The Global Fund
To Fight AIDS, Tuberculosis and Malaria

UGA-C-2014 - Concept Note Integrated View

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A. Program details

Country / Applicant:	Uganda	Principal Recipients	Ministry of Finance, Planning and Economic Development of Uganda The AIDS Support Organisation (Uganda) Limited	Total requested amount	
Component:	HIV/TB			Allocation	USD 132,435,501
Start Month/Year:	July 2015			Above	USD 374,205,164

Summary Budget by Module

Module	Allocated/Above	2015	2016	2017	2018	Total
Prevention programs for general population	Allocation	11,391,918	6,567,367	0	0	17,959,285
	Above	42,608,077	56,791,469	28,396,051	0	127,795,597
Prevention programs for MSM and TGs	Allocation	146,687	352,575	0	0	499,262
	Above	394,986	186,728	208,802	0	790,516
Prevention programs for sex workers and their clients	Allocation	377,526	483,019	0	0	860,545
	Above	1,219,018	274,944	265,944	0	1,759,906
Prevention programs for adolescents and youth, in and out of school	Allocation	842,509	303,619	0	0	1,146,128
	Above	1,985,411	1,060,118	1,079,642	0	4,125,171
PMTCT	Allocation	234,763	118,356	0	0	353,119
	Above	234,763	763,992	728,748	0	1,727,503
Treatment, care and support	Allocation	44,890,672	53,469,513	0	0	98,360,185
	Above	58,870,302	88,846,552	77,495,664	0	225,212,518
TB care and prevention	Allocation	2,318,396	3,148,841	0	0	5,467,237
	Above	497,936	801,246	1,831,873	0	3,131,055
TB/HIV	Allocation	277,320	327,718	0	0	605,038
	Above	228,793	129,336	105,123	0	463,252
MDR-TB	Allocation	2,726,680	3,031,331	0	0	5,758,011
	Above	1,194,255	1,270,582	2,238,929	0	4,703,766
HSS-Health information systems and M&E	Allocation	872,041	284,746	0	0	1,156,787
	Above	1,272,842	1,431,426	1,034,467	0	3,738,735
Community systems strengthening	Allocation	150,670	119,234	0	0	269,904
	Above	241,222	273,694	242,229	0	757,145
Program management	Allocation	0	0	0	0	0
	Above	0	0	0	0	0
Total	Allocation	64,229,182	68,206,319	0	0	132,435,501
	Above	108,747,605	151,830,087	113,627,472	0	374,205,164

Summary Budget by Principal Recipient

Principal Recipient	Allocated/Above	2015	2016	2017	2018	Total
Ministry of Finance, Planning and Economic Development of Uganda	Allocation	63,043,094	66,831,540	0	0	129,874,634
	Above	105,527,168	149,211,159	111,689,401	0	366,427,728
The AIDS Support Organisation (Uganda) Limited	Allocation	1,186,088	1,374,779	0	0	2,560,867
	Above	3,220,437	2,618,928	1,938,071	0	7,777,436
Total	Allocation	64,229,182	68,206,319	0	0	132,435,501
	Above	108,747,605	151,830,087	113,627,472	0	374,205,164

B. Program goals and impact indicators

Goals

1	To contribute to the reduction of HIV new infection by 77% by 2025
2	To improve quality of life of PLHIV and decrease HIV- associated mortality by 70% by 2025
3	To reach a reduction of 34% in TB prevalence by 2020 (113/100,000)

Linked to goal(s) #	Impact indicator	Country	Baseline			Targets				Comments and Assumptions
			Value	Year	Source	Year 1	Year 2	Year 3	Year 4	
1	HIV I-1: Percentage of young people aged 15–24 who are living with HIV		3.7	2011	AIS (AIDS Indicator Survey)	3.2	3.1	3.0		The baseline data is from the 2011 AIS. It is projected that this prevalence will drop from 3.7% to 3.2%, 3.1% and 3.0% over the period 2012 to 2017. In 2011, the prevalence among men was 2.1%, and it is expected to reduce to 1.8% (2015), 1.8% (2016) and 1.5% (2017). While for women, the baseline in 2011 was 4.9%, and expected to reduce to 4.2% (2015), 4.1% (2016) and 3.9% (2017). These projections are based on implementation of the full package of interventions as documented in the National Prevention Strategy. The next AIDS Indicator Survey is expected 2015.
2	HIV I-4: AIDS related mortality per 100,000 population		0.170	2013	Reports (specify)	0.118	0.099	0.082		Baseline mortality data is determined from Ministry of Health Estimates and Projections 2013 using EPP Spectrum modeling jointly conducted annually with UNAIDS. Based on scale up of HIV Care and Treatment, including chronic care and ART. In 2013, the baseline was 170/100,000 and is projected to reduce to 118/100,000 (2015), 99/100,000 (2016) and 82/100,000 (2017). Assumption: The maximum feasible scenario under Investment Case modeling.
3	TB I-1: TB prevalence rate (per 100,000 population)		0.175	2012	Reports (specify)	0.155	0.145	0.137		The baseline value used is derived from the WHO estimate (2012) in the Global TB Report 2013 (Table 2.2, page 10) - base value is 175/ 100,000 (range from 67 to 334). There has been an observed annual reduction of TB prevalence according to WHO estimates. This observed decline was factored into the reduction used to project targets for the period 2015-2020 in the recently developed NSP (July 2014, M&E Plan - document attached). The projections is 155/100,000 (2015), 145/100,000 (2016) and 137/100,000 (2017). The first national prevalence survey has been initiated in 2014 and early data and analyses is expected to be available in October 2016 and this target may be revised once firm prevalence data is available.

C. Program objectives and outcome indicators

Objectives:	
1	To increase equitable access to ART by those in need from 50%(2014) to 80% by 2018
2	To increase condom use at high risk sex from 50% to 75%
3	To detect 85% of estimated TB cases and successfully treat 90% of them by 2020
4	Provide TB/HIV integrated care to co-infected patients and enroll >90% on ART by 2020
5	To detect 80% of estimated DR-TB cases and treat successfully 80% of them by 2020

6	To strengthen systems for effective management of Tuberculosis and Leprosy services to meet the NSP targets

Linked to objective(s) #	Outcome Indicator	Country	Baseline			Targets				Comments and Assumptions
			Value	Year	Source	Year 1	Year 2	Year 3	Year 4	
1	HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		83	2013	HMIS	83	84	85		It is expected that retention will be improved by 3% through increased follow up using interventions including CSS.
2	HIV O-3: Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse		15	2011	AIS (AIDS Indicator Survey)	50				Based on the UAIS 2011, this was 16% for women and 15% for men. This is expected to increase to 50% in 2015. The current Investment Case forecast is 75% by 2018. This target will be achieved through increased condom quantities and enhanced distribution to high risk populations.
3	TB O-1a: Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases		131	2013	R&R TB system, quarterly reports	144	149	153		NTLP is implementing an SSF Phase II grant. The signed performance framework documents targets for case notification rates @ 140 for 2014, 144 for 2015 and 149 for 2016, using the 2012 CNR of 138 as the baseline. The July 2014 version of the NSP 2015-2020, with the goal of reducing prevalence to 113 by 2020, targets CNR for the years 2015 to 2020 to decline from 116 in 2015 to 97 in 2020. This version of the NSP is near final, has been developed after elaborate consultations with stakeholders including Implementing Partners and donor agencies in the country. It is also the reference document for this investment application. The NTLP has proposed to keep the absolute number of the estimated incidence of TB (all forms) at 65,000 - this is the 'best' estimate from the most recent WHO Global TB Report 2013 (data of 2012). It then proposes to increase case detection from within this constant denominator incrementally from 73 to 81% during the investment period, using the baseline of 2013.
3	TB O-2b: Treatment success rate - bacteriologically confirmed new TB cases		77	2012	R&R TB system, quarterly reports	78	79	82		Quarterly treatment outcome cohort reviews for cases started one year ago are conducted, and treatment outcomes determined. These are reported together with the case notification reports for the quarter. At the end of the year, an annual treatment success rate is computed for the previous year's cohort. This is because TB treatment is for a minimum of 6 months, and a cohort analysis is done at a minimum of 3 months later. PR will ensure uninterrupted supply of medicines and lab consumables. PR has planned to scale up patient treatment initiation and adherence. Community engagement in an integrated model with HIV community networks and involvement of the private sector in TB care and expanding community based DOT. PR has also targeted to improve reporting. The urban model for TB care and control demonstrated successfully through the WHO TB REACH funded SPARK project will be scaled up. With this intervention it is anticipated treatment success rate will improve from 77% to 82% in 2017.
5	TB O-3: Notification of RR-TB and/or MDR-TB cases - Percentage of notified cases of bacteriologically confirmed, drug resistant RR-TB and/or MDR-TB? as a proportion of the estimated number of RR-TB and/or MDR-TB cases among notified TB cases		19	2012	TB patient register	39	46	53		It is estimated 1,010 MDR-TB cases occur annually in Uganda (WHO GTBR 2013, Uganda Country Profile, page 133). NTLP initiated PMDT in 2012 and expanded to 14 sites in 2013. 52 XpertMTB/Rif machines have been procured and are operational. It is proposed to procure additional 20 machines annually to expand access to DST across the country, linking with the TSRS and the HUB system already established and functional within the country. PMDT guidelines are under revision and will be published shortly. The recent exercise to develop a national NSP 2015 - 2020 identified targets for scaling up diagnosis and treatment of MDR-TB in the country. The NTLP will work closely with partners supporting diagnosis and treatment support for MDR-TB to achieve these targets. XpertMTB/Rif machines available, adequate supplies of cartridges, reporting tools available, patients referral according to guidelines, HUB system functional. The targets for this indicator are from the NSP 2015-2020, indicator 3.1.1.

D. Modules

Module: Prevention programs for general population

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline N# / D#	Baseline %	Baseline Year	Baseline Source	Total Targets	Year 1	Year 2	Year 3	Year 4
GP-1: Number of women and men aged 15+ who received an HIV test and know their results	Ministry of Finance, Planning and Economic Development of Uganda	National program	7,120,069		2013	HMIS	Allocation + Other Sources	6,115,643	5,116,423	4,000,000	
							Above+Allocation+Other sources	9,641,129	8,760,132	9,655,437	
Comments [1]	Estimated total population aged 15-49 years in 2015 is 17.8 million increasing to over 20 million by 2017. The NSP target is to provide HCT to 50% of adults 15-49 years annually. It is assumed PEPFAR support to provide HCT to 4 million individuals will be maintained at the 2014 level over the years 2015-2018. Anticipated rate of scale-up: Due to population growth (3%), annual target is increased by 350,000 – 375,000. Population size estimates: EPP Description of indicator/package of services: HIV testing and counseling, with linkage to other prevention and care services such as SMC, Pre-ART care, ART Data source: The denominator is the estimated population 15-49 years based on the United Nations Population Division (UNPD) Projections. The numerator is reported in HMIS.										
GP-5: Number of male circumcisions performed according to national standards	Ministry of Finance, Planning and Economic Development of Uganda	National program	801,678		2013	HMIS	Allocation + Other Sources	324,994	324,994	303,743	
							Above+Allocation+Other sources	1,001,875	1,026,961	1,001,624	
Comments [1]	Data source: Denominator estimates: As of 2015, total population of males 15-49 years is 8,953,241. Of these, 4,924,283 are already circumcised leaving 4,028,958 eligible (MOH Estimates and Projections). As of 2016, total population of males 15-49 years is 9,298,818. Of these, 5,951,244 are already circumcised leaving 3,347,574 eligible. As of 2017, total population of males 15-49 years is 9,656,760. Of these, 6,952,867 are already circumcised leaving 2,703,893 eligible. The denominator is the estimated population 15-49 years based on the United Nations Population Division (UNPD) Projections. The numerator is reported in HMIS.										

Module budget - Prevention programs for general population

Allocated request for entire module	USD 17,959,285	Above allocated request for entire module	USD 127,795,597

Intervention	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Behavioral change as part of programs for general population	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	246,686	260,829	0			Activities other donors and the government are already funding in support of this intervention: USG Partners including: Communication for Healthy Communities (CHC) develop and disseminate messages in HIV/AIDS, TB, Malaria UN family Joint UN Programme for HIV/AIDS (JUPSA) Civil Society Fund (funded by DFID, DANIDA, USG) GOU through MOH support and UAC through Health Promotion and Education Division
		Above	1,527,278	952,605	476,302			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	219,240	313,200	156,600			

Description of Intervention [2]

Target population: General population (particular focus on 16 high prevalence districts around Lake Victoria and Lake Kyoga) Context: HIV prevalence for 15-59 year olds in Uganda increased from 6.4% in 2004-5 to 7.3% in 2011, higher among women (8.3%) than men (6.1%) (AIS 2011). The 2014 Modes of Transmission (MOT) study, shows a significant proportion of new HIV infections comes from the general population; individuals with multiple partners and their partners contribute 17% and stable married couples 17% while those who have one partner in a non-marital partnership contribute 16%.The 2011 UAIS reports a reduction in condom use in those engaged in high risk sex from 47% to 29% women and 53% to 38% for men despite the high level of awareness of HIV/AIDS. To advance from awareness to behavior change, information needs to be tailored to individual or group risks and needs. The challenge of conflicting messaging has been addressed by the establishment of a message clearing committee at Uganda AIDS Commission (UAC). The high cost of designing and dissemination of IEC materials coupled the multiplicity of languages and limited evaluation of impact of messaging are among the remaining challenges. There is an ongoing evaluation of primary prevention by a GF consultant that may help address the latter gap. Approaches/Strategies: 1. Develop and disseminate tailored HIV messages through multiple channels a) Design, pre-test, and produce tailored messages. As part of this process, an assessment of personal and group risk perceptions will be necessary to identify actual information needs for BCC in the population. BCC materials need to be adapted accordingly, to bring about accelerated behavior change, including radio talk shows in all regions of the country. b) Scale up IEC/BCC messages using multiple and innovative channels. These include utilizing community structures such as cultural and religious leaders and VHT c) Train and orient media practitioners from local media institutions to enhance accurate and responsible reporting on HIV issues. d) Conduct community dialogue meetings at village level: at least one meeting per village per year in 80% of the 60,501 villages in the country. These will be conducted by one health facility staff within their catchments. e) Dissemination of messages for risk reduction and demand creation using film vans (vans will also be used for outreach services in under-served regions) 2. Scale-up community mobilization using 'Champions' for HIV. This will entail engaging influential leaders in community dialogues and talk shows for mobilization of communities for HIV control, as well as conducting regional behavior change campaigns presided over by the Champions. 3. Strengthen the dissemination of HIV prevention and care messages through existing community structures: Engage existing structures as community change agents in BCC for HIV prevention. In order to build on the knowledge for integrated community case management for malaria, training of trainers for VHTs will be conducted from the districts to cater for the different regions. The existing VHT trainers will be used for the training. Supervision for VHTs will be conducted monthly for continuous skills development (This activity will leverage resources from the HSS application and other in country resources for RMNCAH). 4. Conduct quarterly coordination meetings of the District and Sub County AIDS Committees: to be conducted at district and sub-county levels in each district, each meeting to be attended by 30 participants, each facilitated with SDA and transport refund. This equals 5,312 SAC meetings and 448 DAC meetings. This structure is intended to increase advocacy for HIV prevention. This will be budgeted under program management. Funding Request from this GF grant: 1) Developing and dissemination of tailored HIV messages: Designing, pre-test and production of tailored messages 2) Dissemination of messages through multiple media and community structures (religious and cultural leaders, PLHIV, and VHT). These messages will capture crosscutting HIV prevention issues including individual and couple HIV testing, reducing multiple and concurrent partnerships, condom use, male involvement in PMTCT, among others. 3) Training media practitioners 4) Procure film vans (14) to support comprehensive SBCC campaigns for multiple interventions for primary prevention and other service uptake (condom programming, HIV testing, PMTCT campaigns, outreaches for MARPs interventions, among others) 5) Conduct regional community mobilization and engagement HIV prevention campaigns using commmunity leaders (religious, cultural, civic, and political leaders) focusing on the implementation of combination HIV prevention with emphasis on BCC.

Condoms as part of programs for general population	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	3,773,314	3,330,209	0			Procurement and Distribution of condoms: UNFPA, USG, Global Fund
		Above	16,337,542	20,639,461	10,193,253			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	476,736	0			

Description of Intervention [2]

Target Population: Adults aged 15-60 years in both rural and urban settings nationally with estimated total population of 18,392,243 (particular focus on high prevalence districts around Lake Victoria and Lake Kyoga) Context and implementation approach: Funding for condom-related activities including procurement (male and female condoms), distribution of condoms, training of service providers and coordination is largely supported by partners especially United Nations Fund for Population Activities (UNFPA), GFATM, and USAID/PEPFAR. The country has recently adjusted modalities of implementing the condom post-shipment testing policy, and this has greatly improved the condom throughput. Current challenges include: 1. Inadequate condom supplies: In 2012, of the projected need of 184 million, only 87 million were supplied. A similar trend has been observed over the years. 2. Declining condom utilization: The 2011 UAIS reports a reduction in condom use in those engaged in high risk sex from 47% to 29% women and 53% to 38% for men despite the very high general awareness of HIV/AIDS. 3. Gaps in condom distribution: Public sector condoms are mainly distributed by National Medical Stores (NMS) to health facilities which may not be accessible by healthy individuals. Distribution of condoms through social outlets and hot spots where communities congregate and can easily access condoms has been low and promotion with targeted education activities that raise demand and increase use of condoms for risky sexual behaviors, have not been implemented adequately. 4. Low acceptability of unbranded condoms: The MOH/ UNFPA Condom situation analysis /mapping report of 2011 recommended that condom should be made more appealing and acceptable to consumers. The public sector condoms are not branded and UNFPA is providing support for the branding process. Priority strategies 1. Procurement of adequate male and female condoms to ensure consistent supply: procure more appealing branded condoms. 2. Scale-up community condom distribution outlets a. Targeted hotspots will be equipped with condom vending machines/self- dispensers b. Village health teams, peer educators and other community resource persons will be utilized c. Use mobile teams for delivery of condoms 3. Hold quarterly coordination meetings at national and district level to harmonize condom programming 4. Build capacity for condom education and distribution through social marketing, community based organizations, and other user friendly channels to reach the final consumer. Priority Activities to be funded through this grant: 1. Procure additional condoms to meet the projected country needs. An additional 150 million pieces are needed. 2. Procure additional 2,000 condom dispensing machines. These will be placed at Hot Spots at community level; they contribute to reduction of stigma and improve accessibility to condoms. 3. Procure 20,000 condom demonstration tools for both male and female condoms. 4. Conduct condom promotion events, i.e. social mobilization for adoption of prevention options e.g. Condom use for dual protection 5. Two- day training of 12,000 community condom distributers to increase condom distribution in communities. This will be conducted in collaboration with CBOs. 6. Conduct study on condom availability, effectiveness of distribution channels, uptake and condom use dynamics

HIV testing and counseling as part of programs for general population	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	6,775,369	2,432,945	0			Procurement of test kits mainly USG and Global Fund; Implementation GOU; DFID gap filled in last Financial Year
		Above	11,366,278	21,200,139	11,967,944			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target population and geographic scope: Adults aged 15+ years of age in the general population (particular focus on high prevalence districts around Lake Victoria and Lake Kyoga; MARPs (sex workers, MSM, uniformed personnel, fisher folk, truckers, couples, health facility based PITC for patients). Context and Implementation approaches: HIV testing and counseling (HTC) is an important entry point into prevention and care and treatment services. The HIV testing policy allows for different models including facility, community, client-initiated and provider initiated approaches. According to the AIDS Indicator Survey (UAIS 2011) 56% of the population had ever had an HIV test (66% of females and 45% for the males). The NSP target is to provide HCT to 50% of individuals aged 15-49 years annually by 2015. In 2013/14, over 9,732,968 individuals received HTC (DHIS2). Major challenges for HTC include: 1. Inadequate supply of HIV test kits with frequent stock-outs for testing kits 2. Linkage to treatment for identified HIV-positive clients is inadequate, especially those identified during community testing 3. Limited couple counseling and testing (the DHIS2 data for 2013/14 shows that only 5% of individuals tested as couples) 4. Poor quality of HCT service delivery in private health facilities: quality assurance interventions are mostly focused in public health facilities 5. Human resource constraints for counselling and inadequate data management 6. Home-based HCT remains one of the best approaches to reach men, children and youth, and couples who do not come to the health facilities (Over 95% HCT uptake UAIS 2011), yet there is almost no funding for this approach Priority strategies and activities: 1. Procure additional quantities of HIV test kits to ensure uninterrupted supply. 2. Strengthen linkage to care and HIV prevention services 3. Enhance the utilization of PITC through knowledge and skills development for health workers: 4. Conduct home based and community testing outreaches in high prevalence communities e.g. fishing communities to improve access to HTC. 5. Utilization of strategic events in HCT provision: Social, cultural, religious and political functions such as market days, political rallies, sports galas and entertainment events provide opportunities to reach out people at high risk of HIV acquisition. Outreaches conducted to gatherings will complement existing efforts for scale -up of HCT services to the population. 6. Enhance couples counseling and testing by engaging religious, cultural and other community structures Funding request 1. Support for procurement of additional HIV test kits to reduce the current stock-outs. 2. Training of health workers at HC III and HC II in integration of PITC/couples counseling and testing services. 3. Support targeted home based and community HIV testing campaigns in selected high prevalence communities and districts (districts around Lake Victoria and Kyoga).

Male circumcision	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	596,549	543,384	0			USG and GOU. USG for procurement of commodities while GOU supports program implementation.
		Above	13,157,739	13,209,328	5,601,952			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target Population and geographical coverage: Uncircumcised men in the age group 15-49 years in the entire country (particular focus on high prevalence districts around Lake Victoria and Lake Kyoga and low circumcision coverage districts of north-eastern Uganda and focusing on the younger boys and men (10-35 years were the impact is highest based on recent modeling scenarios by MoH and PEPFAR) Context and implementation approach: There has been continued scale-up of safe male medical circumcision (SMC) since 2011. A mixed model approach was adopted using static and mobile sites at facilities. Some sites also adopted the 'MOVE' model where each member of a team performs a specific task for several clients, one-after another, to increase efficiency. The number of males provided with SMC in 2013/14 was 1,023,357 at 1295 sites countrywide. The country is targeting a minimum of 1,000,000 circumcisions annually. In 2015 PEPFAR plans to support 303,743 circumcisions mainly targeting eligible adolescents and men. Despite the roll-out of SMC, coverage remains low at 26% in 2011 (UAIS 2011). Major bottlenecks include: 1. Capacity gaps in relation to provider skills and numbers dedicated to provide SMC, and facility infrastructure 2. Inadequate SMC supplies to satisfy the high demand 3. Reaching older males at risk of HIV acquisition Priority strategies 1. Strengthen the supply chain for SMC commodities (under PSM module) 2. Support roll-out of new technologies for SMC. The MOH has adopted the use of non-surgical SMC procedures such as Prepex which is currently going through the active surveillance phase at 10 sites. 3. Enhance SMC services at health facility level (static clinics). This will involve capacity building for providers and infrastructural improvements. 4. Conduct SMC medical camps within the target communities especially uniformed personnel, fishing communities, and mid-northern Uganda with the lowest circumcision prevalence and high HIV prevalence 5. Engage traditional surgeons to make traditional circumcision safer. The SMC policy recognizes the existence of traditional male circumcision (SMC Strategy, page 30). The training of traditional surgeons is necessary to improve the skills for prevention of transfer of infection through surgical procedures. Priority Activities to be funded through this grant: 1. Procure surgical and non-surgical equipment for SMC for 1,500 HF – HC IV and HC III: PrePex has been approved for use for SMC in the country. 2. Support SMC for 200,000 men including demand creation (20% using Prepex). 3. Training of Health Care Workers in SMC 4. Support SMC outreaches for selected communities (hot spots, fishing communities)

RMNCH linkages and gender-based violence (GBV)	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			Joint UN Program (UNFPA); USG, UNICEF
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target audience: Young women and girls aged 15-24 years, women aged 15-49 years attending RMNCH clinic, boys and girls of reproductive age group including women and girls 15-19 and 20-24 years. (Greatest focus on 16 priority districts—fishing communities around Lake Victoria and Lake Kyoga) Context: Women and girls constitute the largest proportion of PLHIV, 8.3% for women compared to 7.3% for men, (AIDS 2011 page 104). UNAIDS further estimates that 1 in every 4 new infections among women aged 15-49 years occurs in adolescents and young women aged 15-24 years (UNAIDS Gap report page 7). Additionally, young women who have experienced intimate partner violence are 50% more likely to acquire HIV compare to women who had not experienced violence. Impact: Integration of HIV prevention at RMNCH is aimed at maximizing efficiencies using a one service delivery point model to provide risk reduction counselling, HIV testing , TB screening and referral for appropriate services, clinical management of GBV and HIV prevention BCC messages. Implementation approach: RMNHC services are largely implemented through clinics in health facilities. HIV services have been integrated into ANC, delivery, postnatal care, Young Child Clinics (YCC) and adolescent clinics. In an effort to promote safe motherhood health workers will be oriented to provide pre- and post-conception counselling and support for young women and girls living with HIV. This will also support conception planning and informed contraception choices. There will be targeted integrated outreaches to ensure easy access for communities. These services will be offered as part of the integrated RMNCAH clinics and community outreaches once every 3 months. Strategies 1. Engage communities (religious and cultural, among others) and law enforcement personnel to reduce SGBV, and support processes towards Justice for victims of SGBV (funded under the HSS-CSS grant). 2. Integrate RMNCAH into HIV prevention, care, and treatment services (e.g. cervical cancer screening, FP and safer conception counseling and support, adolescent friendly services) 3. Provide male and female condoms, to all women and girls in ways that do not stigmatize them, and empower them with condom negotiation skills 4. Provide age-appropriate sex education to small groups and GBV counselling and referrals for GBV management 5. Mainstream SGBV screening and management into HCT and other HIV services Funding request: 1. Orient health workers to SGBV issues in HIV and RMNCAH service delivery (integrated with AFHS training) 2. Support religious and cultural leaders to mobilize communities and reduce SGBV (captured under CSS)

Programmatic Gap

Coverage Indicator : GP-1: Number of women and men aged 15+ who received an HIV test and know their results

Current National Coverage 8774834	Year	Source	Latest Results		
	2013	HMIS	8774834.0		
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	17'882'258	18'583'740	19'310'874	20'062'463	Based on the United Nations Population Division (UNPD) population projections for age group 15-49 years.
B. Country targets (from National Strategic Plan)	8'941'129 50.00 %	9'291'870 50.00 %	9'655'437 50.00 %	10'031'231 50.00 %	
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	4'000'000 22.37 %	4'000'000 21.52 %	4'000'000 20.71 %	4'000'000 19.94 %	These estimates reflect procurements and not all services related to HCT. In 2014 PEPFAR contributed test kits to provide HCT to 4 million individuals and the rest were procured through GOU, DFID, GF and other donor support. It is assumed that PEPFAR support will be maintained at the 2014 level over the years. Assuming flattening of PEPFAR contribution from 2014- 2018, 20% of need is available.
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	13,882,258 77.63 %	14,583,740 78.48 %	15,310,874 79.29 %	16,062,463 80.06 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	1'415'643 7.92 %	1'648'161 8.87 %	0 0.00 %	0 0.00 %	
F. Coverage from Allocation amount and other resources C+E	5,415,643 30.29 %	5,648,161 30.39 %	4,000,000 20.71 %	4,000,000 19.94 %	
G. Targets to be potentially financed by above allocation amount	3'525'486 19.71 %	3'643'709 19.61 %	5'655'437 29.29 %	6'031'231 30.06 %	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	8,941,129 50.00 %	9,291,870 50.00 %	9,655,437 50.00 %	10,031,231 50.00 %	In order to achieve the NSP target of testing 50% of adults, CCM requests funding to provide HCT to 3,125,000 individuals within allocation annually and the balance from the above allocation (1.8m in 2015, 2.1m in 2016, 2.5m in 2017, 2.9m in 2018, assuming PEPFAR continues to support testing for 4 million people annually

Coverage Indicator : GP-5: Number of male circumcisions performed according to national standards

Current National Coverage 1023357	Year	Source	Latest Results		
	2013	HMIS	1023357.0		
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	4'028'958	3'347'574	2'703'893		Eligible aged 15-49 according to the national policy. As of 2015, total polulation of males 15-49 years is 8,953,241. Of these, 4,924,283 are already circumcised leaving 4,028,958 eligible. As of 2016, total polulation of males 15-49 years is 9,298,818. Of these, 5,951,244 are already circumcised leaving 3,347,574 eligible.As of 2017, total polulation of males 15-49 years is 9,656,760. Of these, 6,952,867 are already circumcised leaving 2,703,893 eligible. As of 2018, total polulation of males 15-49 years is 1,026,633. Of these, 8,021,306 are already circumcised leaving 2,005,327 eligible.
B. Country targets (from National Strategic Plan)	1'001'875 24.87 %	1'026'961 30.68 %	1'001'624 37.04 %	%	Assumption: We shall have covered 55% of the eligible by 2015, 64% by 2016, 72% by2017, and 80% by 2018.
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	303'743 30.32 %	303'743 29.58 %	303'743 30.33 %	%	
Programmatic Gap					
D. Expected annual gap in meeting the need B-C	698,132 69 %	723,218 70 %	697,881 69 %	0 0 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	100'000 9.98 %	100'000 9.74 %	100'000 9.98 %	%	Given the funding constraints we are requesting for support to provide 100000 male curmucisions within the allocated funds
F. Coverage from Allocation amount and other resources C+E	403,743 40.30 %	403,743 39.32 %	403,743 40.31 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	598'132 59.70 %	623'218 60.69 %	597'881 59.69 %	%	The country would require incentive funding given the need and existing capacity for male circumcision.
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	1,001,875 100.00 %	1,026,961 100.01 %	1,001,624 100.00 %	0 0 %	

Module: Prevention programs for MSM and TGs

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets								
							Total Targets	Year 1		Year 2		Year 3		Year 4	
			N # D #	%	Year	Source		N # D #	%	N # D #	%	N # D #	%	N # D #	%

Indicator	Responsible PR	Current grant	Baseline value	Baseline %	Baseline year	Baseline source	Target type	Year 1 N/D	Year 1 %	Year 2 N/D	Year 2 %	Year 3 N/D	Year 3 %	Year 4 N/D	Year 4 %	
KP-1a: Percentage of MSM reached with HIV prevention programs - defined package of services	The AIDS Support Organisation (Uganda) Limited	Current grant	427	4	2013	Reports (specify)	Allocation + Other Sources	1,072	10	1,572	14	572	5			
			10,533					10,848		11,174		11,509				
							Above+Allocation+Other sources	1,500	14	2,828	25	2,828	25			
								10,848		11,174		11,509				

Comments [1]	
Comments [1]	Overall assumptions: PEPFAR support maintained at Semi-annual Progress Report 2014 level achievement adjusted by 30%(about 572 by end of 2014 through 2018). Enabling legal environment for service delivery. Anticipated rate of scale-up: National coverage targets are based on Investment Case and NSP Mid-Term Review. The NSP target is to increase access to comprehensive HIV prevention services to 50% by 2018, Population size estimates: The estimated MSM population at baseline is 10,533 (UAC Review Report: Multi-sectoral HIV Programming for MARPS in Uganda: Review of Profiles Size Estimates, and Program Coverage 2014. This population has been assumed to increase by at least 3% annually. Description of indicator/package of services: Package of services- HIV testing and counseling, BCC, promotion of condom use, STI care, referral for immediate ART/test and treat if HIV-infected regardless of CD4 count, Data source: Program reports from PEPFAR, special studies and surveys. phased

Module budget - Prevention programs for MSM and TGs

Allocated request for entire module	USD 499,262	Above allocated request for entire module	USD 790,516

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only)					Cost Assumptions [3]	Other funding [4]
		Total Targets	Year 1	Year 2	Year 3	Year 4		

Behavioral change as part of programs for MSM and TGs	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	32,101	101,407	0			USG; DANIDA, Joint UN program, Global Fund, GOU
		Above	32,101	1,701	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	114,586	251,168	0			
		Above	362,885	185,027	208,802			

Description of Intervention [2]

Target Population: MSM and TGs and other KPs groups Impact: Improved access to comprehensive HIV/TB/SRH and STI prevention services for MSM and TGs in a non-stigmatizing manner, tailored to the unique needs of these populations. Context: Key populations including MSM are among the MARPs (UAC, 2014) page 2.) In Uganda the prevalence of HIV among MSM is 13.7% [Crane Survey 2010]. HIV prevention and treatment interventions for MSM and TG are still limited in coverage and scope (package), and largely in Kampala. Furthermore, the MSM and TGs are constrained from freely accessing HIV services because of stigma (from communities and providers) and criminalization. The double stigma and discrimination of being HIV positive and MSM drives a significant population underground. Efforts to coordinate the response and provide a strategic direction at national level have been initiated, however, this needs to be strengthened, supported and cascaded lower down to districts up to community level. Tracking of service delivery to MSM and TG is also limited since the existing tools do not capture MSM and TG as a distinct population. Priority strategy 1. Establish integrated prevention and care services for MSM and TG at four additional facilities using the Mulago Most –At-Risk Populations Initiative (MARPI) clinic model. Implementation approach: 1. Establish four (4) additional sites MARPI model clinics at the regional referral hospitals (RRHs) in each of the four regions of Uganda. The clinics will provide integrated services at the facility and through outreaches within each region. Lessons derived from the MARPI clinic will be used to benchmark the quality of care to ensure access to HIV prevention information and commodities, SRH and family planning information and services, STI management, TB screening prophylaxis and treatments services, ART among others. 2. Promote HCT at static sites and through outreaches using peer-to-peer networks. Condom promotion through community education will be a priority. 3. Develop tailor made IEC/BCC messages. 4. Roll out 'test and treat' for MSM and TG. Clients will receive HIV and TB management services as part of the integrated package of services both at the static clinics and outreaches. The clinics will be equipped to work in hours that are convenient to the key populations. Health workers will be trained in human rights and access to services tailored to key populations. 5. GBV screening and management services as well as adolescent SRH will be integrated. Activities for the clinic will be integrated in the general running of the hospitals and sustained beyond the funding period. Some of the activities to be undertaken will include Behavior Change communication (intervention) 1. Train and re-orient existing peer educators for MSM and TG communities 2. Operationalize the four additional regional clinics for KAPs 3. Implement a BCC campaign tailored to the unique issues of MSM and TG, including one-on-one risk-reduction and small group dialogue sessions in safe places/venues 4. Support service outreaches in the Drop in Centers for MSM and TG 5. Support Toll free lines in Drop in Centers for MSM/TG to enable the communities to call in for counseling and guidance and pilot internet based (twitter and Facebook mobilization of communities) 6. Evaluate effectiveness of service delivery models for MSM and TG Funding request intervention for BCC: 1. Support toll free lines in drop-in centers and internet based mobilization for service uptake 2. Support services outreaches in drop in Centre (DiCs) for MSM and TG 3. Evaluate effectiveness of service delivery models for MSM and TG (including effectiveness of the BCC strategies, among others)

Condoms as part of programs for MSM and TGs	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Condom programming priorities: 1. Conduct trainings for MSM/TG peer educators focusing on use, promotion and distribution of condoms and lubricants. 2. Support the trained peers to conduct community education to increase use of condoms and lubricants 3. Set up condom and lubricants outlets within MSM and TG communities Funding request: 1. Conduct trainings for peer educators focusing on use, promotion and distribution of condoms and lubricants 2. Support the trained peers to distribute condoms and lubricants

Diagnosis and treatment of STIs as part of programs for MSM and TGs	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Priority activities: 1. Adapt existing STI/STD treatment guidelines to address unique MSM/TG needs 2. Conduct sensitivity trainings for health care providers to provide syndrome Diagnosis and treatment of STIs 1. Adapt existing STI/STD management guidelines to address unique MSM/TG needs 2. Conduct trainings for health care providers to provide syndrome STI management and other clinical care services for MSM and TG 3. Regularly conduct STI and cancer screening and treatment at friendly facilities, drop in centers, satellite clinics and in safe spaces using tested approaches such as targeted outreaches, peer-to-peer mechanisms referral, mobile services, and partner notification. Funding Request: 1. Health infrastructure development to create a friendly corner within the four facilities e.g. renovations/furniture, computers, examination couches 2. Training providers to ensure delivery of quality services for MSM and TG (including human rights, respect and dignity) 3. Develop standard operating procedures for integrated service delivery for MSM/TG Other cross cutting areas requiring funding: 1. Mapping through peer to peer networks and service needs assessment for MSM and TGs and other KPs 2. Data collection and reporting tools revise tools to permit disaggregation by sub-population category served

HIV testing and counseling as part of programs for MSM and TGs	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			USG, Global Fund, Joint UN program, DANIDA
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

HIV testing and counseling priotities: 1. Regularly conduct HTC as part of the integrated static and community mobile clinics 2. Enhance linkages to HIV care (including test and treat) and prevention services for MSM and TG Funding request: 1. Funding for HTC outreaches (integrated services including HTC)

Programmatic Gap

Coverage Indicator : KP-1a: Percentage of MSM reached with HIV prevention programs - defined package of services

Current National Coverage 4%	Year	Source	Latest Results
	2013	Other (specify) PEPPER semi annual report	4.0

	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	10'848	11'174	11'509		The prevention services coverage for MSM in the first year will be trippled in year 1, given the current very low coverage; the target is to reach 50% by 2018
B. Country targets (from National Strategic Plan)	1'500 13.83 %	3'000 26.85 %	4'500 39.10 %	%	This is the current coverage by PEPFAR (SAPR 2014) adjusted upwards by 30% for annual coverage assuming funding flatling 2015-2018
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	572 5.27 %	572 5.12 %	572 4.97 %	%	This is the current coverage by PEPFAR (SAPR 2014) adjusted upwards by 30% for annual coverage assuming funding flatling 2015-2018
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	10,276 94.73 %	10,602 94.88 %	10,937 95.03 %	0 100 %	This is the current coverage by PEPFAR (SAPR 2014) adjusted upwards by 30% for annual coverage assuming funding flatling 2015-2018
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	500 4.61 %	1'000 8.95 %	0 0.00 %	%	
F. Coverage from Allocation amount and other resources C+E	1,072 9.88 %	1,572 14.07 %	572 4.97 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	428 3.95 %	1'256 11.24 %	4'442 38.60 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	1,500 13.83 %	2,828 25.31 %	5,014 43.57 %	0 0 %	

Module: Prevention programs for sex workers and their clients

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets								
							Total Targets	Year 1		Year 2		Year 3		Year 4	
			N # D #	%	Year	Source		N # D #	%	N # D #	%	N # D #	%	N # D #	%

KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services	The AIDS Support Organisation (Uganda) Limited	Current grant	15,059.0 54,549.0	27.6	2013	Reports (specify)	Allocation + Other Sources	23,426.0 54,549.0	42.9	26,644.0 56,185.0	47.4	19,577.0 57,871.0	33.8	19,577.0 59,607.0	32.8
							Above+Allocation+Other sources	27,275.0 54,549.0	50.0	33,711.0 56,185.0	60.0	40,509.0 57,871.0	70.0	47,687.0 59,607.0	80.0
Comments [1]	Anticipated rate of scale-up: National coverage targets are based on Investment Case and NSP Mid-Term Review. The NSP target is to increase access to comprehensive HIV prevention services to 80% by 2018. 3) Population size estimates: The estimated sex worker population at baseline is 54,549 (UAC multi-sectoral HIV Programming for MARPS in Uganda: Review of Profiles Size Estimates, and Program Coverage 2014). This population is assumed to increase by at least 3% annually (based on Uganda population growth). 4) Description of indicator/package of services: Package of services- HIV testing and counseling, BCC, promotion of condom use, STI care, family planning, referral for immediate ART/test and treat if HIV-infected regardless of CD4 count 5) Data source: Program reports from PEPFAR, special studies and surveys. 6) Other relevant information: A phased scale-up is planned since programming for Sex Workers is relatively young.														

Module budget - Prevention programs for sex workers and their clients			
Allocated request for entire module	USD 860,545	Above allocated request for entire module	USD 1,759,906

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only)					Cost Assumptions [3]	Other funding [4]
		Total Targets	Year 1	Year 2	Year 3	Year 4		

Behavioral change as part of programs for sex workers and their clients	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	33,468	22,312	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	66,936	22,312	22,312			
	The AIDS Support Organisation (Uganda) Limited	Allocation	257,442	331,910	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	602,784	241,952	232,952			
Description of Intervention [2]								
Target population: Sex workers and their clients countrywide (this module also includes other MARPs such as truckers, uniformed personnel and fisher folk since literature shows a link between these populations and sex work) Context: Female sex workers are among the MARPs defined in Uganda's HIV Investment Case and NSP. The Uganda AIDS Commission (UAC) and UNFPA review of 2014, estimated the sex worker population at 54,549 with a prevalence of 33% on average. According to the draft 2014 MOT, sex workers and their clients contribute 12.9% of the new HIV infections in Uganda. Sex workers conduct their trade in multiple venues including brothels, lodges, bars, nightclubs and streets. A manual for HIV prevention in sex work settings has been developed by MoH. The manual prioritizes skills building and alternative livelihoods for women and girls in sex work. Sex workers need easy and nondiscriminatory access to sexual and reproductive health services, STI management, HIV and AIDS care services (KAPs consultative workshop report, 2014, page 10). Some population groups with the highest HIV prevalence such as uniformed personnel, truckers and fishermen have been linked to sex work (KMCC 2014). In the UAC/UNFPA in 2014 review truckers were estimated at 31,588 with HIV prevalence of 25-32%; uniformed personnel were estimated at 650,000 with HIV prevalence of 10-18%; HIV prevalence in fishing communities was 23-35% and the population size was estimated at 2 million. Among these groups, fisher folk contribute the largest number of new HIV infections in Uganda (32%), due to their large population size and have been selected for the test and treat approach in the addendum the national ART guidelines. These populations are also quite mobile and require innovative service delivery approaches to address their needs. Fishing communities are particularly disadvantaged to due limited access to facilities and other health services. Implementation approach a) Sex workers: Building on the integrated clinics established at the four RRHs (under Prevention programs for MSM and TGs) we shall have dedicated sex-venue based outreaches to target both the sex workers and their clients. Some of the tested models for reaching such populations that have previously been proven effective under the USG support working with both government and non- government providers e.g. "moonlight clinic model" used by the AIDS Information Center, The AIDS Support Organization (TASO) and Reach-out Mbuya. Sex workers will be mobilized through their network leaders. b) Truckers, uniformed personnel and fisher folk: A comprehensive package of services including SBCC, HIV testing, condom promotion and distribution as well as SMC, HIV care and treatment will be provided to these populations using various approaches. Uniformed personnel such as Police and Army (UPDF) have organized medical services and structures that will be utilized to enhance service delivery. Outreach services for sex workers targeting hotspots will also integrate services (including SMC) for truckers. A combination of approaches will be used to serve fishing communities, including enhanced support for and accreditation of facilities within fishing communities (up to HCIIs) to provide comprehensive services and use of outreaches. A "boat-to-boat" variant of home-based HIV testing approach which has been previously used in Kalangala, one of the fishing communities will be implemented in fishing communities. This will be coupled with enhanced linkage to HIV care and treatment for those who are HIV infected and prevention services (including SMC) for the uninfected. Community structures such as the Beach Management Units (BMUs) and peers will be engaged for mobilization. Some of the activities to be undertaken include: Behavior change communication intervention for Sex workers and their clients - to b included in the fuding request 1. Train/Reorient existing peer educators for SW communities, truckers, uniformed personnel, and fisher folk, for peer mobilization to enhance service uptake and retention 2. Innovative BCC such as one-on-one risk reduction discussion and small group dialogue sessions in safe places/venues targeting sex workers, truckers, uniformed personnel, and fisher folk 3. Support health service delivery in brothels and Drop-in Centers for SW and truckers 4. Support Toll free lines in facilities and satellite sites providing interventions for SW								
Condoms as part of programs for sex workers and their clients	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	86,616	128,797	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	549,298	10,680	10,680			
Description of Intervention [2]								
Priority activities: 1. Conduct trainings for peer educators and other community resource persons for sex workers, truckers, uniformed personnel, and fisher folk, focusing on use, promotion and distribution of condoms and lubricants (integrated with BCC peer training) 2. Support the trained peers and resource persons in their communities promoting 100% condom use campaigns 3. Set up condom outlets (including dispensing machines) in hotspots (bars, hotels, brothels, drop-in center etc.), for sex workers, truckers, uniformed personnel, and fisher folk) and support distribution mechanisms for condoms and lubricants Funding request: 1) Strengthen prevention services including condom distribution in the drop-in centres (condom refills, peer counsellor, lubricants, etc.) 2)Training and support for peers and networks to enhance condom distribution for sex workers, fisher folk, truckers, and uniformed personnel								
Diagnosis and treatment of STIs (sex workers and their clients)	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	0	0	0			
Description of Intervention [2]								
Priority activities: 1. Regularly provide integrated services including cervical cancer screening and treatment, family planning and STI management, Post-rape, GBV counselling and PEP, post-abortal care, PMTCT using innovative friendly approaches 2. Provide STI diagnosis and treatment services for clients of sex workers, truckers, uniformed personnel and fisher folk 3. Support MARPI model program as learning site to build national capacity for scale up Funding request 1. Integrated clinics targeting sex-work hot spots to be done by staff from the four regional referral hospital clinics – 1-week community based camps and moonlight clinics to busy townships at least once every two months 2. Evaluate effectiveness of service delivery models for sex workers (including effectiveness of the BCC strategies, among others)								
HIV testing and counseling as part of programs for sex workers and their clients	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			USG, DANIDA, Joint UN Program (UNFPA), Global Fund, GOU
		Above	0	0	0			
Description of Intervention [2]								
Priority activities: • Regularly conduct HTC (and retesting) using the tested approaches such as targeted outreaches, home based (boat-to-boat), peer-to-peer mechanisms, mobile services, partner testing and HTC campaigns. • Enhance linkage to care (including test and treat) and prevention services for sex workers, uniformed personnel, fisher folk Funding request: 1) Targeted home based (boat-to-boat) and outreach testing and linkage to care (including test and treat for sex workers and fisher folk) and prevention services including SMC targeting fishing communities and truckers								

Programmatic Gap

Coverage Indicator : KP-1c: Percentage of sex workers reached with HIV prevention programs - defined package of services

Current National Coverage	Year	Source	Latest Results
	2013	Other (specify) At SAPR, PEPFAR reported reaching 15,059 sex workers which is 27% of the estimated 54,549. Ref: UAC Multi-sectoral HIV programming for MARPs in Uganda: Review of profiles, sizes, and program coverage, 2014	27.0

	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	54'549	56'185	57'871		The estimated SW population at baseline is 54,549 assumed to increase by at least 3% annually. Source of estimates: UAC Multi-sectoral HIV programming for MARPs in Uganda: Review of profiles, sizes, and program coverage, 2014
B. Country targets (from National Strategic Plan)	27'275 50.00 %	33'711 60.00 %	40'509 70.00 %	%	Aiming to reach 80% by 2018
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	19'577 35.89 %	19'577 34.84 %	19'577 33.83 %	%	
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	34,972 64.11 %	36,608 65.16 %	38,294 66.17 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	3'849 7.06 %	7'067 12.58 %	0 0.00 %	%	
F. Coverage from Allocation amount and other resources C+E	23,426 42.95 %	26,644 47.42 %	19,577 33.83 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	3'849 7.06 %	7'067 12.58 %	20'932 36.17 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	27,275 50.01 %	33,711 60.00 %	40,509 70.00 %	0 0 %	

Module: Prevention programs for adolescents and youth, in and out of school

Module budget - Prevention programs for adolescents and youth, in and out of school

Allocated request for entire module	USD 1,146,128	Above allocated request for entire module	USD 4,125,171

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only)						
		Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]

Behavioral change as part of programs for adolescent and youth	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	670,124	120,866	0			UNFPA, Civil Society Fund, USG, GOU
		Above	938,608	164,232	154,194			
	The AIDS Support Organisation (Uganda) Limited	Allocation	172,385	172,385	0			
		Above	689,539	344,770	354,144			

Description of Intervention [2]

Target population: Adolescents and youth target audience projected at 12,685,216 people aged 10-24 years all over the country (16 priority districts—fishing communities around Lake Victoria and Lake Kyoga). Context/Description of the current situation: According to the AIS 2011, nearly all youths and adolescents were aware about HIV/AIDS (99.6% females and 99.4% males). However, comprehensive knowledge was low. Knowledge about condom use as a preventive measure was 79% and 84% among young women and men aged 15-24 respectively; and 76% and 82% among adolescents aged 15-19 years. Additionally, 2.1% of the girls and 8.1% boys engaged in multiple sexual partnerships and only 28% were circumcised (UDHS 2011 pp 187, 198 & 207). The national Abstinence, Be faithful and Condom use (ABC) behavioral prevention strategy will continue to be the focus for HIV prevention programming for adolescents and youth. The focus for younger adolescents is on promoting abstinence and providing education about condom use. While for older youth, the approaches and package of services are similar to those in the general population. Schools have very organized systems for information flow and shape the behavior of young children. The recent AIDS review identified the limited IEC in Schools as a big missed opportunity since many young boys and girls spend most of their time in Schools and could be reached with HIV/AIDS messages through civic education. The Ministry of Education and Sports has integrated health education in the school curriculum which includes HIV/AIDS and there are organized programs for HIV prevention within Schools. Implementation approach: 1. HIV/AIDS prevention integrated into the school health program will continue. Students and teachers will be equipped with skills for peer education and support for positive behavior change. These interventions have been supported by several partners including UN Agencies, DFID, USAID and Civil Society Fund (CSF) but are limited in scope and not targeting the most vulnerable and high prevalence districts. UNFPA supports 12 districts including Katakwi, Kaabong, Kanungu, Kotido, Moroto, Yumbe, Mubende, Oyam, Pader, Gulu, Arua, and Kalangala. 2. CCM proposes to prioritize high HIV prevalence districts in fishing communities around Lake Victoria (Kalangala, Mukono, Buikwe, Buvuma, Namayingo, Wakiso, Mayuge, and Kayunga district) and Lake Kyoga (Amolatar, Apac, Buyende, Dokolo, Kaberamaido, Kayunga, Nakasongola, and Serere). 3. In addition to broader risk reduction BCC, HIV testing and condom knowledge and/or use, male youth will be targeted for SMC since a recent modeling scenarios by MoH and PEPFAR showed highest in the 10-35 year age-group. Female youth will be the focus for comprehensive SRH interventions integrating HIV prevention and SGBV. 4. Making Youth Friendly Health Services (YFHS) affordable, accessible and utilizable by adolescents and young people in public and private health facilities enhances HIV prevention. Strategies 1. Strengthen provision of youth friendly health services 2. Enhance comprehensive HIV prevention RMNCAH services using innovative models for in- and out of School youth, including addressing early pregnancies, SGBV Priority activities to be implemented include: 1. Establish youth friendly corners in the 16 target districts, and train providers to provide YFHS 2. Print and disseminate the Adolescent Strategy (Hold a 2 day national workshop to disseminate the Adolescent Strategy). 3. Train teachers and peers to impart skills for behavior change to students and teachers. 4. Conduct peer-led outreaches in 1,500 primary, secondary and tertiary schools all over the country. The output of the outreaches is formation or reactivation of school HIV/AIDS clubs (Funded by UNFPA, CSF and USAID) 5. Conduct BCC outreaches for out of School youth 6. Use social media: Face book, twitter, short text messaging for BCC for students in tertiary institutions Funding Request from this GF grant for BCC: 1. Establish youth friendly corners in the 16 target districts, and train providers to provide YFHS 2. Print and disseminate the Adolescent Strategy (Hold a 2 day national workshop to disseminate the Adolescent Strategy). 3. Train selected teachers and peers in the targeted districts to impart skills for behavior change to students and teachers: training to address comprehensive HIV prevention and RMNCAH issues including early pregnancies, SGBV, and alcohol/drug abuse issues (alcohol and drug abuse are major problems in fishing communities and exacerbate risky behaviors) 4. Conduct BCC outreaches for out of School youth in the selected districts 5. Technical assistance to develop and translate IEC materials 6. Pilot electronic based platforms for youth in tertiary institutions countrywide

Condoms part of programs for adolescent and youth	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			USG, UNFPA, Global Fund, Civil Society Fund
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Condom programming for older youth (18-24) Education and availability and distribution of condoms through peers, youth friendly corners, and through entertainment venues. Funding request: Integrated into BCC for youth and condom programming for adults in the general population

HIV testing and counseling as part of programs for adolescent and youth	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0			USG, Global Fund, GOU, Civil Society Fund
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target population: Adolescents and youth target audience projected at 12,685,216 people aged 10-24 years all over the country (16 priority districts—fishing communities around Lake Victoria and Lake Kyoga). Context: It is estimated 110,000 adolescents are to be living with HIV in Uganda. Youth are targeted by the national HIV testing program (MOH HCT Guidelines, page 16). However, access to testing among youth is limited. Implementation approach: The Ministry of Health (MOH) AIDS Control Program will work closely with the other MOH health departments; maternal and child health (School health), Reproductive health division, and the Ministry of Gender, Labor and Social Services and Ministry of Education to address HIV programming for adolescents and youth. Other stakeholders will include District health teams, health facility and community workers. Under MOH Reproductive Health division, there is an adolescent health program that builds capacity of health facilities to plan, implement and monitor adolescent and youth friendly health services. The focus will be to scale up a comprehensive prevention package that integrates HIV testing. Priority activities to be implemented include: 1. Demand creation for HTC: Using music and drama festivals and engagement of local musicians and celebrities, and sports galas 2. Providing HTC services in youth friendly corners and adolescent friendly services, and enhance linkage to HIV care and prevention services 3. Integrating SGBV and comprehensive RMNCAH services Funding request: costed under BCC for youth and general population HTC

RMNCH linkages and GBV as part of programs for adolescent youth	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	10,368	0			UNFPA, UNICEF, GOU, USG, Civil Society Fund
		Above	357,264	551,116	571,304			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target population: Adolescents and youth including young girls and young key populations projected at 12,685,216 people aged 10-19 and 20- 29 years all over the country (16 priority districts—fishing communities around Lake Victoria and Lake Kyoga). Context: Uganda has one of the highest teenage pregnancy rates in sub-Saharan Africa- 24% of adolescent girls become pregnant before 19 years, and close to 50% marry before 18 years. Early marriage and initiation of sex with inadequate SRH information increases risk of HIV infection (UDHS 2011 page 158). Overall, 3% of adolescent girls 15-19 years live with HIV and prevalence doubles by 24 years (7.1%), UAIS 2011. Adolescent girls are faced with GBV including sexual abuse, have limited access to education, health and social protection services. Implementation approach: Integrated RMNCAH services with strong HIV prevention package. Integrated package will include HIV prevention, FP cervical cancer screening, maternal and child health services, post-abortion care at facilities providing adolescent friendly services. There will be at least one health worker trained in provision of adolescent friendly services at each of the facilities in the selected districts. Education and information about sexual and reproductive health will be availed using trained health workers and peers. Priority activities to be implemented include: 1. Provide counseling, management and referral services for SGBV survivors, including GBV counseling, HIV testing, PEP, etc. 2. Engage boys to address cultural norms, beliefs and practices (male masculinity) that impede uptake of SRH services and to access SMC, through various avenues (peers, teachers, parents) 3. Provide SRH with integrated service package Integrating HIV and PMTCT services for adolescents into existing adolescent SRH and other services 4. Develop, print and distribute translated IEC materials 5. Health education and life skills training for adolescent and youth leaders and teachers 6. Enhance capacity of the health workers through trainings and on site mentorship and supervision to offer comprehensive adolescent friendly services. Funding request: Integrated into BCC for youth

Module: PMTCT

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline N# / D#	Baseline %	Baseline Year	Baseline Source	Total Targets	Year 1 N# / D#	Year 1 %	Year 2 N# / D#	Year 2 %	Year 3 N# / D#	Year 3 %	Year 4 N# / D#	Year 4 %
PMTCT-2: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Ministry of Finance, Planning and Economic Development of Uganda	National program	101,283.0 / 119,156.0	85.0	2013	HMIS	Allocation + Other Sources	95,596.0 / 122,009.0	78.4	100,455.0 / 124,882.0	80.4	78,044.0 / 126,434.0	61.7	78,224.0 / 126,901.0	61.6
							Above+Allocation+Other sources	116,001.0 / 122,009.0	95.1	119,256.0 / 124,882.0	95.5	120,446.0 / 126,434.0	95.3	119,626.0 / 126,901.0	94.3
Comments [1]	Anticipated rate of scale-up: From 85% to 95% ART coverage of HIV infected pregnant women. National coverage targets are based on Investment Case and NSP Mid-Term Review. Population size estimates: The estimated number of HIV-positive pregnant women is derived from SPECTRUM Estimated Population Projections 2014-2020. Annual pregnancies are about 1.5 million, and HIV prevalence 6.5% among pregnant women. Data source: Numerator is derived from the HMIS. The estimated number of HIV-positive pregnant women (denominator) is derived from SPECTRUM Estimated Population Projections 2014-2020. Annual pregnancies are about 1.5 million, and HIV prevalence 6.5% among pregnant women.														
PMTCT-3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Ministry of Finance, Planning and Economic Development of Uganda	National program	25,136.0 / 115,599.0	21.7	2013	HMIS	Allocation + Other Sources	50,000.0 / 97,607.0	51.2	55,000.0 / 99,905.0	55.1	30,000.0 / 101,147.0	29.7		
							Above+Allocation+Other sources	97,607.0 / 122,009.0	80.0	99,905.0 / 124,882.0	80.0	101,147.0 / 126,434.0	80.0		
Comments [1]	Anticipated rate of scale-up: From 38% to 80% assuming better retention and access to EID testing services. National coverage targets are based on Investment Case and NSP Mid-Term Review. Population size estimates: Of the estimated mothers in need of PMTCT, about 5% may not attend ANC, and 15% may suffer a miscarriage. The number of HIV exposed infants requiring virological testing is a fraction of this. As per EPP 2014-2020, the estimated HIV positive mothers in need of PMTCT is 115,599 (2013), 118,743 (2014), 122,009 (2015), 124,882 (2016), 126,434 (2017), 126,901 (2018). Description of indicator/package of services: Package of services includes HIV testing and counseling for all pregnant and lactating women attending ANC, labor and postnatal clinics, provision of lifelong ART (Option B+) within MCH setting, BCC, promotion of condom use, STI care. Data source: Numerator is derived from the MOH EID Data base. Denominator 95% women attending ANC and adjusting for miscarriage in 15%														

Module budget - PMTCT

Allocated request for entire module	USD 353,119	Above allocated request for entire module	USD 1,727,503

Intervention	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Monitoring and Evaluation (M & E)	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						USG, Global Fund, GOU, Joint UN Program (UNICEF, UNFPA, WHO)
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						

(Intervention budget (request to the Global Fund only) spans Total Targets through Year 4.)

Description of Intervention [2]

Monitoring and Evaluation (M & E) Ensuring data quality has been a challenge with the current multiple reporting tools and PMTCT codes. Data use is still limited especially at facility level and district leadership level. Priority activities moving forward will include: - Basic data collection during mentorship and supervision visits - Quality Improvement workshops that are integral components lifelong ART for pregnant and lactating women - Printing of the revised HMIS tools to be used for patient monitoring – these include the Integrated ANC/Maternity/ PNC registers; Pre-ART and ART registers; ART cards; EID register; and Infant clinical chart - Printing of the new longitudinal register to be rolled out in a phased manner with a view of replacing the integrated ANC register. - Strengthen community-based reporting systems- VHT HMIS reporting tools and Family Support Group guidelines and registers constitute key monitoring tools for the eMTCT Continuum of Response & Strengthening Retention and adherence to care: This will focus on: - Establishing a system of “District Response Teams” to provide district-level technical support to improve retention, adherence, and linkages among HIV-positive women and their infants - Working with IPs to ad0pt an existing training program and develop an SOP for retention monitoring targeted at Option B+ sites and mother-baby care points Strengthening the supply chain management system for HIV Commodities and supplies to support PMTCT: Stock out of HIV test kits and irregular supplies of ARVs contribute to missed opportunities for PMTCT interventions. Mitigation actions will include continuous strengthening of the supply chain systems, improved forecasting and ordering procedures both at health facility and national level. Strengthening EID services: Uptake of EID services is not optimal and many HIV-exposed infants are being captured after 2 months of age which has led to delayed opportunity to establish HIV sero-status and deliver appropriate interventions especially ARVs. Linkage to care for the HIV exposed infants remains low as only 65% given cotrimoxazole within two months of birth (SAPR 2014), 37% receive EID within 8 weeks of birth and 34% of infants born to HIV-positive women received ARVS for prophylaxis (SAPR 2014). This is reflective of the suboptimal retention of the mother-baby pair. To address retention of mother and baby pairs, focus areas adopted by the country include: - Establishing the mother baby care points at all PMTCT sites - Implementing other retention strategies e.g. SMS reminders, community support interventions like FSG,VHT and linkage facilitators - Providing health education messages to emphasize EID testing within 8/52 of birth

Prong 1: Primary prevention of HIV infection among women of childbearing age	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	70,488	0				
		Above	70,488	70,488	35,244			
	The AIDS Support Organisation (Uganda) Limited	Allocation	141,403	24,066				
		Above	141,403	175,864	175,864			

Description of Intervention [2]

Target Population & Geographical scope: All women in the reproductive age group nationally Context: Primary HIV prevention is the most effective PMTCT strategy. While this is important, it has not been well emphasized and implemented in Uganda. There is a need to implement proven interventions that are spelt out in the HIV Communication Strategy and National HIV Prevention Strategy. Current PMTCT interventions largely start with pregnant women who present to the health facilities. Implementation Approach: Current bottle necks to implementing these activities include: 1. Structural barriers including the low status of women, limited education, decision-making and access to information including HIV prevention; sexual and gender based violence (SGBV) among others 2. Limited engagement and involvement of community structures to address prong 1 issues 3. Missed opportunities for integrating primary HIV prevention in Reproductive Maternal Neonatal Child & Adolescent Health (RMNCAH) services e.g. Family Planning (FP) services, male involvement, Priority activities to address primary prevention of HIV include: 1. Scaling up adolescent-friendly service delivery packages, including STI management, HCT, condom use and family planning including adolescent PMTCT care packages within the MCH setting 2. Training community extension health workers (2 per parish) who would go out and educate, testing, and return the results to the facility along clear referral mechanisms. 3. Community engagement to address structural barriers including (detailed under prevention for the general population) including promotion of uptake of HIV prevention services 4. Strengthening male involvement and couple HIV counseling and testing and test and treat for HIV infected persons in sero-discordant relationships 5. Risk reduction counseling and support for HIV negative women at various RMNCAH services including FP, ANC and other opportunities—enhancing primary prevention at all contacts with HIV uninfected women (including access to condoms and condom negotiation skills) Activities to be supported through this grant: 1. Training providers at the lower level facilities and within communities (extension workers) on primary HIV prevention strategies (including condom use), HCT, couple HCT and risk reduction interventions (to be integrated into VHT training under HSS application) 2. Promoting male involvement including couple HIV counseling and testing (training and messaging integrated into BCC under prevention for the general population) 3. Procurement of HIV test kits, condoms and other family planning methods to be used at community level (for populations out of school, in higher education institutions, prisons and military communities and other eligible populations (budgeted under HIV prevention for the general population module)

Prong 2: Preventing unintended pregnancies among women living with HIV	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	22,872	0				
		Above	22,872	31,897	31,897			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	94,290				
		Above	0	94,290	94,290			

Description of Intervention [2]

Target Population & Geographical scope: All HIV positive women of reproductive age group and their partners. Context: The unmet need for Family Planning (FP) remains high (34%) and contraceptive prevalence rate is also low at 30% (UDHS 2011). FP provision is mainly facility-based up to HC II (mainly through post-natal and MCH clinics). Integration of FP into HIV services has been initiated based on the National Sexual and Reproductive Health (SRH)-HIV Integration Strategy. However, there are still some challenges and missed opportunities. Staffing challenges (numbers and skills) limit provision of FP to HIV-infected men and women. Other factors include cultural/religious beliefs and persistent myths, and low male involvement. Implementation Approach: To implement the SRH-HIV Integration strategy including FP counseling and support at all points of contact with HIV infected men and women (HIV care, ANC, labor and delivery, post natal, Young Child Clinics such as immunization services) and HIV testing in MCH settings. Some of the proposed priority activities include: 1. Strengthening capacity of health workers to provide FP services including counseling, skills to provide long-term and other FP methods 2. Integration of FP services at various HIV service delivery points including ART clinics, the Mother-Baby Care Points, HTC services, and HIV testing within MCH settings. 3. Procurement of FP commodities and strengthening the FP supply chain (supported by World Bank and GOU) 4. FP/HIV/RH IEC/BCC messaging: Disseminate more IEC materials and FP commodities to the communities 5. Conducting a study to determine the unmet need for FP among women living with HIV (explore integrating into the next AIDS Indicator Survey (AIS). Activities to be supported through this grant: 1. Integrated training and mentorships for providers (training integrated with other PMTCT prongs) 2. Integrated support supervision and mentorship for FP activities 3. Establishing Youth Friendly FP services – also mentioned under ART and Care 4. Conducting baseline study on unmet need for FP among women living with HIV

Prong 3: Preventing vertical HIV transmission	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0				
		Above	0	0				
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	0	0				

Description of Intervention [2]

Target Population & Geographical scope: All women in Reproductive Maternal Neonatal Child & Adolescent Health (RMNCAH) settings nationally, their partners and babies Context: Uganda is implementing PMTCT in alignment with the global Elimination of Mother to Child Transmission (eMTCT) strategy including life-long ART for HIV-infected pregnant and lactating women. Uganda has scaled up PMTCT services to 3248 sites countrywide (DHIS2, June 2014). HCT coverage among antenatal care (ANC) attendees is >95% while ART coverage is 85% (101,283/119,801) (DHIS2 data June 2014). One of the outstanding challenges in PMTCT is the retention of Mother-Baby pairs, in the continuum of care. While 95% of mothers attend one ANC visit, only 47.6% attend 4 or more ANC visits (UDHS 2011). The percentage of births attended to by skilled health personnel is only 58% (UDHS 2011). Furthermore, early infant care for HIV exposed infants still lags behind other MCH indicators; only 39% of HIV-exposed infants access EID within 8 weeks of birth (June 2014 EID Database). Other challenges include stock-out of HIV test kits, Nevirapine syrup, and maternal ARVs. Stock out of syphilis kits is also common (only 6% of ANC women in 2013/14 had a syphilis test). Implementation Approach: Strategies 1. Strengthen community mobilization (through VHT, mentor mothers, mentor fathers, family support groups) for early and sustained ANC attendance and facility deliveries by expectant mothers 2. Strengthen Procurement and Supply Chain Management (PSM) for HIV test kits, ARVs for the mothers and babies, and drugs for opportunistic infections Priority interventions to support prong 3 implementation will include: 1. Implement Provider Initiated HIV testing (and partner testing), timely ART, enhance retention and adherence, and male involvement. Women identified as HIV negative will be offered repeat testing in later pregnancy, labor or postnatal to exclude new HIV infections acquired during pregnancy. 2. Integrate TB screening and treatment into all PMTCT prongs. Activities for integration of TB/HIV services in maternal health settings will include a) Screening of all pregnant women living with HIV at each encounter preferably within the MNCAH platform. If the woman is diagnosed with TB disease, anti-TB therapy will be initiated within the MNCAH platform; b) Provision of IPT if active TB disease is ruled out. 3. Other services to be provided include testing for syphilis, Hb estimation, urinalysis, and OI prevention and management. 4. Accreditation of private Health Facilities (HF) for ART and PMTCT provision (to be supported by other in-country partners) Activities to be supported through this grant: 1. Procurement of commodities including HIV test kits, syphilis rapid test kits, ARVs, cotrimoxazole, Hb estimation supplies, urinalysis, 2. Strengthening the PSM to selected facilities to make correct and timely requisitions for HIV test kits (under HSS application). 3. Capacity building for TB integration in MCNAH settings (to be covered by other partners)

Prong 4: Treatment, care & support to HIV+ mothers, their children & families	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0				USG, Global Fund, GOU, Joint UN Program (UNICEF, UNFPA, WHO)
		Above	0	391,453	391,453			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	0	0				

Description of Intervention [2]

Target Population & Geographical scope: All post-natal women living with HIV, their HIV-exposed infants, partners, and other family members Context: Prong 4 is an essential component of the continuum of care for HIV infected postnatal mothers, their exposed infants and families. Major achievements include rapid scale-up of PMTCT services (3,248 facilities), new guidelines for life-long ART rolled out throughout the cou+D134ntry and establishment of the EID in all districts (> 1900 facilities linked to EID services). However, several gaps remain largely related to linkage, retention, and adherence to treatment. For example, ANC attendance four times is 47%, facility deliveries is 58% (UDHS 2011), only 38% of exposed infants receive EID within 8 weeks of birth while 65% of exposed infants initiate cotrimoxazole at 6 weeks of age(DHIS2 June 2014). Major bottlenecks to retention include poor health seeking behavior related to delivery at facilities and postnatal care attendance, transition from MNCH to HIV chronic care, low male involvement (less than 20% of males accept HCT) and low HIV status disclosure, limited psychosocial support, and inadequate community systems for follow-up. Implementation Approach: Interventions to address prong 4 gaps 1. Community mobilization coupled with improved quality of services to enhance sustained ANC attendance, facility-based deliveries and postnatal attendance 2. Educate communities to reduce HIV stigma, increase uptake of testing including couples HIV testing and HIV status disclosure 3. Male involvement: Male-friendly services and use of mentor fathers for mobilization 4. Promote retention of Mother-Baby pairs – establish Mother-Baby care points, promote POC technology for rapid results delivery, strengthen community systems including support groups for adherence and retention 5. Strengthen capacity of providers to deliver quality postnatal services 6. Strengthen EID and linkage to care for children (cotrimoxazole, ART, TB screening and management) 7. Enhance RMNCAH linkages: Cervical cancer screening and FP for women, HIV testing within YCCs Priority interventions to be funded by Global Fund grant: 1. Community system strengthening (for demand creation, service uptake, male involvement, retention and adherence support): under CSS module for TB-HIV and application 2. Conduct PMTCT impact evaluation study

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Programmatic Gap

Coverage Indicator : PMTCT-2: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

Current National Coverage 85%	Year	Source	Latest Results		
	2013	HMIS			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	122'009	124'882	126'434		The estimated number of HIV-positive pregnant women is derived from SPECTRUM Estimated Population Projections 2014-2020. Annual pregnancies are about 1.5 million, and HIV prevalence 6.5% among pregnant women.
B. Country targets (from National Strategic Plan)	109'808 90.00 %	118'638 95.00 %	120'112 95.00 %	%	The target is 95% of the national estimated number of HIV infected pregnant women (NSP). This target includes pregnant women already on ART before current pregnancy. According to the Estimates and Projections 2014-2020, the proportion of HIV-infected pregnant women already on HAART before current pregnancy was projected to be 33% in 2014, 38% in 2015, 42% in 2016, 47% in 2017, and 51% in 2018. Only the newly diagnosed HIV infected women require treatment initiation.Assuming ANC attendance,PICT in ANC, labour and post-natal, facility delivery, and availability of supplies
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	74'596 61.14 %	77'455 62.02 %	78'224 61.87 %	%	Assuming a proportion of the targeted women are already on ART before current pregnancy, GOU is flat lined, and PEPFAR initiates ART for about 30,000 annually. NB: These numbers are also included in the national ART numbers.
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	47,413 38.86 %	47,427 37.98 %	48,210 38.13 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	21'000 17.21 %	23'000 18.42 %	0 0.00 %	%	A proportion of pregnant women who need to be initiated on ART are included within allocation.
F. Coverage from Allocation amount and other resources C+E	95,596 78.35 %	100,455 80.44 %	78,224 61.87 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	20'405 16.72 %	18'801 15.06 %	42'402 33.54 %	%	A proportion of pregnant women who need to be initiated on ART are included above allocation.
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	116,001 95.07 %	119,256 95.50 %	120,626 95.41 %	0 0 %	To achieve the 95% coverage for ART among pregnant women, CCM is requesting funding to support an estimated 1 - 24% of women within allocation over the years, and another 17 - 10% above allocationb over the years assuming GOU and PEPFAR support is maintained.

Coverage Indicator : PMTCT-3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

Current National Coverage 30%	Year	Source	Latest Results		
	2013	HMIS			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	97'607	99'905	101'147		Based on the 95% women attending ANC and adjusting for miscarriage in 15% of pregnancies. Of the estimated mothers in need of PMTCT, about 5% will not be reached and 15% may suffer a miscarriage. As per EPP 2014-2020, the estimated HIV positive mothers in need of PMTCT is 115,599 (2013), 118,743 (2014), 122,009 (2015), 124,882 (2016), 126,434 (2017), 126,901 (2018)
B. Country targets (from National Strategic Plan)	50'000 51.23 %	79'924 80.00 %	80'918 80.00 %	%	The target is to have 80% of HIV-exposed infants tested within 2 months of birth. This will require programmatic support for improved retention of mother baby pair and linkage to EID services. Babies seen after 2 months of age (but below 18 months) will also be offered EID.
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	30'000 30.74 %	30'000 30.03 %	30'000 29.66 %	%	The number of infants tested below 2 months of age was 25,136. The estimated number of HIV-exposed infants in 2013 was 115,599 giving an EID coverage of 38.7% below 2 months of age. The total number of infants who received a virological test was 44,743 of which 56% was below 2 months of age. In 2013/14, 57,424 exposed infants were tested with DNA PCR but the disaggeregation by age of infant is unavailable (DHIS2, HIBRID). Assuming existing resources are maintained over the years.
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	67,607 69.26 %	69,905 69.97 %	71,147 70.34 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	20'000 20.49 %	25'000 25.02 %	0 0.00 %	%	
F. Coverage from Allocation amount and other resources C+E	50,000 51.23 %	55,000 55.05 %	30,000 29.66 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	47'607 48.77 %	44'905 44.95 %	71'147 70.34 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	97,607 100.00 %	99,905 100.00 %	101,147 100.00 %	0 0 %	In order to achieve the NSP target of testing 50% of adults, CCM requests funding to provide HCT to 3,125,000 individuals within allocation annually and the balance from the above allocation (1.8m in 2015, 2.1m in 2016, 2.5m in 2017, 2.9m in 2018, assuming PEPFAR continues to support testing for 4 million people annually

Module: Treatment, care and support

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets									
							Total Targets	Year 1		Year 2		Year 3		Year 4	
			N # D #	%	Year	Source		N # D #	%	N # D #	%	N # D #	%	N # D #	%

Indicator	Responsible	Geographic	Baseline N/D	%	Year	Source	Type	Year 1 N/D	%	Year 2 N/D	%	Year 3 N/D	%			
TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	Ministry of Finance, Planning and Economic Development of Uganda	National program	680,514.0 / 1,475,315.0	46.1	2013	HMIS	Allocation + Other Sources	705,972.0 / 1,565,002.0	45.1	711,022.0 / 1,806,908.0	39.4	464,725.0 / 1,806,908.0	25.7			
							Above+Allocation+Other sources	892,001.0 / 1,565,002.0	57.0	1,077,020.0 / 1,806,908.0	59.6	1,259,019.0 / 1,888,859.0	66.7			
Comments [1]	Anticipated rate of scale-up: From 46% to 80% coverage assuming resources are available. Population size estimates: As per Uganda national ART eligibility guidelines the numbers eligible are as follows: 1,475,315 in 2014; 1,565,002 in 2015; 1,656,954 in 2016; 1,748,638 in 2017; and 1,841,985 in 2018. This is about 90% of all estimated HIV-infected persons. Description of indicator/package of services: ARVs, adherence support, ART monitoring, prevention and treatment of opportunistic infections. Data source: Numerator data is derived from HMIS June 2014. The denominator is the total population living with HIV is derived from ACP-MOH SPECTRUM EPP 2014-2020 modelling.															
TCS-3: Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources									
							Above+Allocation+Other sources									
Comments [1]																
TCS-4: Percentage of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug in the last 12 month	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources									
							Above+Allocation+Other sources									
Comments [1]																

Module budget - Treatment, care and support

Allocated request for entire module	USD 98,360,185	Above allocated request for entire module	USD 225,212,518

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Antiretroviral Therapy (ART)	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	40,817,435	49,171,177				
		Above	53,060,482	82,056,188	69,707,101			
Description of Intervention [2]								
Target population and geographical scope: All antiretroviral therapy (ART) -eligible clients as per the National Care and Treatment guidelines (2011) and Addendum (2014) countrywide Context: The goal of ART is to reduce HIV-related morbidity and mortality, improve quality of life, and reduce risk of HIV transmission. In 2013, Uganda adapted the WHO 2013 ART guidelines using the CD4 threshold of 500 for adults, ‘test and treat’ for selected categories of clients including: a) HIV infected pregnant and lactating women; b) HIV infected children <15 years; c) TB-HIV co-infected patients; d) co-infection with hepatitis B with chronic liver disease; e) HIV infected partners in sero-discordant relationships; f) selected MARPs including sex workers, MSM, fisher folk. The choice to adapt these guidelines was determined based on several modeling assumptions (in the HIV Investment Case) that led to selection of the scenario that were most effective in averting new HIV infections, reducing mortality, and long-term cost savings. In the case of children, the decision was based on gaps in CD4 testing for eligibility determination and need to enhance retention. By June 2014 there were 1603 active ART facilities countrywide. Major challenges include low ART coverage that stands at 46% (680,514/1,475,315), and lower coverage for some populations, especially children (28%), TB/HIV co-infected clients (56%) and key populations. Although the MoH has adopted viral load monitoring, its availability is still limited. Implementation approach: Strategies 1. Rapid scale-up of ART to reach 80% coverage by 2018 per the Investment Case. 2. Enhance patient retention and adherence support Priority activities: 1. Enhance capacity and accredit more ART sites especially targeting all HC III and all PMTCT sites 2. Procurement of drugs and laboratory commodities: Viral load testing, CD4 reagents, hematology, chemistry for ARV services 3. Develop specific programs/models that target children, adolescents, and MARPs (truckers, fisher folks, CSW and MSM), and sero-discordant couples to ensure implementation of ‘test and treat’ and sustained ART adherence. a. Identify, support and accredit lower level facilities in under-served communities such as fishing communities and enhanced support for outreach services (e.g. Islands from the districts of Kalangala, Mukono, Buikwe, Buvuma, Namayingo, Wakiso, Mayuge, Kayunga). b. Capacity building for health providers to ensure quality services for key populations such as commercial sex workers and MSM 4. Provide Post Exposure Prophylaxis for health care workers and survivors of SGBV (rape victims) 5. Promoting integration of TB and ART treatment to create one-stop-centres. 6. Strengthen systems to support ART especially supply chain management, reporting, quality improvement, services integration, and community systems Funding request: 1. Procurement of ARV drugs and laboratory reagents 2. Enhanced capacity and accreditation of sites and infrastructural upgrading of facilities and outreaches in the fishing communities 3. Drug resistance surveys								
Counseling and psycho-social support	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
Description of Intervention [2]								
Target population: Clients in HIV care, clients on ART, their family members Geographical scope: Countrywide at all sites providing HCT, HIV care, ART, SMC, at facilities and in communities. Context: Psychosocial support and counselling are essential elements of PLHIV chronic care, ensuring retention in care, adherence to treatment and reduction in new infections (through risk reduction counselling). Challenges include limited counseling staff especially at high volume clinics, capacity gaps in provision of nutritional counseling and support, and weak linkages with other social services (e.g. legal and food, poor). Priority interventions: 1. Train providers at health centre level in provision of psychosocial support and counselling 2. Develop and implement staffing norms for recruitment of counsellors in facilities providing HIV services from HCIV and above 3. Procure nutrition commodities especially therapeutic foods 4. Linkages with other services such as legal support, sustainable livelihood and to income generating activities 5. Procure anthropometric measurement equipment for all health units 6. Support infant and young child feeding Funding request: This will be covered by other country partners								

Pre-ART care	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	4,073,237	4,298,336				
		Above	5,089,621	6,025,816	7,153,365			
Description of Intervention [2]								
Target population and Geographical scope: All PLHIV enrolled in pre-ART care Context: Pre-ART care is a critical component of chronic HIV care aimed at reducing morbidity and mortality while contributing to HIV prevention. Pre-ART care includes provision of ongoing psychosocial support, prevention and management of opportunistic infections (OIs), assessment and preparation for ART initiation. A Basic Care Package for Uganda has been defined to include cotrimoxazole prophylaxis, family-based HCT and care, safe water interventions and condoms, TB screening and monitoring disease progress for ART eligibility. Pre-ART care is provided at facilities countrywide up to HCIII and some selected HCIIs. By June 2014, 1721 public and private facilities were providing care to about 963,272 clients (62% of PLHIV) of whom 680,514 were on ART (MOH ART quarterly report January -June 2014). While over 80% of clients in care receive cotrimoxazole prophylaxis and regular TB screening, CD4 coverage is estimated at only 60% and TB case finding is low. In addition, there is a low enrollment of males, children, adolescents, MARPS; and inadequate integration of TB and FP. Implementation approach: Priority strategies and activities: 1. Enhance strategies for diagnosing (PITC and targeted community testing for high-risk/high prevalence groups) and timely linkage to care 2. Implementation of TB Intensified Case Finding (ICF) guidelines in pre-ART care and rollout the IPT guidelines 3. Improve utilization of GeneXpert to enhance TB diagnostic yield 4. Strengthen RMNCAH linkages (cervical cancer screening, FP and safer conception support/counseling, STI diagnosis and treatment, adolescent friendly services) 5. Ensure timely eligibility assessment for adults, including clinical and CD4 testing 6. Nutrition assessment, counseling and support 7. Strengthening retention in care: Through strong community systems for retention, such as SMS messaging, flexible appointments and increasing access to point-of-care diagnostics. Funding request: 1. Procurement of HIV commodities including CD4 reagents, condoms, cotrimoxazole, isoniazid; cryptococcal antigen lateral flow assay, anti-TB drugs; TB infection control masks & respirators; GeneXpert cartridges 2. Strengthening community systems to support linkage and retention in care (under CSS)								
Prevention, diagnosis and treatment of opportunistic infections	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
Description of Intervention [2]								
Target population and geographical scope: All clients enrolled in HIV care (Pre-ART and on ART) at health facilities providing HIV care and / or TB care Context: The management of opportunistic infections (OIs) is a crucial element of chronic care to ensure the prevention, timely diagnosis and treatment of life threatening OIs, improve quality of life, and survival of PLHIV. This package of care is provided in a continuum at facility and community levels and in home based care settings. At every visit, clients are assessed for OIs and treated if necessary. A Basic Care Package comprising of safe water vessel, ITN, condom and cotrimoxazole is also recommended. Current challenges include: Lack of OI diagnostics and medications for treatment especially cryptococcal infection diagnostics, and TB diagnosis in adults and children and limited capacity for screening for cervical cancer. Implementation Approach: All PLHIV enrolled in care will be initiated on cotrimoxazole or dapsone prophylaxis for life (in line with national guidelines). Furthermore, in the new ART prevention and treatment guidelines, pre-emptive treatment for latent cryptococcal infection with fluconazole is recommended and will be provided for clients with CD4 less than 100 cells/ul. Because of increased risk of cervical cancer among PLHIV (Sekirime et al), cervical screening will be integrated. In order to prevent occurrence of TB, Isoniazid Preventive Therapy (IPT) will be given to all newly-enrolled HIV-infected adults and children with no signs and symptoms of active TB. It is also anticipated that earlier treatment initiation will contribute to reduction in incident TB and other OIs. Priority strategies to address challenges: 1. Strengthen supply chain for OI diagnostics and medications 2. Build capacity for management of OIs and non-communicable diseases such as cervical cancer Funding Requested for: 1. Procure of OI medications including - cotrimoxazole (and dapsone), fluconazole, isoniazid, anti-TB medications. 2. Procure OI diagnostics: lab equipment, cryptococcal Ag testing kits Lateral Flow Assay, HBV screening kits to identify co-infected clients that require ART irrespective of CD4, TB screening and diagnosis (sputum smears, GeneXpert cartridges) 3. Procure basic care package components (Water Guard-disinfectant, Mosquito nets and Condoms).								
Treatment adherence	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	59,600	44,700	22,350			
Description of Intervention [2]								
Target population and Geographical scope: All clients enrolled on HIV treatment countrywide at all facilities providing ART (1603 as of June 2014) and labs performing ART monitoring tests Implementations approach: In order to ensure good treatment outcomes, it is essential to monitor treatment progress for patients. ART monitoring is achieved through clinical and laboratory methods (CD4 and viral load testing). A patient monitoring system is in place as part of the HMIS to monitor longitudinal treatment outcomes. CD4 and viral load (VL) testing is done through the laboratory hub system and POC CD4 equipment. However, there are significant gaps in access to CD4 monitoring; at initiation 50% get a CD4 count declining to <30% after one year. Recently the country has adopted VL monitoring for ART and will progressively shift from CD4 to VL monitoring in a phased manner. Through funding from GF Round 7 cost extension and PEPFAR, up to 100,000 VL tests will be performed in 2014/2015. Scale-up thereafter will be 200,000 tests in 2015/16, 400,000 in 2016/17, and up to 1,000,000 tests by 2017/18. VL will be performed 6 months after ART initiation and annually thereafter. CD4 monitoring (6 monthly) will be phased out as the VL coverage is brought to scale. With the increasing number of ART patients, there is concern about treatment failure and HIV Drug Resistance (HIVDR). There is a large number of patients who have been on treatment for over 5 years. Currently, 3.3% of all adult and 6.5% of pediatric ART clients are on second line ART. There is need to develop enhance HIVDR testing. Priority Interventions include: 1. Strengthen capacity for VL monitoring – procure equipment, reagents, and train providers. This should contribute to strengthening of the laboratory sample referral and transport network 2. Capacity building to identify and manage treatment failure and strengthening drug resistance monitoring strategies 3. Prevention and monitoring of ART drug resistance 4. Review and update the National HIV drug resistance and Monitoring Strategy and costed plan Funding request: Activities to be supported through this grant include: 1. Procurement of viral load and HIV drug resistance testing supplies/bundles2. Procurement CD4 reagents 3. Strengthening the lab-hubs through equipment procurement (especially heavy duty printers), equipment maintenance, human resource and reagents.(in HSS) 4. Conduct HIVDR monitoring studies to inform program 5. Review and update the National HIV drug resistance Prevention and Monitoring Strategy and costed plan 6. Conduct pre-ART and ART drug resistance and Early Warning Indicator (EWI) surveys								
Treatment monitoring	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0				
		Above	500,099	505,848	505,848			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	160,500	214,000	107,000			
Description of Intervention [2]								

Target population and Geographical scope: All clients on antiretroviral therapy attending at accredited ART, TB and PMTCT sites and at community level and all health facilities providing HIV, TB or PMTCT nationally. Impact: Good adherence is vital for viral suppression, reduced risk of OIs, and better treatment outcomes with reduced risk of HIV transmission. Adherence reduces the risk of treatment failure, and switching to more costly ART regimens and prevention of HIVDR. Context: Adherence strategies in place include: adherence counseling (with enhanced counseling for clients with sub-optimal adherence) and adherence assessment using self-report and pill counts. Because of the high coverage of mobile phone network (National coverage of 70%, 2011 UDHS), initiatives to use mobile phone calls and SMS reminders have been implemented at some facilities to enhance adherence. Other adherence strategies include use of peer support groups, expert clients, treatment supporters etc. With rapid scale-up of treatment, earlier initiation of treatment, limited human resource, there are anticipated challenges of adherence to HIV treatment (and a need to use community structures to augment health worker capacity). Other challenges include inadequate assessment and documentation of adherence as well as weak community follow-up mechanism. In a rapid assessment of ART adherence from a randomly selected sample of 100 facilities conducted in August - September 2014, 68% of active ART clients had adherence assessment performed and documented on their cards. Of these, 90% had good adherence, 7% had fair adherence and 3% had poor adherence. (MOH Jan-June 2014 ART Semi-annual report, October 2014). Implementation approach: Priority activities: 1. Conduct a comprehensive evaluation of adherence monitoring and retention 2. Strengthen routine assessment and recording of adherence in the medical records through QI approaches 3. Finalize and rollout national treatment adherence strategy 4. Implement effective evidence-based adherence support interventions such as SMS reminders 5. Strengthening psycho-social and adherence support groups at facilities and communities Funding request: 1. Conduct a comprehensive evaluation of adherence monitoring and retention 2. Strengthen psycho-social and adherence support groups at facilities and communities 3. Conduct facility based out reaches to track lost to follow-up 4. Procure airtime for follow of lost patients

Programmatic Gap

Coverage Indicator : TCS-1: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV

Current National Coverage 46%	Year	Source	Latest Results		
	2013	HMIS			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	1'720'650	1'806'908	1'888'859		The total population at risk are all projected HIV positive in the country using ACP-MOH SPECTRUM 2014 March model. For 2014 , this was 1,631,828. The ART eligible clients as per the new national guidelines are 1,475,315 (for 2014); 1,565,002 (for 2015); 1,656,954 (for 2016) ; 1,748,638 (for 2017) and 1,841,985 (for 2018). The estimated population increases over the years as people on ART live longer, while new infections continue to occur.
B. Country targets (from National Strategic Plan)	892'051 51.84 %	1'077'020 59.61 %	1'259'019 66.66 %	%	The NSP target is to achieve 90% ART coverage by 2020. The country targets were based on eligible ART as per the National New guideline (reference Integrated National guideline on ART , PMTCT and infant and Young child feeding Oct 2011 and Addendum to the National ART treatment guidelines December 2013- page 13 and 14). These differ slightly with the ones generate by the module, which takes all HIV infected as the denominator; The country program targets based on ART eligibility are 2014-50%, 2015-57%, 2016-65%, 2017- 72% and 2018 - 80% to be maintained at 80% in order to attain maximum impact based on the Country Investment Case
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	464'725 27.01 %	464'725 25.72 %	464'725 24.60 %	%	This scenario assumes flatlining of GOU and PEPFAR. Support for ART is majorly from GOU, PEPFAR and GF Round 7 Costed extension which end July 2015. In 2014, contribution towards ARV procurement was as follows: GOU 16m USD, Global Fund $49,571,857; PEPFAR $60,734,600; UNITAID $2m. Assuming GOU and PEPFAR funding remains constant in absolute figures for 2014 - 2017 or 30% contribution each of 2014 total on ART. UNITAID support ends 2014. Other program activities (outside ARV procurement) are largely supported by PEPFAR and GOU. The number covered by in-country resources includes support from PEPFAR, GOU and UNITAID and is estimated at 2/3 of the current total on ART.
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	1,255,925 72.99 %	1,342,183 74.28 %	1,424,134 75.40 %	0 100 %	Assuming the GF only maintains the current costed extension numbers of 221,297 over the years and there are a few clients initaiated on ART through the PMTCT program ie 20,000 in 2015, 25,000 in 2016, 30,000 in 2017, and 35,000 in 2018.
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	241'247 14.02 %	246'297 13.63 %	0 0.00 %	%	Assuming the GF only maintains the current costed extension numbers of 221,297 over the years and there are a few clients initaiated on ART through the PMTCT program ie 20,000 in 2015, 25,000 in 2016, 30,000 in 2017, and 35,000 in 2018.
F. Coverage from Allocation amount and other resources C+E	705,972 41.03 %	711,022 39.35 %	464,725 24.60 %	0 0 %	
					An estimated 10% of PLHIV are not eligible for ART using the national guidelines. For example in 2014, estimated HIV infected is 1,631,828 but

					the eligible number is 1,475,315. Secondly about 40% of PLHIV are not in HIV care: The number in care as of June 2014 was 900,000/ 1,475,315 (65%). To achieve 75% ART coverage among all infected by 2018, CCM is requesting funding within allocatin to maintain 221,297 on ART and
G. Targets to be potentially financed by above allocation amount	186'029 10.81 %	365'998 20.26 %	794'294 42.05 %	%	

					additional funding above allocation to support 206,029 in 2015, 390,998 in 2016, 572,997 in 2017, and 787,566 in 2018 assuming GOU and PEPFAR mainatina existing contributions as of 2014.
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	892,001 51.84 %	1,077,020 59.61 %	1,259,019 66.65 %	0 0 %	This above allocation estimate reflects the scale-up plan in NSP and Investment Case. Priority should be given to PMTCT and Paediatric need for ART. The numbers to be prioritised would be as follows: In 2015 (70,155 pregnant women and 22,704 children); In 2016 66,187 pregnant women and 18,506 children); In 2017 (61,320 women and 13,953 children); In 2018 (55,836 women and 11,549 children). These estimates are derived from the MOH-ACP Estimates and Projections 2014-2020.

Module: TB care and prevention

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline N # / D #	Baseline %	Baseline Year	Baseline Source	Total Targets	Year 1 N # / D #	Year 1 %	Year 2 N # / D #	Year 2 %	Year 3 N # / D #	Year 3 %	Year 4 N # / D #	Year 4 %
DOTS-1a: Number of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses	Ministry of Finance, Planning and Economic Development of Uganda		44,934		2013	R&R TB system, quarterly reports	Allocation + Other Sources	47,181		48,750		50,700			
							Above+Allocation+Other sources	47,181		48,750		50,700			
Comments [1]															
DOTS-2b: Percentage of bacteriologically confirmed TB cases successfully treated (cured plus completed treatment) among the bacteriologically confirmed TB cases registered during a specified period	Ministry of Finance, Planning and Economic Development of Uganda		19,260 / 24,916	77	2012	R&R TB system, yearly management report	Allocation + Other Sources	17,269 / 22,140	78	17,234 / 21,815	79	17,614 / 21,481	82		
							Above+Allocation+Other sources	17,269 / 22,140	78	17,234 / 21,815	79	17,614 / 21,481	82		
Comments [1]															
DOTS-1a: Number of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															
DOTS-1b: Number of notified cases of bacteriologically confirmed TB, new and relapses	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															
DOTS-2a: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															

Indicator	Organisation			
DOTS-2b: Percentage of bacteriologically confirmed TB cases successfully treated (cured plus completed treatment) among the bacteriologically confirmed TB cases registered during a specified period	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-3: Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake smear microscopy during the reporting period	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-4: Percentage of reporting units reporting no stock-out of first-line anti-TB drugs on the last day of the quarter	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-5: Number of children <5 in contact with TB patients who began IPT	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-6: Number of TB cases (all forms) notified among key affected populations/high risk groups	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-7a: Percentage of notified TB cases, all forms, contributed by non-NTP providers - private/non-governmental facilities	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-7b: Percentage of notified TB cases, all forms, contributed by non-NTP providers - public sector	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				
DOTS-7c: Percentage of notified TB cases, all forms, contributed by non-NTP providers - community referrals	The AIDS Support Organisation (Uganda) Limited			Allocation + Other Sources Above+Allocation+Other sources
Comments [1]				

Module budget - TB care and prevention

Allocated request for entire module	USD 5,467,237	Above allocated request for entire module	USD 3,131,055

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Case detection and diagnosis	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	160,510	124,151				
		Above	393,314	380,818	287,217			
	The AIDS Support Organisation (Uganda) Limited	Allocation	11,200	79,022				
		Above	104,622	64,622	71,822			

Description of Intervention [2]

Sub-intervention 1: Increase the capacity of health workers to diagnose TB especially childhood TB at regional and district hospitals (already granted in TB SSF Phase 2 activity 1.2.3). This activity intervention will also address capacity gaps in diagnosis of clinically confirmed TB (Clinically diagnosed pulmonary TB and extra-pulmonary TB). Target Population and geographic scope: TB and HIV health workers, health workers manning outpatient departments and health workers in inpatients Implementation Approach Key activities: 1. technical working groups meetings to develop and /or review normative guidance; Print and disseminate guidelines including informing district and facility management about changed guidelines 2. All health workers at all service delivery points in the facilities will also be oriented and regularly updated on the recent TB and HIV care and prevention services including new diagnostics, their locations and the targeted group for these services. 3. Specialised training of health workers at regional and district hospitals in sample collection and equipping facilities with sputum induction apparatus 4. Facilitate the national/ regional TB trainers to conduct mentorships to regional and district hospitals on TB including childhood TB and reverse contact tracing Sub-intervention 2: Support transportation of sputum specimens from prison units without laboratories to health facilities with laboratories (Already granted in TB SSF Phase 2: Activity 4.1.3). This intervention also seeks to improve access to and utilisation of quality laboratory network and radiology services for TB diagnosis the specified target groups. Target population & geographic scope: All presumptive TB cases with emphasis on vulnerable and key populations such as HIV infected, children, urban slums, prisons, fishing communities, others. All DTUs (for TB) and ART clinics Implementation arrangement: This intervention covers diagnosis for TB through laboratory and radiological examination, availability and access to diagnostic tools including microscopy, XpertMTB/Rif and X-ray services. It also includes strengthening of sample referral system, in-service training of laboratory personnel on the use of diagnostic tools and maintenance costs. It also covers notification of laboratory results to patients and health workers. It does not cover diagnosis for DR-TB Key activities:1. PR targets to equip all district hospitals with XpertMTB/Rif machines. Priority will be to all hubs without this services. HIV high volume facilities will also be prioritized for XpertMTB/Rif. Facilities serving key populations will also be prioritized according to need. These services will be managed within the existing structure by NTLP in collaboration with Central Public Health Laboratory (CPHL). 2. Through the hub system, samples will be transferred and results returned to the referring facility. 3. The telephone and other (modern) communication technologies will also be used to communicate results to the referring facility.

Intervention	Responsible Principal Recipient(s)		Year 1	Year 2	Year 3	Year 4	Cost Assumptions	Other funding
Collaborative activities with other programs and sectors	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						

Description of Intervention [2]

Target population: 1. All TB patients attended to in Private Health Providers' (PHP) facilities in urban and peri-urban areas (especially major municipalities) of 15 districts countrywide. These include: Kampala, Wakiso, Mukono, Jinja, Buikwe, Hoima, Kabale, Mbarara, Tororo, Arua, Fort-Portal, Gulu, Kasese, Mbale and Lira. 2. Private Health Providers in facilities located in the urban and peri-urban areas. Implementation arrangements: This intervention strengthens the Public Private Mix through engaging private providers in TB care. A national situational analysis on PPM will be conducted. PPM policy framework and implementation guidelines that are to be developed during the TB SSF Phase 2 grant will be printed and disseminated. Through the Federation for Private Health Professionals, PHP professional bodies are to be facilitated to provide extra support to the NTLP through a PPP arrangement in PHP TB/HIV trainings, M&E, quality control and support supervision of PPM. More PHP/facilities will be trained on TB care and prevention, diagnostics, Logistics Management, TB/HIV and MDR-TB. PHP facilities are to be facilitated with TB IEC materials, reporting tools, quality tools, diagnostic equipment (microscopes + Gene Xperts) & reagents. Through a Public-Private-Partnership (PPP) arrangements, PHP supported facilities are to mutually provide affordable TB/HIV services to communities. PHP facilities are to be linked community support systems to facilitate Case finding, referral linkages, advocacy for PPM DOTS and treatment adherence. MOH/NTLP retain respective mandates to provide stewardship, set & maintain quality assurance, technical support and regulation in this PPM arrangement Additional activities: 1. Adapt the WHO PPM policy guidelines 2. Through the Federation for Private Health Professionals, facilitate the PHP professional bodies to provide extra support to the NTLP in TB/HIV trainings, M&E, quality control and support supervision of PPM. 3. Train additional PHP/facilities in TB care and prevention, diagnostics, Logistics Management, TB/HIV and MDR-TB. 4. Facilitate PHP facilities with TB IEC materials, reporting tools, quality tools, diagnostic equipment (microscopes + Gene Xperts) & reagents. 5. Link PHP facilities to the community support system to facilitate contact tracing, referral of presumptive TB cases, treatment adherence and advocacy for PPM DOTS. Funding request: 1.Through the Federation for Private Health Professionals, facilitate the PHP professional bodies to provide extra support to the NTLP in TB/HIV trainings, M&E, quality control and support supervision of PPM. See phase 2 2. Train additional PHP/facilities in TB care and prevention, diagnostics, Logistics Management, TB/HIV and MDR-TB. Sub-intervention 2: Implement an urban PPM TB care and prevention strategy for cities and municipalities Target population: Cities and municipalities Implementation arrangements: This intervention addresses key issues in TB care such as in adequate case finding, poor treatment outcomes in cities and municipalities partly due to low involvement of the private providers in TB care. The NTLP will evaluate the PPM model (WHO TB REACH project) that has been implemented in the five districts and this will inform the national PPM frame and scale-up strategy. The NTLP will scale up PPM in 10 municipalities with a big urban population. There will be active use of electronic and mobile technology for follow up of patients. Key activities: 1. Evaluate the urban PPM TB care model that has been implemented by partners to inform the national PPM framework. (Combine with PPM situation analysis above) 2. Consolidate PPM in the 5 districts and scale-up to 10 municipalities in 10 districts 3. Establish an electronic and mobile technology system to ease follow-up of patients in urban settings 4. Improve access to new diagnostics (e.g XpertMTB/Rif) to the private facilities through strengthening referrals and transportation system for specimens. 5. Brand private facilities providing TB care and prevention services with MoH signage (TB is curable, test here, treat here). 6. Build capacity of private facilities to access anti-TB medicines from NMS through district health services. 7. Provide support supervision and mentorship to the accredited private health facilities. 8.Provide national TB guidelines, IEC materials and tools (TB, TB/HIV, Childhood, MDR) to private facilities. 9. Strengthen the community network around private facilities to support follow up of TB patients. Funding request:1. Evaluate the urban PPM TB care model that has been implemented by partners to inform the national PPM framework. (Combine with PPM situation analysis above). 2. Consolidate PPM in the 5 districts and scale-up to 10 municipalities in 10 districts .

Intervention	Responsible Principal Recipient(s)		Year 1	Year 2	Year 3	Year 4	Cost Assumptions	Other funding
Community TB care delivery	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						

Description of Intervention [2]

Facilitate Sub-county health workers (49 districts in year 1, 80 in year 2 and 112 in year 3) (Already granted in TB SSF Phase 2: Activity 1.2.1). Build capacity of grass root civil society organizations on TB education (TB SSF Phase 2: Activity 5.2.7). Facilitate grass root civil society organizations to carry out Community TB education and social mobilization (TB SSF Phase 2: Activity 5.2.8). Implement a TB Advocacy and awareness week (one week prior to World TB day) (TB SSF Phase 2: Activity 5.2.1) Hold a 5-day TB exhibition week (TB SSF Phase 2: Activity 5.2.2) Commemorate World TB day (TB SSF Phase 2: Activity 5.2.3) Support two orientation meetings on TB, TB/HIV and MDR for health activists per year (TB SSF Phase 2: Activity 5.2.4) Target population: Patients and their families, Village health team members, linkage facilitators and CSOs/CBOs. Implementation arrangement: Empower patients, their families and communities in TB care through; • referral of presumptive TB patients to diagnostic facilities (generate demand), • supporting treatment adherence through community based treatment observation and support • conducting contact tracing (each patient will lead to activities in the family/community where the patient comes from though the VHT/community support group); • support the provision of IPT to eligible children • increase awareness in the community to reduce stigma and discrimination It includes developing and availing the materials and tools to facilitate community TB care and providing incentives to the community health workers for carrying out the community work Key activities: 1. Develop a training guide for the health workers & community support groups on how to empower TB patients and their families/communities (communications expert, TA incl. triaging, contact investigation, risk groups, key messages) 2. Orient the health workers and community support groups on TB care and communication skills using the training module (e.g. awareness raising, contact tracing & ICF) at community level 3. Supply health centres and VHTs with the necessary tools (contact tracing forms, recording and reporting tools, sputum containers, referral forms) 4. Identify, train and support a pool of TB champions (former TB patients etc.) 5. Facilitate health workers/community support groups to support TB champions, TB treatment supporters in community TB care. HIV support groups (where they exist) will be engaged to support TB case finding, contact tracing and treatment adherence. Funding request: 1.Develop a training guide for the health workers & community support groups on how to empower TB patients and their families/communities (communications expert, TA incl. triaging, contact investigation, risk groups, key messages) 2. Identify, train and support a pool of TB champions (former TB patients etc.) Advocacy for TB. Scale up expert clients from Phase 2.3. Facilitate health workers/community support groups to support TB champions, TB treatment supporters in community TB care. HIV support groups (where they exist) will be engaged to support TB case finding, contact tracing and treatment adherence. Support for the expert clients

Key affected populations	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						

Description of Intervention [2]

Strengthen on-entry screening for all new inmates in thirty five prison units (TB SSF Phase 2: Activity 4.1.1) Conduct annual mass screening of inmates in thirty five prison units (TB SSF Phase 2: Activity 4.1.2). In addition to these, NTLP targets to expand on-entry screening (TB symptom screening) to all prison facilities with or without health facilities. Target population: Most at risk populations including prisoners, HIV infected, children under 5, migrants, refugees, refugees, urban slums, fishing communities, MSM, LGBTI Implementation arrangements: Through this intervention TB care in key populations will be addressed. A situational analysis to inform the framework of TB care and prevention services will be conducted. This intervention will support identification and referral of samples from key populations without diagnostic facilities to nearby TB diagnostic facilities. Activities to link key populations to district health systems. Other activities in key populations may follow depending on the findings and need. Key activities: 1. Conduct a situational analysis on existing TB services in key populations. 2. Develop framework for improving TB services in key affected populations settings 3. Conduct on-entry or periodic mass TB symptom screening to all relevant congregate settings - prisons, army 4. Support referral of samples from key populations without laboratories to nearby TB diagnostic facilities 5. Provide TB diagnostics including LED microscopy, GeneXpert in larger most at risk populations without these services. Key populations with existing HIV care and treatment services will be prioritized. Funding request: 1 Conduct a study on situational analysis on existing TB services in key populations. 2. Develop framework for improving TB services in key affected populations settings 3. Outreaches to Expand to 226 prisons: Conduct on-entry or periodic mass TB symptom screening to all relevant congregate settings - prisons, army.

Prevention	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						
	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						

Description of Intervention [2]

Provision of Isoniazid preventive therapy (IPT) for children in contact with bacteriologically confirmed TB cases, administrative controls for infection control Target Population and geographic scope: Children contacts of all smear positive TB patients attending all DTUs Implementation arrangements: Smear positive patients are systematically identified and prioritised for contact screening. This is done with assistance of the VHT / local communities. Children of smear positive contacts are screened for TB using national guidelines and started on IPT subject to recommendations in the national guidelines. Also elaborated in the intervention describing community engagement Key activity:Provide IPT to close contacts of PTB patients prioritising children below 5 years of age and HIV-infected contacts and protect health workers and patients in health facilities through infection control

Treatment	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	2,146,686	2,945,668				
		Above	0	355,806	1,472,834			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	0	0				

Description of Intervention [2]

Target population & geographic scope: All diagnosed TB patients from all DTUs Implementation arrangement: This intervention will support treatment initiation, reduce initial loss to follow-up and adherence in all diagnosed TB patients. It addresses active follow up of patient initially lost to follow up and patients started on treatment. It also covers reconciliation of lab and unit TB registers.Expand community based DOT in collaboration with USTP and community networks Key activities: 1. Target and identify districts with poor outcomes and prioritise for interventions 2. Collaborate with USTP and community networks to implement community based DOT for these districts 3. Physical handover of all bacteriologically confirmed to the clinician for treatment initiation 4. On a weekly basis, identify initial loss to follow up and send automated text messages to these patients to return to the facility. 5. Actively trace initial loss to follow up and TB treatment interrupters (use of telephone and other (modern) communication technology, home visits); patient support 6. Introduce appointment system and mechanism to follow those patients on their scheduled appointment (through the community support system, phone, home visit)

Programmatic Gap

Coverage Indicator : DOTS-1a: Number of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses

Current National Coverage 65000	Year	Source	Latest Results		
	2012	Reports (specify) Global TB report	65000.0		
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	65'000	65'000	65'000		This is the (best) estimate of the incidence of TB for Uganda (data of 2012) from the WHO Global TB Report 2013. Incidence rates for TB over time (1990 – 2012) demonstrate an observed decline that is documented by the WHO – 624 in 1990 to 179 in 2012. The rate of decline for the period 2000 to 2012 averages -6.9% annually. The epidemiologic analysis also confirms this decline in incidence, although with wide confidence intervals. This best estimate is used for the period of the investment that is applied for, noting that a national prevalence survey is underway and the more accurate data from this survey will inform subsequent programming including setting off targets
B. Country targets (from National Strategic Plan)	47'181 72.59 %	48'750 75.00 %	50'700 78.00 %	%	annually in line with the NSP 2015-2020. These investments include improving access to new diagnostic technology (Xpert MTB/Rif) deployed strategically and used effectively; increasing access to diagnosis of TB and MDR-TB for priority populations including HIV infected, children, prison populations, urban slums in addition to smear negative and extra-pulmonary TB. The diagnostic algorithm has been revised to implemen The increase in proportion of cases notified from among those estimated is in alignment with the NSP 2015-2020 indicator number 1.1.2
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	14'154 21.78 %	14'625 22.50 %	15'210 23.40 %	%	It is estimated that Government of Uganda and Implementing Partners contribute to about 30% of the costs for diagnosis of TB patients and this is factored into this computation
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	50,846 78.22 %	50,375 77.50 %	49,790 76.60 %	0 100 %	This is the estimated gap that will require funding from this grant
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	33'027 50.81 %	34'125 52.50 %	35'490 54.60 %	%	The gap has been put under the allocation amount until the final picture is clearer.
F. Coverage from Allocation amount and other resources C+E	47,181 72.59 %	48,750 75.00 %	50,700 78.00 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	%	%	%	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	47,181 72.59 %	48,750 75.00 %	50,700 78.00 %	0 0 %	

Coverage Indicator : DOTS-2b: Percentage of bacteriologically confirmed TB cases successfully treated (cured plus completed treatment) among the bacteriologically confirmed TB cases registered during a specified period

Current National Coverage 77%	Year	Source	Latest Results		
	2012	Reports (specify) Annual Program Report NTLP MOH			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	22'140	21'815	21'481	21'139	The NTLP notified 25442 bacteriologically confirmed patients in 2013. This approximates to 56% of all incident patients notified that year. The NSP 2015-2020 estimates of the number of bacteriologically confirmed patients notified (indicator 1.3.1 is used to quantify the estimated poppulation at risk for this indicator
B. Country targets (from National Strategic Plan)	17'269 78.00 %	17'234 79.00 %	17'614 82.00 %	17'968 85.00 %	The targets for treatment success of bacteriologically confirmed patients set out in the NSP 2015-2020 are used - see indicator 1.2.1 It is estimated that Government of Uganda contribute to about 25% of the costs for treatment (first line drugs) of TB patients and this is factored into this computation
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	4'317 19.50 %	4'308 19.75 %	4'404 20.50 %	4'492 21.25 %	It is estimated that Government of Uganda contribute to about 25% of the costs for treatment (first line drugs) of TB patients and this is factored into this computation
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	17,823 80.50 %	17,507 80.25 %	17,077 79.50 %	16,647 78.75 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	17'823 80.50 %	17'507 80.25 %	17'077 79.50 %	16'647 78.75 %	The gap has all been put under the allocation amount until the final picture is clearer.
F. Coverage from Allocation amount and other resources C+E	22,140 100.00 %	21,815 100.00 %	21,481 100.00 %	21,139 100.00 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	0 0.00 %	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	22,140 100.00 %	21,815 100.00 %	21,481 100.00 %	21,139 100.00 %	To achieve the target, CCM is requesting funding from the allocated budget.

Coverage Indicator : DOTS-5: Number of children <5 in contact with TB patients who began IPT

Current National Coverage	Year	Source	Latest Results		
	2013	Reports (specify) Data currently not available			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	4'469	7'380	10'105		Target area is the whole Country. This is the population in need according to the NSP projections. It is assumed that for every PTB case there is an average of 2 children under 5 years of age that need to be traced for contact. But then from experience the yield for TB amongst the contacts has been found to be about 2.5%, while 65% of the rest (the 97.5% in whom there was no TB yield) are considered eligible for IPT. Just to illustrate, in 2016, the number of new bacteriologically confirmed Pulmonary TB cases are estimated at 23631. Projecting coverage of 15%, contacts of 3526 new PBC patients will be traced. Assuming that each patient traced has about 2 child contacts <5 years, 7052 children will be reached and screened. The yield of TB among the contacts is estimated at 2.5%, and eligibility for IPT is estimated at 65% of those not found with TB.
B. Country targets (from National Strategic Plan)	1'122 25.11 %	2'026 27.45 %	3'937 38.96 %	%	he NSP plans to increase coverage and therefore yield these numbers amongst the population in need annually.
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	447 10.00 %	738 10.00 %	1'011 10.00 %	%	It is anticipated that the isoniazid will be procured locally, but the implementation costs including training, contact tracing, drug delivery, supervision and monitoring is an investment applied for in this grant
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	4,022 90.00 %	6,642 90.00 %	9,094 90.00 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	675 15.10 %	1'288 17.45 %	2'926 28.96 %	%	The gap has all been put under the allocated amount until the final picture is clearer
F. Coverage from Allocation amount and other resources C+E	1,122 25.10 %	2,026 27.45 %	3,937 38.96 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	1,122 25.10 %	2,026 27.45 %	3,937 38.96 %	0 0 %	

Module: TB/HIV

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets								
							Total Targets	Year 1		Year 2		Year 3		Year 4	
			N # D #	%	Year	Source		N # D #	%	N # D #	%	N # D #	%	N # D #	%

Indicator	Principal Recipient	Responsible	Baseline N#/D#	Baseline value	Baseline year	Baseline source	Targets	Y1 N#/D#	Y1 %	Y2 N#/D#	Y2 %	Y3 N#/D#	Y3 %	Y4 N#/D#	Y4 %
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	Ministry of Finance, Planning and Economic Development of Uganda		43,318.0 47,650.0	90.9	2013	R&R TB system, yearly management report	Allocation + Other Sources	38,957.0 40,580.0	96.0	42,192.0 43,502.0	97.0	45,406.0 46,332.0	98.0		
							Above+Allocation+Other sources	38,957.0 40,580.0	96.0	42,192.0 43,502.0	97.0	45,406.0 46,332.0	98.0		
Comments [1]	NTLP already reports 91% known HIV status among registered TB patients. The programme will ensure to retain this level of effort and increase it to 98% over the grant period in alignment with the targets set out in NSP 2015-202, indicator 2.3.1. The denominator incrementally increases to include the increase in case notification (all forms, new and retreatment) over the investment period in line with the incidence targets described in the program gap analysis Data source is the NTLP records and reports. Over this grant period, this will be integrated into the DHIS-2 and therefore be common across both TB and HIV programmes														
TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment	Ministry of Finance, Planning and Economic Development of Uganda	National program	13,399 20,648	65	2013	Reports (specify)	Allocation + Other Sources	16,277 23,590	69	17,793 24,375	73	19,266 25,350	76		
							Above+Allocation+Other sources	16,277 23,590	69	17,793 24,375	73	19,266 25,350	76		
Comments [1]	The denominator is derived from estimated case notifications (all forms, new and retreatment) and the numerator is aligned with the targets for ART coverage of the co-infected patients set out in the NSP 2015-2020, indicator 2.3.3. Baseline for the 2013 cohort is 65% and is data extracted from annual NTLP reporting. ARVs will be provided by the ACP and this indicator will be jointly reported as recording and reporting are integrated within DHIS-2														
TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	Ministry of Finance, Planning and Economic Development of Uganda	National program	594,387 814,228	73	2013	Reports (specify)	Allocation + Other Sources	0 1,118,423	0	0 1,264,836	0	0 1,416,644	0		
							Above+Allocation+Other sources	894,738 1,118,423	80	1,037,165 1,264,836	82	1,204,148 1,416,644	85		
Comments [1]	overall assumptions used in calculating targets: Estimated reach for people in care among PLHIV at 80%, based on historical performance 2) anticipated rate of scale-up: an increment of 140,000 to 160,000 annually 3) population size estimates: EPP 4) description of indicator/package of services: TB screening part of the HIV chronic care services for all PLHIV in care 5) data source: EPP (denominator); HMIS (numerator) +W326 6) other relevant information The baseline numbers are for April to June 2014, and based on the sites that reported accurately (25% of the facilities either did not report on this indicator or had inconsistent data). We expect the reporting to improve since facilities received feedback and support.														
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															
TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															
TB/HIV-3: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															
TB/HIV-4: Percentage of new HIV-positive patients starting IPT during the reporting period	The AIDS Support Organisation (Uganda) Limited						Allocation + Other Sources								
							Above+Allocation+Other sources								
Comments [1]															

Module budget - TB/HIV

Allocated request for entire module	USD 605,038	Above allocated request for entire module	USD 463,252

Intervention		Intervention budget (request to the Global Fund only)						
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]

Collaborative activities with other programs and sectors?	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	12,862				
		Above	35,347	12,862	12,862			
	The AIDS Support Organisation (Uganda) Limited	Allocation		16,770				
		Above	0	16,770	16,770			

Description of Intervention [2]

Sub-intervention 1: Strengthen collaboration and monitoring mechanism at national and district level Target population and geographical scope: All ART accredited TB treatment facilities starting with RRH, general hosp and HCIV taking care of the ownership mix. Implementation approach: The NTLP/ACP will continue to implement the planned activities in the phase 2 grants to develop, print and disseminate the integrated TB/HIV model and standard operating procedures (SOP's). 2.1.1 Hold two workshops to develop implementation guidelines for the integrated TB-HIV model. 2.1.2 Print 3000 copies of the implementation guidelines for the integrated TB-HIV model. (The SDA identifiers are there to assist costing and may be removed thereafter) In this current grant, The NTLP/ACP will conduct national and regional stakeholders meetings to introduce and build ownership on implementation of the one-stop centre model, followed by regional training of trainers on implementation of the one-stop centre model and on-site training and mentorship of health care providers to implement the model. The NTLP/ACP will conduct joint TB/HIV support supervision to monitor implementation of the one-stop center Implement the one stop center by providing HIV testing among patients with presumptive and diagnosed TB including HIV prevention interventions (ABC); CPT and ART, including IPT for eligible TB/HIV co-infected patients. Strengthen counselling for TB and HIV services at initiation and during treatment including transitions from HIV and TB care points Monitor implementation and scale up of the one-stop center using markers including availability of HIV commodities and records at the TB care point, completeness and accuracy of records/ reports for TB/HIV services. Sub-intervention 2: Implement TB infection control (TBIC) practices in all health care facilities Target population and geographical scope: All health care facilities Implementation approach: Orient health care managers on infection control issues and needs Develop a standard infection control checklist to assess and monitor implementation of TB infection control Build capacity of district and facility teams to conduct periodic TB infection risk assessments so as to inform development of facility specific infection control plans Monitor implementation of the TB infection control plan by ensuring triaging, separating and fast tracking of coughing patients, health eduction on cough etiquette and improved ventilation at patient care points. Conduct annual occupational TB assessment of health workers Funding request: 1. 5days regional training of trainers in the 12 MOH regions. Need perdiem and facilitation for trainers using the revised TB/HIV training manuals and the revised SOPs to 2. conduct the TOT on the one stop center model 3. 3 days on-the-site training and mentorship at health facilities starting with RRH, distrct hosp and selected HC IV's

Engaging all care providers	Ministry of Finance, Planning and Economic Development of Uganda	Allocation						
		Above						

Description of Intervention [2]

Sub-intervention 1: Strengthen collaboration and monitoring mechanism at national and district level Target population and geographical scope: At the national level, target the MOH NTLP and ACP, implementing partners, donor agencies, civil society and key affected populations e.g congregate settings and MARPs. Implementation approach: Reconstitute the national coordination committee (NCC) to ensure equal/ balanced representation of TB and HIV programs and stakeholders Engage the NCC to carry out joint planning, agree on common targets, carry out joint implementation and review of performance. This includes reviatlizing the TB/HIV technical working groups to follow up agreed actions. Quarterly NCC meetings were planned in the phase 2 grant and this will continue during this application. In order to ensure greater TB/HIV stakeholder engagement, the MOH will organise joint annual TB and HIV/AIDS program reviews to evaluate performance and use the forum as advocacy for more funding, with a focus on ensuring equitable access to services among key populations. At the district level, the MOH will target the district health managers, health facility providers, partners, civil society and key affected populations at high risk such as congregate settings and slum dwellers. The DHMT, DHAC and SHAC in the 112 districts will be oriented on TB/HIV collaboration. The committee should include representation of the district TB team (DTLS & DLFP's). At the regional level, monitoring of TB and HIV services will be carried out through joint support supervision by the Regional Performance Monitoring Teams (RPMT's), on a quarterly basis. Monitoring of implementation of TB/HIV collaborartive will be carried out through joint planning including Global Fund or other activities, joint support supervision and reporting of TB/HIV indicators. The existing TB and HIV tools have been revised to capture information on both TB and HIV status for co-infected clients. Sub-intervention 2 (This intervention is already costed in Phase II under SDA 5.3.1 – please use that costing and then remove this line in parenthesis from the modular template. This intervention is common to all three priority modules for TB – TB Care and prevention, TB HIV and MDR-TB) Train Private health workers on TB, TB/HIV and MDR TB. Target population and geographical scope: Private health practitioners, particularly in the urban settings of Uganda Implementation approach: In phase 2 of the Global fund grant, the NTLP planned to engage the private practitioners (PPM) by training the private health workers in TB case management, TB/HIV and MDR TB control. The private practitioners contribute in screening, diagnosis and treatment of TB, depending on their capacity. In addition, they carry out contact tracing and referral of presumptive TB cases to the nearest diagnostic and treatment unit. In order to ensure integrated TB/HIV services delivery by the private practitioners, members of the PPM will be represented at the various coordination levels both at the NCC and the DHMT. This will enable their active participation and engagement in collaborative TB/HIV activities Funding requested for: 1. Joint TB/HIV support supervision involving ACP & NTLP staff. Need for perdiem and transport 2. Joint annual TB and HIV/AIDS program reviews involving NTLP, ACP, UAC, USTP and development partners 3. Orientation meetings for DHMT, DHAC, SHAC in 112 districts 4. Quarterly district coordination meetings involving DHMT, DHAC, SHAC etc

TB/HIV collaborative interventions	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	277,320	298,086				
		Above	193,446	99,704	75,491			

Description of Intervention [2]

Support the implementation of intensified case finding and Isoniazid preventive therapy in HIV care settings Target population and geographical scope: All health care facilities but with priority in HIV settings and on-entry screening in prisons Implementation approach: In phase 2 of the Global Fund grant, the NTLP/MOH planned to implement strategic interventions including integrating TB and HIV services, promoting provider initiated testing and counselling, increasing the uptake of Isoniazid Preventive Therapy (IPT), in people living with HIV, and revising the national policy guidelines on TB/HIV collaborative activities.To-date, the national policy guidelines on TB/HIV collaborative activities have been revised and disseminated at health facilities in almost half of the 112 districts in the country. The IPT guidelines have also been developed and are being printed. The NTLP in collaboration with ACP will carry out countrywide dissemination of the IPT guidelines at national, district and health facility level as well as produce SOPs and job aides for provision of IPT, at the health facilities.The NTLP/MOH will strengthen active TB screening at health care facilities more especially in HIV care clinics, including OPD, MCH, diabetic clinics and medical/ general wards by promoting use of ICF tools for TB symptom screening and linkage of presumptive TB case to the laboratory for diagnosisThe NTLP will support implementation of existing guidelines and SOPS for intensified case finding and Isoniazid preventive therapy at all care points, including OPD, HIV care and TB clinics through implementation of Quality improvement initiatives at the health facilities. SOPs and tools for intensified case finding (ICF forms and presumptive register) will be produced and laboratory diagnostics such as Genexpert machines also need to be procured to increase TB detection especially at the high volume facilities. ICF of TB will be monitored by tracking indicators on screening of PLHIV for active TB and evaluating the yield of TB by monitoring proportion of presumptive TB cases investigated in the laboratory and given results. The NTLP in collaboration with the ACP will conduct on-site training and mentorship of health care providers to implement IPT, targeting all HIV care clinics for PLHIV and TB clinics for HIV negative children under five years of age, who are eligible. Provision of IPT will be monitored by tracking indicator on proportion of eligible PLHIV receiving IPT, as well as HIV negative children under 5 years of age that are eligible for IPT and are receiving it. Funding requested for: 1. Conduct a national TOT on the one stop center model (training manual. 2. 5- days regional training of trainers in the 14 MOH regions. Need per diem and facilitation for trainers using the revised TB/HIV training manuals and the revised SOPs. 3. 3-days on-the-site training and mentorship at health facilities starting with RRH, district hospitals and selected HC IV's: 3 days on-site training & mentoring of health facilities in implementation of IPT

Programmatic Gap

Coverage Indicator : TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment

Current National Coverage 65%	Year	Source	Latest Results		
	2013	HMIS			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	23'590	24'375	25'350		TB/HIV co-infection rate is estimated at 50% of all notified TB cases
B. Country targets (from National Strategic Plan)	16'277 69.00 %	17'793 73.00 %	19'266 76.00 %	%	The targets are in line with the NSP 2015-2020 with the aim to have more than 90% of co-infected patients on ART by 2020.
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	0 0.00 %	0 0.00 %	0 0.00 %	%	The ART targets for TB/HIV co-infected should be included in the general population targets
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	23,590 100.00 %	24,375 100.00 %	25,350 100.00 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	16'277 69.00 %	17'793 73.00 %	19'266 76.00 %	%	
F. Coverage from Allocation amount and other resources C+E	16,277 69.00 %	17,793 73.00 %	19,266 76.00 %	0 0 %	The gap has all been put under the allocation amount until the final picture is clearer.
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	16,277 69.00 %	17,793 73.00 %	19,266 76.00 %	0 0 %	

Module: MDR-TB

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline N# / D#	Baseline %	Baseline Year	Baseline Source	Total Targets	Year 1 N# / D#	Year 1 %	Year 2 N# / D#	Year 2 %	Year 3 N# / D#	Year 3 %	Year 4 N# / D#	Year 4 %
MDR TB-1: Percentage of previously treated TB patients receiving DST (bacteriologically positive cases only)	Ministry of Finance, Planning and Economic Development of Uganda	Current grant	784.0 3,882.0	20.2	2013	R&R TB system, yearly management report	Allocation + Other Sources	2,455.0 4,232.0	58.0	2,949.0 4,537.0	65.0	3,527.0 4,832.0	73.0		
							Above+Allocation+Other sources	2,455.0 4,232.0	58.0	2,949.0 4,537.0	65.0	3,527.0 4,832.0	73.0		
Comments [1]	The baseline for this indicator is from the WHO Global TB Report 2013 - Table A4.7 on page 175. The denominator for the total number of retreatments notified to the NTLP that year is also from the Global TB Report, Table 3.1, page 29. It is estimated that between 7.2% to 8.2% of all notified patients (all forms of new and retreatment patients) are retreatment annually from 2008 to 2012 from the epi analysis. Relapses have been stable at about 3.7% of all incident TB notified and they further also account for about 33% of retreatments. This has been used to compute the denominator for the incremental increase in the number of notifications of retreatments annually The annual targets for the proportion of retreatment patients who will be tested annually is from indicator 3.1.2 of the NSP 2015-2020.														

Module budget - MDR-TB

Allocated request for entire module	USD 5,758,011	Above allocated request for entire module	USD 4,703,766

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Case detection and diagnosis: MDR-TB	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	1,524,505	1,886,832				
		Above	769,731	326,013	710,220			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0				
		Above	0	0				

Description of Intervention [2]

Sub-intervention 1 – Improving case finding of MDR-TB Target population and Geographical coverage: All re-treatment TB patients, Symptomatic Contacts of MDR-TB, all TB patients remaining smear positive at 3/5 months of treatment, Health workers presumed to have TB. Implementation approach: The program aims to find 80% of the estimated cases by 2020 (NSP). MDR-TB case finding strategies have focused on re-treatment TB cases since the beginning of the program due to the high risk associated with this category of patients. MDR-TB contacts were also prioritized for DST given that the disease in this group of patients is likely from a resistant source. Although the prevalence of MDR-TB among new TB cases was estimated at only 1.4%, this group has been shown to contribute about half of all MDR-TB patients estimated in the country. Among new TB patients the following will be sent for rapid DST; HIV positive individuals, children less than 14 years health workers presumed to have TB and late smear converters. The program intends to conduct the following activities to strengthen MDR-TB case finding; 1. Nationwide orientation on MDR / XDR TB program in a phased manner as per the national training guideline and relevant national policies. Target includes frontline HCWs, Health Managers, religious, technical, administrative, political and community leaders and VHTs. Women and CSOs representatives will be prioritized. 2. On job training of health workers on how to use XpertMTB/Rif machine-2 days training: This training will focus on how to use the XpertMTB/Rif machine. The training will be conducted whenever XpertMTB/Rif machines are installed at a facility. The target audience will be the lab personnel and clinicians working in the facility (2 lab tech, 25 other HCWs per machine installed). The clinicians will be taken through basic information on TB diagnosis, diagnostic algorithm and access to XpertMTB/Rif. Support TB Specimen Referral for Routine Surveillance (TSRS) of Drug resistant TB Target population and geographic coverage: Patients requiring /eligible for access to XpertMT /Rif and requiring support to transport samples Implementation approach: Although the number of XpertMTB/Rif machines in the country has recently increased, diagnosis of RR TB is highly dependent on specimen referral to labs where XpertMTB/Rif is located. Patients presumed to be at risk of MDR-TB often require support for their samples to be sent to these labs. Upon diagnosis of RR, patients are also required to submit a sample to NTRL for 1st and 2nd line DST. NTRL works closely with the central public health laboratories to link the TB Specimen Referral System (TSRS) to the Hub system, which is used to transport specimens for laboratory testing from lower to higher health facilities with appropriate laboratory infrastructure. Support for sample transportation is also required for all patients on MDR-TB treatment on a monthly basis to monitor treatment. This also requires procurement of bio safety boxes, falcon tubes, ziplock bags for packaging and transportation of samples, transport refund for staff (back up rider), payment of Courier Services. In addition, it proposed that procurement of diagnostic consumables NTRL: procurement of Gene Xpert cartridge, calibration kits culture,1st and 2nd Line DST(LPA kits MGIT tubes) be supported to ensure un interrupted services both at Xpert labs and NTRL. (Move this to PSM) Sub-intervention 3: HR to assure quality of diagnosis and support supervision Target and geographic approach: National TB Reference Laboratory Implementation approach: Support salaries for two laboratory scientists for the NTRL. The national reference TB laboratory is highly dependent on partner support. The volume of work with MDR-TB patients monitoring and expanding case finding is high. It is proposed to support two additional lab scientists who will support MDR-TB diagnosis patient monitoring, training, EQA, supervision and oversee and support the TB specimen and referral network. Funding requested: 1. Nationwide orientation of technical, political, and community leaders on MDR XDR TB program. Regional trainers in collaboration with the DHOs will organize training for the respective districts. Sensitization session is expected to be completed in one day. 2. Procure laboratory consumables (e.g. falcon tubes and cold boxes) for packaging and transportation of samples. 3. Procurement of culture 1st and 2nd Line DST (LPA kits MGIT tubes) 4.Training of health workers on how to use Xpert machine-2 days for each new machine installed.

Intervention	Responsible Principal Recipient(s)		Year 1	Year 2	Year 3	Year 4	Cost Assumptions	Other funding
Community TB care delivery	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	718					
		Above	112,067	112,786	64,398			
	The AIDS Support Organisation (Uganda) Limited	Allocation	6,400					
		Above		71,680	71,680			

Description of Intervention [2]

Target population and geographical coverage: Patients receiving MDR-TB treatment from Mulago National Referral Hospital. All patients residing in districts of Kampala, Wakiso and Mukono, Kayunga, Luwero, Mpigi districts will be offered the opportunity of home based care. Implementation approach: Drug resistant TB (DR-TB) presents the greatest challenge in the control of TB worldwide. Its control requires a robust surveillance and management system. Patients with MDR-TB are the commonest sources of transmission of the resistant strain. The management of MDR-TB requires provision of comprehensive services to the patient and the family and as a result successful treatment of multi-drug resistant tuberculosis remains a challenge in resource-limited settings. In Uganda, about 1.4% and 12.1% of newly diagnosed and re-treatment TB cases respectively are estimated to have MDR-TB according to the 2010 drug resistance national survey. By the end of 2013, a cumulative total of 290 patients had been enrolled on MDR-TB treatment. The country is implementing a model of care that in some facilities allows patients to be admitted whereas in other treatment facilities patients are initiated on treatment as outpatients and follow up is organized at a nearby facility (follow up facility). The basic management principal for all the patients is to ensure treatment is observed by a health worker or a trained treatment supporter. Patients report daily to the health facility for DOT and monthly to the treatment initiation center for review by a clinician. On the side of the treatment initiation facilities, the follow up facilities are numerous that monitoring of activities at these facilities is complicated. The linkage of the treatment facility and the follow up facility is not coordinated due to high patient volumes and lack of a dedicated health worker at the treatment initiation facility. For Mulago there are over 130 patients on treatment each attached to a different follow up facility and Mulago hospital is a tertiary national referral hospital with a very high patient load. Activities like contact tracing, health education, infection control at home/community not adequately implemented. What needs to be done to address the above challenges, the program proposes to decentralise MDR-TB treatment to ambulatory care at patients homes (home based care) based on the recommendations of the JMM Home-based care offers several important advantages over facility-based care including; accessibility, affordability, safety, reduced infection transmission and assured DOT to the patients. By engaging patients and family members as supportive individuals in their family's medical care, it is an opportunity to both educate the family, home assessment, contact tracing and screening, offer HIV testing, immediate follow up of patients, timely detection and management of adverse effects, maintaining a linkage between the community and the treatment initiation facilities. The overall outcome is improvement in treatment outcomes due to increased adherence, reduced loss to follow up. The overall objective will be to improve the management of MDR TB and MDR TB/HIV Kampala Metro Area through Home Based Care. Main activities to be implemented include; Establishment of coordination teams at national and treatment initiation site(Mulago).Hiring and training of mobile teams, Daily home visits for DOT, Contact tracing, procurement of personal protective equipment, monthly reviews at treatment initiation site, performance reviews and development of monitoring system, referral and linkage of patients, printing of IEC materials. Additionally, the NTLP proposes to coordinate alongside the prioity modules for TB care and Prevention and TB HIV, the following activities to engage communities and involve them in TB care and control. Build capacity of grass root civil society organizations on TB education. Key messages on MDR-TB will be incorporated in the package for CSO to ensure their involvement in care and prevention of MDR-TB. Some key CSOs will be involved in home care delivery for MDR-TB/HIV patients. Facilitate grass root civil society organizations to carry out Community TB education and social mobilization.

Module	Principal Recipient						
Key Affected Populations	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0			
		Above	53,402	53,402	26,701		
	The AIDS Support Organisation (Uganda) Limited	Allocation	12,816	6,408			
		Above	61,200	61,200	61,200		

Description of Intervention [2]

MDR TB and HIV Target population: HIV infected patients and co-infected TB patients, Prisons, Former MDR-TB patients Implementation approach: Drug-resistant TB is often associated with higher mortality rates in patients living with HIV, meaning that better integration of HIV and drug-resistant TB services is necessary, both in high HIV prevalence settings, but also in any setting where HIV co-infection is common among TB patients. Early diagnosis of drug-resistant TB and HIV, prompt initiation of appropriate second line anti-TB drugs and antiretroviral treatment (ART), sound patient support, and strong infection control measures are all essential components in the management of drug resistant TB people living with HIV. The program plans to strengthen MDR-TB/HIV management through; provider initiated counselling, integrated TB/HIV service delivery integrating access to testing for R resistance using XpertMTB/Rif for people living with HIV, increased access to ART Support two orientation meetings on TB, TB/HIV and MDR for health activists per year.- Details in TB care and prevention/CSS (Common across all three priority modules) Identify and train 2 successfully treated MDR patients for each of the 14 MDR treatment sites to identify, support adherence and follow up MDR patients. Facilitate successfully treated MDR patients that will support MDR patients to adhere to treatment. Use of expert patients (Peers); facilitation of 2 peers per treatment site to support MDR-TB patients. The peers will be involved in organizing patients, sharing experiences and facilitating patient support groups in collaboration with the social worker at the monthly review sessions. Prisons: MDR-TB management in prisons has been challenging with many reported cases in some prisons and admitted MDR-TB patients facing support challenges on the ward. The program will strengthen TB diagnosis in prisons and improve access to XpertMTB/Rif services for in mates who are contacts of MDR-TB patients, Training of prison health staff on MDR-TB, establish and MDR-TB treatment initiation centre at Luzira prison.

Module	Principal Recipient						
Prevention for MDR-TB	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	131,242	0			
		Above	170,210	272,729	51,953		
	The AIDS Support Organisation (Uganda) Limited	Allocation	13,822	27,645			
		Above	27,645	0			

Description of Intervention [2]

Target population and Geographical coverage: Patients and community visiting health facilities; health care workers; contacts of MDR patients Implementation approach: The NTLP will continue to prioritize routine TB control to prevent the emergence and further amplification of MDR-TB in Uganda 1. Infection control: Facilitate districts to develop and implement IC activities in their health units; a). IC committees and IC plans, b) facilitate cough monitors(volunteers) to conduct facility entry screening for TB, triage and fast tracking of these patients. One cough monitor in each of the key entry points at all hospitals. (OPD,HIV clinic and MCH=3 per hospital), c) separation of presumed TB patients at the facility, Establish sputum collection corners at the facility.-waiting shades, well ventilated, d).Procure Personal protection equipment (N95) for HCWs and surgical masks for patients.-within the HSS Concept Note. e) Annual screening for TB among HCWs; Specific screening for TB and HIV status among HCWs. Chest X ray and sign and symptom screening and investigation using Xpert for the symptomatic. A team of infection control officers at national and regional/district level will ensure implementation of the screening.-(perdiem, transport for officers) f) Ensure Home assessment and contact screening for close contacts of MDR-TB patients for patients in the district is done. 2.Support the formation of DR-TB management teams at district level. The team should comprise of DHO, DTLS, DLFP, DSFP Biostatistician, TB/HIV focal person and any other relevant person as deemed by DHO. a) Quarterly meeting to evaluate and plan for TB/MDR activities- refreshments,transport,SDA b) Line list of MDR TB patients per district and their treatment status and required reporting needs respecting patient confidentiality c) Empower the DTLS to take lead role in management of DR-TB at District level with emphasis on importance of community centered management- Facilitation/transport and SDA to visit all DTUs and search for high risk patients d) Design, print and disseminate SOPS, IEC materials (minimum package of service for DRTB at district level) on management of TB including DR-TB. Funding requested for: 1. Annual screening for TB among HCWs; Specific screening for TB and HIV status among HCWs. Chest X ray and sign and symptom screening and investigation using Xpert for the symptomatics. A team of infection control officers at national and regional/district level will ensure implementation of the screening.-(perdiem, transport for officers) 2. Conduct home assessment and contact screening for close contacts of MDR-TB patients

Module	Principal Recipient						
Treatment: MDR-TB	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	1,037,177	1,110,446			
		Above	0	372,772	1,252,777		
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0			
		Above	0	0			

Description of Intervention [2]

Target population and Geographical coverage: All diagnosed RR/MDR-TB patients, Treatment initiation facilities and follow up facilities Implementation approach: PMDT has expanded over the years with decentralization of treatment initiation to almost all the regions except the north eastern region. There is one national referral hospital where all complicated cases are managed which is also the main treatment initiation centre for Kampala and neighbouring districts. Other treatment centres include 11 regional referral hospitals and 2 general hospitals. The following will be done : (1)Provide adherence enablers to MDR-TB patients to enhance treatment completion 2: Transport refund for DOT provider to treatment initiation site to escort patients for monthly review and facilitation to conduct home visit and contact tracing once every six months. 3) Provide incentives to 70 Health workers in 14 PMDT treatment centers: Current treatment sites have more than 70 health workers involved in management of MDR-TB patients. The number of health workers proposed to benefit from the incentives will be increased to 120 at 15 treatment sites and 200 from follow up facilities. This implies that 250 additional staff incentives be added to benefit from the incentive. 4) Procure laboratory services for managing MDR-TB patients: 5) Training of health workers in PMDT. 6) PMDT Mentorship and support supervision .7) New treatment initiation facility establishment. 8) Hiring HR-at PMDT sites. 9) Improve Recording, reporting and Performance monitoring for PMDT: Funding requested for: 1. Training of health workers at 6 new treatment sites and newly recruited staff managing MDR-TB 5 day training each 30 health workers per training new site. 12 sites targeted up to 2017 2. Refresher training for current treatment site staff -3 day training 30 HCWs/14 sites. 3. Training of 50 follow up facility / DOT provider 3 days training 4. New treatment site establishment: 6 sites depending on MDR TB cases diagnosed in the area (1 Prisons, 1 Army, 2 and 7 other sites depending on the burden. Assessment of facilities (transport, 2 days per diem for 2 officers per site, upgrading/renovations 5. Risk allowance: for 8HCW per site for 20 sites, health workers, 200 health workers from follow up facilities. Each 100 dollars per quarter. 6. Patient support 7. HR-at PMDT sites: support MOH to hire 3 HR (one doctor, one nurses, one social worker) for 14 treatment sites and allow time for transitional of personnel into MOH structure for sustainability; 8. Introduce Home based care in Kampala-2,000USD per patient for 200 patients in 3yrs (phased as 100, 150, 200).

Programmatic Gap					
Coverage Indicator : MDR TB-1: Percentage of previously treated TB patients receiving DST (bacteriologically positive cases only)					
Current National Coverage 19%	Year	Source	Latest Results		
	2013	Other (specify) Global TB Report 2013			
	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	CCM Comments
Current Estimated Country Need					
A. Total estimated population in need/at risk (from National Strategic Plan)	4'232	4'537	4'832		This is the number of patients estimated to require retreatment from among all forms of TB notified to the NTLP. From 2000, the proportion of relapses among incident notification has been stable at 3.7% and relapses have also contributed to about 33% of all retreatment. These factors have been used to estimate the numbers of retreatment patients.
B. Country targets (from National Strategic Plan)	2'455 58.01 %	2'949 65.00 %	3'527 72.99 %	%	This increase in testing is in alignment with the target planned in the NSP 2015-2020, indicator 3.2.2
Country Need Already Covered					
C. Country need planned to be covered by domestic & other sources	0 0.00 %	0 0.00 %	0 0.00 %	%	20 XpertMTB/Rif modules planned to be procured annually as part of the expansion plan for three years and investment is applied for through this grant. Support for cartridges from implementing partners is limited and only confirmed till June 2015. Therefore full investment is sought through this application.
Programmatic Gap					
D. Expected annual gap in meeting the need A-C	4,232 100.00 %	4,537 100.00 %	4,832 100.00 %	0 100 %	
Country need planned to be covered by domestic & other sources					
E. Targets to be financed by allocation amount	2'455 58.01 %	2'949 65.00 %	3'527 72.99 %	%	The gap has been covered under the allocated amount until the financial picture is clear
F. Coverage from Allocation amount and other resources C+E	2,455 58.01 %	2,949 65.00 %	3,527 72.99 %	0 0 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	%	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	2,455 58.01 %	2,949 65.00 %	3,527 72.99 %	0 0 %	

Module: HSS-Health information systems and M&E								
Module budget - HSS-Health information systems and M&E								
Allocated request for entire module		USD 1,156,787				Above allocated request for entire module		USD 3,738,735
Intervention		Intervention budget (request to the Global Fund only)						
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]

Analysis, review and transparency	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	2,500	0	0			
		Above	124,783	127,283	127,283			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Operationalizing the M&E Framework The M&E framework will guide efforts for tracking the implementation, outcomes and impacts of HIV/AIDS prevention, care and treatment interventions in the health sector, as well as the magnitude and dynamics of the epidemic. It will also guide the sector to track progress against planned targets, and to identify gaps that should form the basis for redirecting efforts. Furthermore it will harmonize HIV/AIDS M&E processes in the sector that hitherto, were fragmented and uncoordinated. The Framework provides for harmonized processes of data collection, reporting, analysis, review and dissemination in a collaborative and transparent environment. Implementation of the Framework will form the basis of analysis, review and transparency of M&E processes. Support will be required to operationalize the framework at districts level. Districts will need to conduct regular data reviews, support and mentor health facilities in reporting to ensure accurate data is submitted timely, analyze district specific data, summarize, disseminate and utilize the data at this level. 2. Performance Review Meetings - Organize joint TB and HIV Review and joint dissemination data quality assessment tools 3. Strategic Plan Reviews 4. Strengthen TB and HIV support supervision at all levels. Implementation approach: 1. Conduct Bi-annual joint support supervision of regions by Central Unit staff (NTLP and ACP staff) 5 days. 2. Support District supervisors to conduct Monthly supervision of DTUs and District Laboratory focal persons HSD FPs 3. Procure vehicle for HIV M&E Coordination activities 4. Monthly support supervision visits to community groups and VHTs (from health facilities) 5. Develop integrated TB/HIV manual for data quality audit (DQA) and SOPs for data management at all levels: this will be a 5-day workshop in hired hotel hall in Kampala. 20 data management and M&E expert officers of MoH and selected partners will develop the manual and SOPs. The manual will an integral component of indicator manual. 6. Conduct DQA visits to districts and health facilities: audits will be conducted on quarterly basis by central team on 25% of the districts, prioritizing those showing poor data quality issues. The district s will be sampled from each region. Logistics: per diem 10 officers and 5 drivers. Funding request: 1. Conduct Bi-annual joint support supervision of regions by Central Unit staff (NTLP and ACP staff) 5 days. 2. Quarterly enhanced cohort reviews at regional MDR sites 3. Roll out the Health Sector HIV/AIDS M&E framework at national and regional level 4. Support M&E activities at district level (monitoring visits, indicator data compilation and analysis, M&E report writing, dissemination) by M&E focal persons 5. Support national biannual HIV/AIDS and TB program review meetings 6.Maintainance M&E, program staff and the new laboratory staff, data manager for TB,MDR -TB focal person salary for USTP staff and operational costs for USTP office

Routine reporting	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	445,847	161,662	0			
		Above	549,035	525,875	645,496			
	The AIDS Support Organisation (Uganda) Limited	Allocation	218,748	123,084	0			
		Above	499	29,743	111,688			

Description of Intervention [2]

These include 3,248 facilities providing HIV/AIDS care and treatment, of which 1,603 are providing comprehensive care & treatment, including ART. This also includes 1,158 facilities that are providing TB diagnosis and treatment (DTU). Competency building services will target 112 District Biostatisticians, Health Information Assistants (HIA) of each health facility, 112 DTLS and other focal point persons involved in R&R system for TB and HIV/AIDS services in the facilities.

Surveys	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	204,946	0	0			
		Above	598,525	748,525	150,000			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Target population&geographical scope:Obtaining comprehensive data for monitoring the magnitude and dynamics of HIV/AIDS and TB as well as coverage and impact of programs also relies on other methodologies besides routine reporting, surveys and surveillance. These include operations research and program evaluations, systematic reviews and data triangulation, mathematical modeling and projections, as well as drawing on data from other ongoing research programs and activities. Most programme impact and outcome indicators will be ascertained through periodic population-based and facility surveys. These surveys often provide estimates for national level, often disaggregated by urban and rural, geographical regions, and by socio-demographic, economic and behavioural subgroups, although they often don't provide district-level estimates. Two types of surveys have been conducted in the past, i.e. UDHS - which don't provide HIV prevalence estimates, and UAIS - which provide data on HIV sero-prevalence and several other HIV/AIDS programme Indicators. Other adhoc subnational household surveys covering various areas of the country also augment monitoring of the HIV/AIDS at subnational level. Subnational surveys that target MARPs such as sex workers, fishing communities, long distance truckers, etc, are not necessarily house-hold based, but utilize a range of sampling techniques such as client-driven, convenience, or consecutive sampling designs. They should be based on protocols reviewed and approved by IRBs. They often collect data on a wide range of indicators including population size of the various groups, HIV/AIDS burden, risk factors, programme coverage, knowledge, attitude, sexual behavior and practices. Health facility surveys for assessment of quality of services provided in facilities, stock status of medical and pharmaceutical supplies, as well as capacity of facilities and health workers to deliver quality services also provide vital outcome monitoring data. These surveys should be based on standard protocols and data collection tools. There is need for coordination of planning, implementation, analysis and dissemination of the surveys in order for data collected to support national level programme . HIV sero-prevalence and behavioral Surveys to be conducted in 2015, whose preparations has started, will measure trends and risk of HIV transmission. Modes of Transmission studies is in the final stages and will help analysis of the distribution of new infections in the population and make recommendations for prevention. Population based surveys in Uganda include UDHS and household surveys that are being supported by other development partners. HIVDR surveillance has been Designed and established in the program with support from PEPFAR and now on going. Condom surveys are important to follow on the condom use after distribution, need to be conducted every year in the second year of implementation HIVDR transmission surveys will be required to track HIV drug resistance and inform our guidelines process. Information on evolution of resistance to antiretrovirals is critical to inform appropriate treatment choices in patients about to start treatment. Funding Request: 1. Annual antenatal HIV Sentinel Surveillance – laboratory reagents, field operations, report writing (above allocation) 2. Conduct an assessment of the epidemiological situation in the country including the TB surveillance system every two years (within allocation) 3. Conduct a cascade of OR capacity strengthening –national, regional and district in order to improve data quality and data use at the point of collection: Program and partner capacity to conduct OR will be improved through a cascade of OR training. National level trainings will be undertaken. The persons trained will then trainers of lower level staff. (within allocation) 4. Conduct Drug Resistance survey (TA); DR – Survey: There is need to maintain surveillance for MDR TB in the country. A follow up national survey will be conducted. (above allocation) 5. Conduct TB disease mapping using geospatial and molecular analysis to identify TB hot spots to aid in the focusing of TB control interventions: in order to find the undetected TB cases in the country there is need for innovations case detection strategies. In partnership with Makerere University geospatial and molecular analysis will be undertaken to identify TB high burden areas (hotspots). Case detection and other TB controls strategies will then be focused on these hotspots(above allocation)

Module: Community systems strengthening

Module budget - Community systems strengthening

Allocated request for entire module	USD 269,904	Above allocated request for entire module	USD 757,145

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]
Advocacy for social accountability	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above	93,359	84,194	84,194			
Description of Intervention [2]								
Activity description 1: Raise awareness and build community level capacity to change negative gender norms, beliefs and practices through targeted audience specific messaging and advocacy. Target Population: community groups and networks of people living with the diseases (TB and HIV), households and individuals. Impact: Through advocacy, harmful gender based and socially discriminatory practices that hinder access to and use of health services may be reformed. Community engagement through advocacy transforms community attitudes about partner abuse and raises awareness about women's rights as well as the negative effects of intimate partner violence (IPV). Context: Generally there is a noticeable reduction in the proportion of PLHIV that report cases of SGBV from 39% to 25%. In 2013, PEPFAR supported programs reached 543,833 individuals with interventions that explicitly addressed GBV; 609,020 individuals with interventions and services that addressed legal rights and protection of women and girls impacted by HIV; and 943,964 individuals with interventions that explicitly addressed norms about masculinity related to HIV (UAC NSP-MTR working draft report 2, page 36). To further mitigate vulnerability for women and girls living with and /or affected by HIV/TB, and in line with the universal health care coverage to all, we shall build on evidence from a district level community intervention implemented in Rakai (CEDOVIP, 2011; Wagman et al., 2012), and implement a rigorous community led campaign to reduce IPV by transforming community attitudes about gender norms and the negative consequences of IPV. Implementation Approach: Under this grant we request that Global Fund supports the country to scale –up community mobilization in 28 districts with high GBV prevalence as well as identify and equip regional GBV model sites that will serve as management and referral centers for survivors. Activities for community level empowerment and rights literacy have been requested under the CSS Module in the HSS Concept Note. The TB-HIV concept note shall prioritize community mobilization and education to compliment policy makers and opinion leaders such as Parliamentarians, cultural leaders, religious leaders, networks of people living with HIV, and religious leaders at national and regional levels. Complimentary psychosocial support services specifically targeting safe disclosure, post-rape care and GBV post trauma counseling will be offered as part of HIV risk reduction counseling for all women in HIV routine care under RMNCAH linkages. Working with the district level GBV champions, survivors will be referred to regional centers for management and rehabilitation. Adaptation and use of existing manuals and guidelines for the management of GBV shall be prioritized. Mobilization and community sensitization shall be through group meetings, dialogue sessions, mass media, development and distribution of print and electronic advocacy materials. Funding Request: 1- Dialogue meetings with cultural leaders, religious leaders, members of Parliament, networks of people women living with diseases 2- Develop and distribute communication and advocacy materials 3- Identify and equip regional GBV model sites that will serve as management and referral centers for IPV/GBV survivors 4- Training and skills development for law enforcement officers, health workers and community leaders in management of GBV survivors								
Community-based monitoring for accountability	The AIDS Support Organisation (Uganda) Limited	Allocation	19,368	63,301				
		Above	78,210	66,444	66,444			
Description of Intervention [2]								
Activity description 1: Conduct annual gender assessment of the national disease response for HIV and TB in order to establish responsiveness to gender inequalities that hinder access to and use of prevention, care and treatment services. Target Population: National level policy makers and service provision sectors, beneficiary communities at all levels. Impact: To establish progress attained in responding to Gender inequalities as one of the structural drivers for HIV/TB infection. This activity will help assess whether we have built community level capacity to demand and utilize HIV and TB prevention and treatment services. It also helps assess progress in policy reform to address emerging issues with respect to reforming gender norms, beliefs and practices that constrain access and use of TB and HIV services (plus the legal and rights environment and how it impacts on access to TB and HIV services). Interventions for training for community level legal and rights literacy have been provided for in the HSS CN. Implementation approach: This activity will be undertaken using the Consolidated Gender and HIV Scorecard (CGSC). The scorecard that was developed based on the national action plan for women, girls, gender equality and HIV/AIDS 2012-2014 will be adapted for this purpose. The Ministry of Gender, Labour and Social Development (MoGLSD) working with the Uganda AIDS Commission (UAC) developed the consolidated scorecard to assess performance in four main areas namely: awareness and focused HIV/AIDS response for marginalized women and girls; multi-sector Gender mainstreaming of HIV/AIDS response; enabling environment; good governance; monitoring and evaluation in the context of HIV/AIDS. The assessment process using the CGSC provides valuable feedback that helps to improve programming and provides important information to guide policy development and reforms. During the implementation period of this grant, the country will conduct gender assessments annually. The findings will be presented during the Joint Annual Health Review and the Joint Annual AIDS review Assemblies. The plan is to make these gender assessments routine. Additionally, work will be done to explore integration of gender elements in regular service assessments at facility and community levels. The UN Joint Program on AIDS in Uganda provided funding for: (a) Technical assistance for the development of the consolidated score card (b) National and lower level stakeholder consultation meetings for buy-in and adoption, and (c) Initial pilot that was undertaken in 5 sectors of health, local government and public administration; gender, social services; justice and constitutional affairs and education sector. In addition to the gender review, CCM intends to support an annual compilation of TB and HIV services citizens' report to share community level satisfaction regarding the response to HIV and TB programs; this activity is budgeted under the HSS application. Funding Request: 1. Technical assistance to conduct the annual gender assessments using the existing CGSC. 2. 2-day regional stakeholder meetings during the annual gender assessments to consult communities in 4 regions of Uganda. 3. Print and distribute the gender assessment report during the Joint Annual Health Review and the Joint AIDS and TB review Assemblies								
Institutional capacity building, planning and leadership development	The AIDS Support Organisation (Uganda) Limited	Allocation						
		Above						
Description of Intervention [2]								

Activity description1: Strengthen multisectoral oversight and support supervision for addressing gender inequalities and strengthening responses for women and girls. Target Population: Uganda AIDS Commission, Ministry of Education, Ministry of Justice and Constitutional Affairs, Ministry of Health, Ministry of Gender Labour and Social Development, Civil Society, Networks of People Living with or Affected by Diseases, Development partners' in-country, Uganda Stop TB Partnership (USTP). Impact: improved coordination for the multi – sector interventions targeting gender inequalities at national and sub national levels. Implementation Approach: This intervention will involve establishment of a multi-sectorial HIV/AIDS Steering Committee for addressing Gender inequalities and strengthening responses for women and girls (SCoGiS). This committee will be convened by Uganda AIDS Commission to ensure an all-encompassing approach that does not conflict with individual sector mandates. The SCoGiS will comprise of not more than 15 members. They will be nominated from networks of people living with or affected by the diseases, Ministry of Health, Ministry of Gender Labor and Social Development, Ministry of Finance Planning and Economic Development, Ministry of Justice and Constitutional Affairs, Ministry of Education and Sports, Parliamentary Committees on HIV and Social Services, UN Joint Program team on HIV/AIDS, and the UN convergence group on gender equality and empowerment of women and girls among others. A full time specialist will be recruited to coordinate national level activities aimed at improving collaboration, linkages and resources mobilization for a gender sensitive response. Funding Request: 1. Identify and equip regional GBV and referral sites 2. Quarterly meetings for the SCoGiS 3. Recruitment and retention pay for a Gender specialist at the Uganda AIDS Commission 4. A computer laptop for the specialist 5. A vehicle to ease national and district level coordination involving the regional GBV-survivor sites and district GBV champions Activity Description 2: Improve coordination and management of non-public sector responses targeting key populations. Target population: CSOs and CBOs providing services to MARPs Impact: Improved coordination and access to health services by MARPs Implementation approach: Under this grant we propose that organizations implementing MARPs services be supported to enhance their coordination; the coordination role will be done by a CSO that has the capacity to coordinate and bring together the MARPs providers. They will actively participate in national and subnational level programming for key populations working with the disease control teams and provide supportive supervision to subnational level teams. This grant will provide technical assistance and local staff to a local network of key populations to: 1. Coordinate group planning activities 2. Convene and/or participate in coordination meetings involving central government departments and agencies, local authorities and other development partners 3. Convene stakeholder quarterly meetings 4. Coordinate training legal rights and literacy for key population communities 5. Monitoring to ensure timely access to health commodities. Activity description 3: A management grant to the Uganda Stop TB Partnership for 18 months post December 2015 Funding request: A management grant to USTP for 18 months post December 2015 to: - Support to USTP, CBOs, CSOs, Coalition etc. to carry out community TB education and social mobilization (visual acoustic model/VAM model) as activities in poorly performing central and north eastern regions, (3 sessions per region per year) 9 sessions per year. Note: The 2012 treatment success rate and loss to follow up rates in these two regions were 69% and 64% as well as 18% and 16% respectively, according to the NTLP annal report 2012/13 page 44. - Hold training sessions on planning, leadership and governance, budgeting for USTP's, CSOs, CBOs, CSO Coalitions to enable them support their partners around the country align their interventions to contribute to the NSP (Regional level, for the 12 regions, 1 session per region per year each targeting 30 people, coordinators), total 360 people per year - Technical assistance to conduct mapping of TB/HIV partners in the country. - Hold annual advocacy meeting with Health services committee of parliament. Activity description: Increase access to tailor made health services through tailor made services and reducing stigma and discrimination and promoting rights based approaches to health care Funding request: 1. Mapping Key populations through peer to peer networks 2. Service needs assessment 3. Data collection and reporting tools

Intervention	Responsible Principal Recipient(s)		Year 1	Year 2	Year 3	Year 4	Cost Assumptions	Other funding
Social mobilization, building community linkages, collaboration and coordination	The AIDS Support Organisation (Uganda) Limited	Allocation	131,302	55,933				
		Above	69,653	123,056	91,591			

Description of Intervention [2]

Activity description 1: Sensitize communities and leadership to improve demand and uptake of HIV/TB prevention, treatment and care services. Target Population: Parliamentarians and sector Ministry leaders, Ministry of Health, Uganda AIDS Commission, religious and cultural leaders, national level networks of people affected with the diseases, civil society networks and key population networks, the media and people living with or affected by the diseases. Impact: improved uptake for HIV and TB prevention, treatment and care services. Implementation Approach: Key leaders at various levels will be identified to engage communities and their constituents to address the risk factors to HIV infection such as inconsistent and incorrect condom use, and non-adherence to treatment. This intervention will involve group meetings and dialogue with leaders such as parliamentarians, religious and cultural leaders. Print and electronic Information, Education and Communication materials shall be developed to facilitate this process. The activities will also include training of health workers, law enforcement officers and judicial officers to raise awareness about negative behaviors and practices. Regional SGBV response sites shall be identified and equipped with a post-trauma counselor using government resources, SGBV evidence collection kits and first response health commodities with the intention of providing relief to the survivors. All survivors will be linked to a health service facility for post-exposure prophylaxis (PEP). Interventions for enhancing collaborations and linkages at community level involving affected communities; local authorities and CBOs have been planned for under the HSS grant. This includes working with and engaging communities to expand the community-based model of DOT to improve treatment adherence, reduce loss to follow-up and increase demand for TB diagnosis and treatment services in the community. In addition, the HSS grant will support identification and skilling for SGBV champions. There will be regular media meetings (electronic and print) and press conferences, to clarify ambiguities in the response to HIV and TB as well as give visibility to the challenges associated with TB and HIV control in the country. Funding request 1. Develop and reproduce IEC and advocacy materials for addressing SGBV, stigma and discrimination for HIV and TB. 2. Support advocacy campaigns such as World AIDS campaign on World AIDS day in December every year 3. Organise TB advocacy week 4. Commemorate world TB day in March every year 5. Organize Kick TB/HIV campaign for advocacy and mobilization for TB/HIV 6. Organize a TB symposium 7. Engage policy and religious leaders such as Parliamentary Standing Committee on HIV, Social Services Committee of Parliament, the Uganda Women Parliamentarians Association, religious and cultural leaders to raise the profile of SGBV, stigma and discrimination and their effect on HIV and TB service uptake. 8. Psychosocial and adherence support groups at facility and community levels and for follow-up have been provided for under the HSS concept note. A request to finance activities of Community linkage facilitators (CLiFs) has also been made through the HSS concept note.

Module: Program management

Module budget - Program management

Allocated request for entire module	USD 0	Above allocated request for entire module	USD 0

Intervention	Intervention budget (request to the Global Fund only)							
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Year 4	Cost Assumptions [3]	Other funding [4]

Supporting procurement and supply management	Ministry of Finance, Planning and Economic Development of Uganda	Allocation	0	0	0		All cost have been covered under HSS grant .	
		Above	0	0	0			
	The AIDS Support Organisation (Uganda) Limited	Allocation	0	0	0			
		Above	0	0	0			

Description of Intervention [2]

Procurement and Supply Management (PSM) Coordination The PSM systems, including the laboratory diagnostics, drive the overall inputs into the health services delivery and to a considerable extent service uptake. The national PSM system comprises of public, PNFP and PFP stakeholders. The MoH Pharmacy Division (MoH/PD) is charged with the mandate of coordinating the pharmaceutical sector. MoH is responsible for overall health regulation with most of the functions delegated to semi-autonomous institutions in which the NDA is mandated to regulate medicines and health supplies. NDA conducts regulation of registration, importation and post-marketing surveillance for all medicines and health supplies. The Integrated Commodity Security Group (CSG), which is under the Pharmacy Division/QPPU, meets monthly to discuss commodity procurement and supply chain issues related to HIV, malaria and TB commodities. Topics include review of current stock levels at central warehouses, order pipelines, Web-Based ARV Ordering System (WAOS) performance and any other issues related to commodity availability and management. The CSG draws together the relevant technical and programmatic staff from MOH as well as national and international stakeholders. The country enjoys support to the PSM system through GoU and donor support. The just awarded USAID/HSCSS project is expected to build on the gains from the concluded SURE-II project in building national capacity in supply chain management for essential commodities including laboratory products. GF under HSS Round 10 Phase 1 Grant provided some support for the establishment and functionalizing of Regional Performance Monitoring Teams (RPMTs) to serve as a bridge between the central and the district health systems. Quantification and Procurement Planning The quantification and procurement planning for the HIV and TB commodities are conducted centrally in MoH by the Quantification and Procurement Planning Unit (QPPU) and sub-nationally by the health facilities. This area needs expansion in terms of Human Resource and capacity to collect facility level data. Interventions to this end have been proposed and included in the HCSS grant application concept note. Warehousing Uganda has four central warehouses (National Medical Stores -NMS, Joint Medical Stores - JMS, Medical Access Uganda Ltd - MAUL and Uganda Health Marketing Group - UHMG) responsible for the procurement, storage, and distribution of Essential Medicines and Health Supplies (EMHS) to the public, Private Not For Profit (PNFP) and Private for Profit (PFP) sectors. Distribution The warehouses operate a pull/requisition system for HIV/TB commodities. NMS closed trucks deliver medicines directly to hospitals and to the district stores. A 3rd party is contracted to ensure secure and timely delivery of commodities to lower level health facilities. JMS and MAUL deliver medicines and Health supplies directly to the health facilities. The three warehouses make bi-monthly deliveries to the facilities according to a published delivery schedule in response to bimonthly orders from the health facilities. LMIS System The Logistics Management Information System (HMIS) consists of a mix of computerized and paper-based systems. The 2nd District Health Information System (DHIS-II) hosts the WAOS which is used for ordering ART commodities, reporting logistics data (product stock levels and consumption) and patient numbers. The WAOS links facility orders directly to their designated warehouses. The scope of the system is expected to widen to include TB and laboratory commodities. This is expected to solve the problem of prolonged delays in reporting on patient numbers and commodity ordering by health facilities. Quality assurance The National Drug Authority (NDA) is mandated to quality assure all pharmaceuticals imported in the country. In addition, the NDA ensures that premises and operations of all health facilities, pharmacies and drug shops comply with good pharmacy practice principles. The Uganda National Bureau of Standards is responsible for establishing standards and enforcing quality assurance of non-pharmaceutical commodities. A number of challenges in the supply chain have been identified and interventions proposed to overcome them with support from GF under the HCSS grant. Funding request: this is budgeted for under the HCSS grant.

E. Financial Gap Analysis and Counterpart Financing

Country: Uganda	Currency: USD
Component: HIV/AIDS	Cycle: July - June
Year of CN Submission: 2015	

	Current and previous			Estimated					
Part One: National Strategic Plan Funding Needs and Resources									
Total Funding Needs									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total Funding needs for the National Strategic Plan (provide annual amounts)			515,811,173	716,014,011	857,411,828	1,001,824,315			Data source HIV investment case 2014-2025
LINE A: Total Funding needs for the National Strategic Plan	515,811,173			2,575,250,154					

Domestic Resources									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total Resources										
Domestic source B1: Loans										
Domestic source B2: Debt relief										
Domestic source B3: Government revenues	44,725,599	49,478,322	48,860,475		48,650,475					MOFPED, MOLGs
Domestic source B4: Social health insurance										
Domestic source B5: Private sector contributions national										
LINE B: Domestic Resources	44,725,599	49,478,322	48,860,475		48,650,475	0	0	0	0	

External Resources										Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Ireland	7,600,000	8,580,000	8,580,000		8,580,000					Data source- COuntry Operational Report
Joint United Nations Programme on HIV/AIDS (UNAIDS)	13,259,000	14,150,000	14,150,000		13,250,000					Data source- Strategic Plan. Level funding from partners until new plan is approved.
Netherlands	7,100,000	7,100,000	7,100,000		7,150,000					
United States Government (USG)	294,844,800	299,136,807	323,983,410		323,983,410	323,983,410	323,983,410			Data source PEPFAR Country Operational Plan flat line budgets after
Sweden	2,600,000	2,130,000	2,160,000		2,000,000					Data source SIDA Operational Plan reports. No commitment available for funding after 2015.
Clinton Foundation	0	0	5,480,000		2,900,000					Data source- CHAI reports 2014
LINE C: External Resources	325,403,800	331,096,807	361,453,410		357,863,410	323,983,410	323,983,410	0	0	

Global Fund Resources									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
UGD-304-G04-H	0	0	0	0	0	0			
UGD-708-G13-H	12,694,193	30,261,245	897,283	0	0	0			
UGD-708-G07-H	42,389,673	605,918	36,118,569	0	0	0			
LINE D: Global Fund Resources	55,083,866	30,867,163	37,015,852	0	0	0	0	0	

Total Request									
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total anticipated resources (annual amounts)	425,213,265	411,442,292	447,329,737	406,513,885	323,983,410	323,983,410	0	0	
LINE E : Total anticipated resources (Line B+C+D)	1,283,985,294			1,054,480,705					
Annual Anticipated Funding Gap (Total funding need - Total anticipated funding gap)	0	0	68,481,436	309,500,126	533,428,418	677,840,905	0	0	
LINE F: Total anticipated funding gap (Line A - E)	-768,174,121			1,520,769,449					
LINE G: Total Funding Request to the Global Fund									
LINE H: Funding request within the Allocated Amount									
LINE I: Funding request above the Allocated Amount									

Part Two: Overall Health Sector - Government Health Spending

Government Health Spending									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Domestic source J1: Loans									
Domestic source J2: Debt Relief									
Domestic source J3: Government funding resources									
Total government health	0	0	0	0	0	0	0	0	

Part Three: Counterpart Financing Low income = 5% low income, lower lower-middle income = 20%, upper lower-middle income (high level) = 40%, upper-middle income = 60%										
Counterpart Financing										
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total government resources	44,725,599	49,478,322	48,860,475							
Average of government resources	47,688,132									
Average of request within allocated			0							
Counterpart financing based on existing commitments									100.00%	
Average of total request			0							
Counterpart financing based on total funding request									100.00%	

Country: Uganda	Currency: USD
Component: Tuberculosis	Cycle: July - June
Year of CN Submission: 2015	

	Current and previous				Estimated					
Part One: National Strategic Plan Funding Needs and Resources										
Total Funding Needs										Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total Funding needs for the National Strategic Plan (provide annual amounts)			35,775,588		52,611,957	36,187,958				
LINE A: Total Funding needs for the National Strategic Plan	35,775,588				88,799,915					

Domestic Resources										Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total Resources										
Domestic source B1: Loans										
Domestic source B2: Debt relief	1,953,125	1,953,125	2,100,500		2,392,222	2,400,000	2,300,000			
Domestic source B3: Government revenues										
Domestic source B4: Social health insurance										
Domestic source B5: Private sector contributions national										
LINE B: Domestic Resources	1,953,125	1,953,125	2,100,500		2,392,222	2,400,000	2,300,000	0	0	

External Resources									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
United States Government (USG)	8,251,565	8,251,565	8,251,565	8,251,565	8,251,565	8,251,565			Data source- PEPFAR Country Operational Plan. Flat line budgets, indicative figures.
Germany	602,000	139,000	326,000	186,000					Germany Leprosy Foundation
Other	500,000	500,000	560,000	560,000					FIND Operational reports
LINE C: External Resources	9,353,565	8,890,565	9,137,565	8,997,565	8,251,565	8,251,565	0	0	

Global Fund Resources									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
UGD-T-MoFPED	0	3,616,073	0	0	0	0			
LINE D: Global Fund Resources	0	3,616,073	0	0	0	0	0	0	

Total Request									
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total anticipated resources (annual amounts)	11,306,690	14,459,763	11,238,065	11,389,787	10,651,565	10,551,565	0	0	
LINE E : Total anticipated resources (Line B+C+D)	37,004,518			32,592,917					
Annual Anticipated Funding Gap (Total funding need - Total anticipated funding gap)	0	0	24,537,523	41,222,170	25,536,393	-10,551,565	0	0	
LINE F: Total anticipated funding gap (Line A - E)	-1,228,930			56,206,998					
LINE G: Total Funding Request to the Global Fund									
LINE H: Funding request within the Allocated Amount									
LINE I: Funding request above the Allocated Amount									

Part Two: Overall Health Sector - Government Health Spending

Government Health Spending									Data Sources/Comments
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015	07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Domestic source J1: Loans									
Domestic source J2: Debt Relief									
Domestic source J3: Government funding resources									
Total government health	0	0	0	0	0	0	0	0	

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Part Three: Counterpart Financing
Low income = 5% low income, lower lower-middle income = 20%, upper lower-middle income (high level) = 40%, upper-middle income = 60%

Counterpart Financing										
	07/2012 - 06/2013	07/2013 - 06/2014	07/2014 - 06/2015		07/2015 - 06/2016	07/2016 - 06/2017	07/2017 - 06/2018	07/2018 - 06/2019	07/2019 - 06/2020	
Total government resources	1,953,125	1,953,125	2,100,500							
Average of government resources	2,002,250									
Average of request within allocated			0							
Counterpart financing based on existing commitments									100.00%	
Average of total request			0							
Counterpart financing based on total funding request									100.00%	

Footnotes

1 - Target Assumptions :
Please describe:
1) overall assumptions used in calculating targets,
2) anticipated rate of scale-up,
3) population size estimates,
4) description of indicator/package of services,
5) data source,
6) other relevant information

2 - Description of Intervention :
Please describe:
1) rationale for Global Fund support,
2) linkages to national strategic plan,
3) target population and geographic scope,
4) implementation approach, and
5) other relevant information.
Please differentiate between scope of allocated and above allocated request

3 - Cost Assumptions for the request of the Global Fund
Please describe:
1) cost assumptions and data sources,
2) key activities,
3) other relevant information.
Please differentiate between allocated and above allocated

4 - Other funding received for this intervention (including scope of activities funded)