and partners. At the national level, quarterly technical supervision to implementing partners and Districts is conducted. RPMTs also supervise each District at least once in a quarter. All partners in the District are coordinated and supervised by the DHO and his team. The DHO assigns malaria control responsibilities to the District Malaria Focal Person and other staff. The Malaria Focal Person (MFP) supervises implementation of malaria control activities. In collaboration with the DLFP; they ensure that all malaria diagnostic facilities' laboratories participate in External Quality Assurance (EQA). The District team is supposed to conduct support supervision to all facilities while the health facilities supervise the VHTs in five (5) days every month.

This activity was under the priorities of round 10 grant but due to the commoditisation, the funds were redirected to commodities and only one partner PMI through Stop Malaria Project (SMP) has been supporting this in the 34 districts. The integrated support supervision has been well mapped and planned under the RBM partnership meetings that there is no duplication and this activity.

These will be implemented in harmony with support from Government and in-country partners' such that supervision findings are shared during periodic meetings to share progress on implementation of the activities.

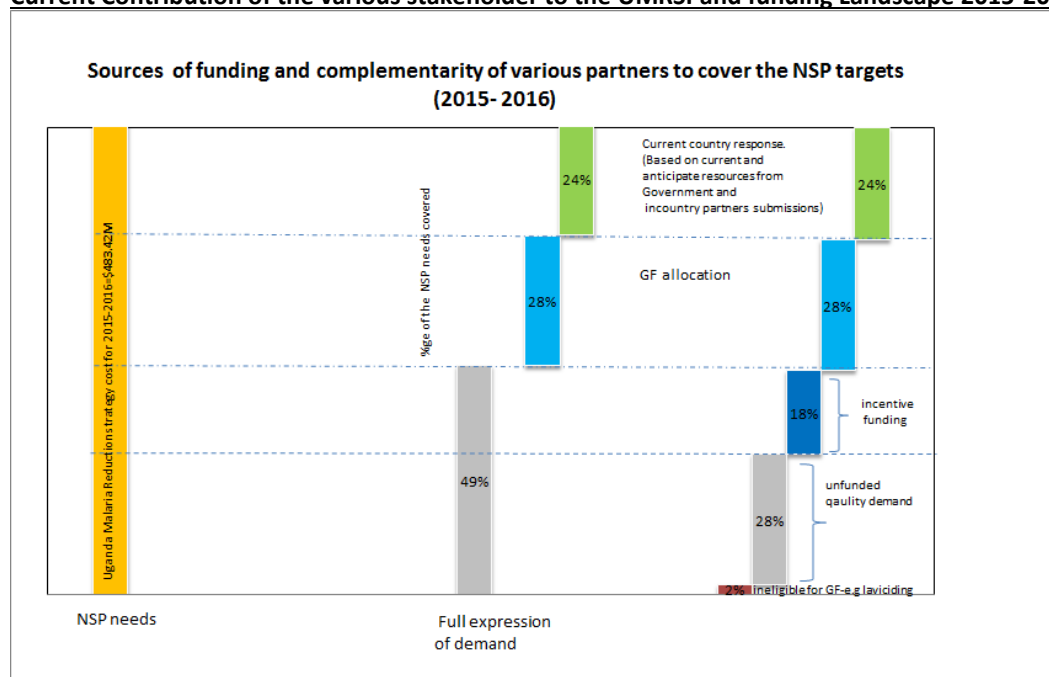
Monitoring and evaluation:

Through the malaria Round 10 reprogrammed grant PR 1 procured only ACTs, malaria RDTs and Injectable Artesunate commodities. Support for strengthening capacity in M & E, operations research and Data Management was all relocated to commodities. The In country partners supported the HMIS reporting for the public sector through DHIS II, as well as reporting of malaria medicine consumption data through m-Track. These achievements have been factored in the programmatic gap analysis conducted in the development of this malaria concept note. Only DQA and support to private sector reporting activities have been proposed as they were identified as a major weakness in the HMIS during MTR. There is no duplication in these activities in the previous funding and with the current implementing partners, but complementarity in terms of district coverage.

To improve uptake of interventions such as LLINs, parasitological diagnosis funded under the previous Global Fund Rounds and to demonstrate impact, BCC activities will be accelerated in this grant and evaluated using the operations research as ongoing implementation.

The figure below illustrates the contribution of the various

Current Contribution of the various stakeholder to the UMRSP and funding Landscape 2015-2016



4.3 Minimum Standards for Principal Recipients and Program Delivery

Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.

PR1 Name	MoFPED	Sector	Public
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a crosscutting health system strengthening grant(s)?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Minimum Standards		CCM assessment	
1. The Principal Recipient demonstrates effective management structures and planning		The MoFPED plays a pivotal role in the co-ordination of development planning; mobilisation of public resources and ensuring effective accountability for the use of such resources for the benefit of all Ugandans. Under its mandate, MoFPED as a PR regulates financial management and ensures efficiency in public expenditure. PR derives its mandate and	

	<p>functions from the 1995 Constitution of the Republic of Uganda and other related subordinate laws, including; the Budget Act (2001), the Public Finance and Accountability Act (2003) and acts establishing agencies and auxiliary organisations.</p> <p>In the delivery of health services, The Ministry of Health provides leadership role and responsibility for policy and guidelines, resource mobilization, monitoring and accountability.</p>
<p>2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)</p>	<p>Ministry of Local Government coordinates and supports Governments in the sustainable, efficient and effective service delivery in the decentralized system of governance. This is done through the districts, Municipalities and sub-counties. The Local Governments have the responsibility for the delivery of health services. In addition, they are tasked with planning, budgeting, resource mobilization and allocation for health services. The Local Government system ensures that functions, powers and responsibilities of PR are devolved and transferred to local government units, oversee monitors the provision of Government services or the implementation of projects in their areas.</p>
<p>3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud</p>	<p>The PR `s internal controls are quite strong, sound and robust to detect and prevent misuse through the use of different reviewers including but not limited the Internal Audit staff. The installation of the Navision accounting software is hoped to greatly increase the information reliability and flagging of fraud such as double payments.</p>
<p>4. The financial management system of the Principal Recipient is effective and accurate</p>	<p>Although, the PR currently uses the Integrated Financial Management System (IFMS) to track Government and other donor`s expenditure, the Global Fund off-budget supported Expenditure is tracked using excel systems that are further reviewed by the Local fund Agent for accuracy and appropriateness. However, the installation of the MS Navision by December 2014 will effectively improve the Financial Management System and provide accurate data for expeditious, reliable and informed decision making.</p>
<p>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</p>	<p>NMS has a perimeter wall with 24hour and alarm system with rapid response and robust security protocols</p> <p>NMS is approved by the National Drug Authority and has over 13,000sqm of storage and operational area, over 3000 pallet positions with a strong Quality Assurance department charged with ensuring quality of medicines supplied. It is currently transiting from MACS&SAGE to Commodity Management Platform software to improve its financial & inventory management efficiency.</p>

<p>6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions</p>	<p>NMS using a two-tier distribution system. NMS closed trucks deliver medicines directly to hospitals and district. A 3rd party is contracted to ensure secure and timely delivery of commodities to lower level health facilities.</p>
<p>7. Data-collection capacity and tools are in place to monitor program performance</p>	<p>Data used in the monitoring of program performance comes from two sources; first, HMIS through which data on the majority of malaria is reported and programmatic reports through which data for indicators that are not routinely reported on is obtained.</p> <p>For the data obtained through HMIS, standard tools are used. These are centrally developed and periodically updated and distributed to all data collection points, both public and private by the Resource Center of Ministry of Health. In addition, there are reports that are produced on a weekly, monthly, quarterly or annual basis.</p> <p>At every data capture point, there is a Records Assistant who oversees data collection and does basic data quality control checks. It is also their responsibility to fill and remit periodic report through their supervisors. There are two intermediate levels – at the Health Sub-District and District. At each of these levels, there is an HMIS Focal person who aggregate reports, ensures quality and enters the data into the DIS2. These are trained and supervised by the Resource Center. Both PRs use HMIS data to monitor program performance.</p> <p>To collect of data for non-routine data, tailor-made tools are used. For a number activities and indicators, each PRS has a set of tools while for some activities such as trainings, a common tool is used.</p>
<p>8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately</p>	<p>The Ministry of Health has integrated all stand-alone disease reporting systems into one web-based District Health Information System (DHIS-2). The system has been rolled-out nationwide with all 112 district bio-statisticians enabled to access and input data into the DHIS-2. This has increased efficiency while ensuring sustainability of reporting to the national level from the district level. All routinely collected malaria indicators can be captured and collated through the DHIS-2</p>
<p>9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain</p>	<p>The National Drug Authority (NDA) is mandated to quality assure all pharmaceuticals imported in the country.</p> <p>In addition, the NDA ensures that premises and operations of all health facilities, pharmacies and drug shops comply with good pharmacy practice principles.</p> <p>The Uganda National Bureau of Standards is responsible for establishing standards and enforcing quality assurance of non pharmaceutical commodities</p>
<p>4.3 Minimum Standards for Principal Recipients and Program Delivery</p>	

Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR1 Name	TASO	Sector	Non-Government
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a crosscutting health system strengthening grant(s)?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Minimum Standards		CCM assessment	
1. The Principal Recipient demonstrates effective management structures and planning		TASO is governed by a Board of Trustees. The Executive Director is responsible for the day-to-day operations of the organisation and has a Senior Management team (comprising of Directors and Team Leaders), which reports directly to her. The Global Fund grants are managed by the Grants Management Unit, which is headed by the Project Co-ordinator, who also reports directly to the Executive Director and is a member of the Senior Management Team.	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		<p>TASO has for many years now, been sub-granting funds to various CSOs/CBOs, some of whom have sub-sub grantees.</p> <p>Under the on-going Global Fund grants, TASO currently has 10 sub-recipients and 2 SSRs. Various controls have been put in place, to ensure effective management of the SRs. For example:</p> <ul style="list-style-type: none"> Capacity assessments were performed for each of these SRs and areas for capacity development identified, before the SRs were taken on board. Templates have been developed for SR financial and programmatic reporting, and SRs are required to report on a quarterly basis, at which point on-site visits are made to verify the SRs' financial and programmatic results. <p>Reviews are also made by the Senior Internal Auditor before a disbursement is made to an SR.</p>	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		<p>TASO has comprehensive and up to date Operational Procedures Manuals, including the Finance Manual, which include guidance on internal controls are to be applied.</p> <p>Additionally, the organisation has an effective Internal Audit function, which is headed by the Chief Internal Auditor, who reports directly to the Executive Director. The Grants Management Unit also has a Senior Internal Auditor who is specifically involved in the day-to-day operations of the Global Fund grants.</p>	
4. The financial management system of the Principal Recipient is effective and accurate		TASO uses the Navision accounting system	
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health		JMS is ISO certified, approved by the National Drug Authority, has approximately 4000sqm of storage capacity and 4,423 pallet positions. It rolled out its new Enterprise resource planning	

products	software in 2013, which has improved its inventory management efficiency. JMS has a perimeter wall with 24hour intrusion alert system.	
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	JMS rolled out the USAID funded, direct distribution to all PNFP health facilities. 3 rd party transporters are contracted to ensure timely and secure last mile delivery	
7. Data-collection capacity and tools are in place to monitor program performance	The Grants Management Unit, which is responsible for implementing the Global Fund grants has an M&E department, which is headed by the M&E Manager and includes a team of four M&E officers. Tools have been developed to collect data from PR and SR activities in order to monitor performance. The M&E team also regularly makes visits to SRs to verify implementation.	
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The GMU reports on a monthly basis to the TASO HQ finance team. Additionally, every six months, the GMU team completes the PUDR form, which is submitted to the Global Fund within the required timeframe. Annually, the GMU’s operations are included into the TASO Consolidated Financial Statements, which are audited by KPMG (previously E&Y).	
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	This is the responsibility of the National Drug Authority. Periodically Joint Medical Stores also selects samples and performs quality tests.	
4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance		
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers’ capacity, and past and current performance issues. b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.		
4.4 a & b. Analysis of Risks and Proposed Mitigation Implementation of activities will be subject to several risks, which will require timely and appropriate mitigation. The table below presents analysis of possible risks and proposes mitigation.		
Risk Description	Risk Rating	Proposed Mitigation Measures
Inadequate number of technical staff at NMCP and at district level Inadequate staffing levels at health facility levels (at H.C II and H.C III s staffing levels is at 55% as per the Health sector review report 2013).	High	Program support includes 5 TA support of 2 M&E staff, 1 pharmacist and 1 Program Officer and 1 statistical epidemiologist to be financed from this grant to support NMCP. The NMCP will engage the Child Health Unit in the MCDMCH and partners to pool resources for scale up of iCCM The Ministry of Health has developed a National Human Resources for Health Strategic Plan (NHRHSP) 2011-2015 aimed at addressing the human resources crisis in the health sector. The NMCP and partners will use the review as a basis for improving staffing levels at NMCP.
Socio-cultural factors Socio-cultural factors including gender dynamics impact	Medium	On achieving universal coverage, intensifying IEC/BCC has been the major focus of the UMRSP. This has been included in this application. Use of VHT to penetrate

negatively on the health seeking behavior, and utilization of malaria control service such as use of LLIN. According to the 2011 UDHS, about 39-42% of currently married women reported that decisions on their own health care, major household purchases, and visits to their family or relatives were made primarily by the husband. This status has negative implications utilization of malaria control services.		the community at the household level with interpersonal communication has been emphasized as the key strategy to improve utilization of malaria control services as well as targeting male involvement.
Decreased durability of ITN and retention and use of LLIN distributed through routine distribution: Recent research in other countries reports show that nets may not last for 36 months as manufacturers suggest. This may require that nets be replaced at 12–24 months intervals, increasing the cost of the ITN program.	High	The NMCP will conduct operations research on this to guide programming. A third channel of routine distribution through school has also been adopted to ensure the target coverage met through out the years till the next universal coverage
Insufficient program management structures Weak NMCP structures have led to poor coordination of the program internally and externally with stakeholders including district structures.	Medium	Regular stakeholders meetings, joint annual work-plan and reviews will be implemented and funds to support these activities have been incorporated in this funding request. All actions points in all these meetings are followed up and fulfilled such that efforts are synergized. A capacity building plan for NMCP and elevation has been proposed to ensure strong coordination of stakeholders and holistic implementation of malaria control activities. Through the capacity building, the NMCP will be taking on more of policy, resource mobilization, guidelines and QA roles than actual implementation at district and lower levels.
Inadequate funding to the health sector GOU contribution to health is still below the Abuja declaration target of 15%. The health budget is heavily reliant on external donor funding with multiple players which makes it difficult to project the expenditure on the overall health care service delivery as there are numerous challenges in information sharing. Lack of adequate financial controls Although the PR has properly documented internal controls in	High	The MoH and other stakeholders in the health sector including the Parliamentary Committee on Health will advocate for the increased allocation of resources to the health sector by the Government in order to achieve the Abuja Target of 15%. The MoH is currently developing a national health financing strategy that will help mitigate the inadequate funding to the sector. GOU has shown commitment through increasing allocations in the national budget for HIV, TB, and Malaria (Reference to section 2.2). The country has addressed the identified weakness as properly articulated in the Risk Mitigation strategy document. A description of the risk mitigation measures currently in place and the enforcement

the past, there has been serious laxity in enforcing them. This has led to situations where the PR has refunded money to GF as a result of ineligible and questionable expenditures		mechanisms have been clearly documented (Annex 1 – Risk Mitigation Strategy)
Stock outs or over stocks due to poor supply planning. Delays in procurement of malaria commodities.	High	<p>The Quantification Procurement and Planning Unit (QPPU) was established under MOH to strengthen the previously limited capacity of the national procurement and disposal system in order to address challenges at various levels including quantification, forecasting and supply planning.</p> <p>The CCM has made a decision that the HSS grant is entirely to address the PSM system challenges across all levels of service delivery.</p> <p>The NMCP will support a pharmacist staff that will work under QPPU and represent malaria in the Commodity Security Group (CSG). This person will support the program in PSM activities. CSG TORs will be expanded to ensure that all the main stores, MOH, and quality regulatory bodies are represented, coordinated and actively participate in the implementation of decisions agreed upon.</p>
HMIS operational limitations Issues relating to HMIS that have been identified include: i) Now that the electronic database (DHIS2) has been updated, the districts are now entering data directly into this system. However, there are no validation procedures for the data entered into the new electronic database which negatively affects the quality of data provided. ii) Although data will now be entered directly into the electronic database, there is still a shortage in the number of staff within the HMIS Unit, which has direct implications for the quality assurance of data, particularly the unit's ability to provide technical support and conduct data validations at the district level. This is particularly pertinent for the malaria grant since the NMCP is totally dependant on the HMIS for its clinical indicators.	Medium	<p>Planned data quality assessment activities and data review at the district and health facility levels to improve data quality.</p> <p>Regular meeting are planned between Resource Centre and the two PRs to ensure that PNFP and Private Facilities are included in the DHIS 2 as well as data validation rules embedded to avoid wrong entries.</p>

<p>iii) The DHIS2 is a web-based reporting system, which implies DHIOs require hardware, software and internet connectivity to submit results in a timely manner. The Resource Centre/HMIS however reports that this is not available in all Districts.</p> <p>iv) There is an inadequate and inconsistent supply of the most recent HMIS tools (data collection and reporting forms) to Facilities, which are necessary to capture, and report data in the format required for capture into the DHIS2.</p>		
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CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☐ **Table1: Financial Gap Analysis and Counterpart FinancingTable**
- ☐ **Table 2: Programmatic Gap Table(s)**
- ☐ **Table3: Modular Template**
- ☐ **Table4: List of Abbreviations and Annexes**
- ☐ **CCM Eligibility Requirements**
- ☐ **CCM Endorsement of Concept Note**