Application Form:
Health System Strengthening (HSS) Support
in 2016

Deadlines for submission of application:

15 January 2016

1 May 2016

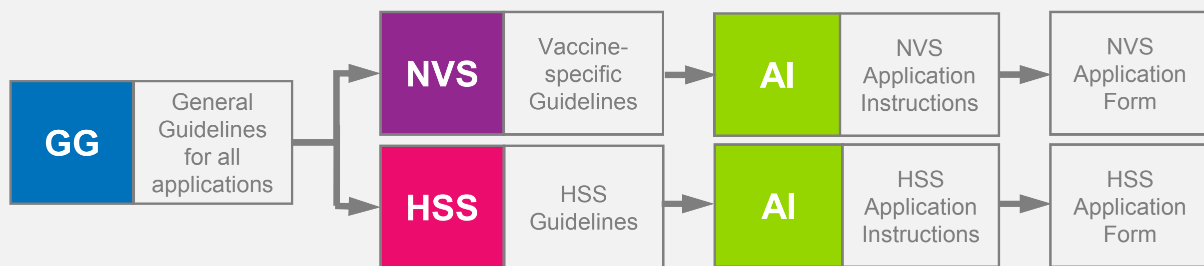
9 September 2016

Document dated: October 2015

(This document replaces all previous versions)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



Purpose of this document:

This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.

The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Weblinks and contact information:

All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

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PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	*This should correspond exactly to the budget requested in Question 17 (detailed budget).* ***30,600,000.00 USD (Thirty Million Six Hundred Thousand US Dollars Only)***	
Does your country have a finalised and approved National Health Sector Plan?	Yes ☑	No ☐
	*Indicate the **end year** of the NHSP:* ***2020*** ***Provide Mandatory Attachment #8: NHSP***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes ☑	No ☐
	Indicate the end year of the cMYP: ***2020*** *Provide **Mandatory Attachment #11**: cMYP*	
Proposed HSS grant start date:	*Indicate the month and year of the planned start date of the grant.* ***Planned Start Date: 1st January 2017***	
Proposed HSS grant end date:	*Indicate the month and year of the planned end date of the grant.* ***Planned End Date: 31st December 2021***	
Joint appraisal planning:	*Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.* ***The joint appraisal will be conducted: June / July Annually 2016*** ***HLRP meeting the joint appraisal report will be submitted to:*** ***Mr Tito Rwamushaijja & Ms Sabrina Clement***	

2. Application development process *(Maximum 2 pages)*
Provide an overview of the collaborative and participatory application development process. *Include the following **Mandatory Attachments:*** ***#4**: Minutes of HSCC meeting, at which the HSS application was endorsed- **Attached**;* ***#5**: Last 3 minutes of HSCC meeting- **Attached** s; and* ***#15**: TOR of HSCC- **Attached*** ***Uganda National Expanded Program on Immunization (UNEPI)*** is the MOH arm that steers and manages the EPI/VPD program through a Central Team led by the Program Manager. UNEPI, under the stewardship of MOH Director General of Health Services, examined its medium term (2015 – 2020) programmatic prospects and discussed the need to apply for the second Gavi HSS support[1, 2, 3] *(;)*. This was in view of evident resource inadequacy for improving the country's immunization program in line with EVMA and EPI Review recommendations.

[1] *Combined EPI Review Report 2015, pgs 11-14*
[2] *EVM 2014*

Decision to apply for Gavi HSS Support by UNEPI/MOH Uganda: This is Uganda's second application for Gavi HSS support to the country. The decision to apply for the second Gavi HSS support was initiated through EPI Technical working Group (which comprises of UNEPI, Health Development Partners and other key stakeholders) and the EPI National Coordination Committee (NCC). The inclusion of Health Development Partners (HDP) in the membership of the EPI TWG and NCC by MOH is to ensure transparency, accountability and robust partnerships in the country's health system. The decision to apply was further sanctioned by the Top management of MOH (Hon. Minister, Permanent Secretary, Director General of Health Services), EPI NCC and MOH Health Policy Advisory Committee (HPAC) based on expressed need for additional resources for improving the performance of the country's EPI. This is critical since the reprogrammed Gavi HSS-I is scheduled to end in June 2015,, without the imminent Gavi HSS support, crucial EPI services are bound to grossly scale down with dire consequences on EPI and RMNCAH service beneficiaries countrywide.

Procurement of TA: The HSS proposal development was led by Ministry of Health with support from stakeholders such as in-country development partners, CSOs with additional TA from consultants. Using its robust partnerships, MOH/UNEPI in collaboration with WHO and CHAI procured technical assistance to bolster the existing in-country efforts towards development of a quality Gavi HSS 2016 proposal. The additional TA consisted of the HSS and costing consultant all contributing to the development process, costing/budgeting, financial gap analysis and the work plan of the proposal.

Formation of HSS WGs / Proposal Writing Team: Under the stewardship of the DGHS, the NCC mandated the Program Manager and the Management of UNEPI to proceed with development of the Gavi HSS 2016 proposal for Uganda in time for submission on 1st May 2016. Subsequently, UNEPI management, in collaboration with health development partners and the consultants, guided formation of five HSS WGs*: Stewardship & Health Financing; Procurement and Supply Chain Management(PSM)/Cold Chain; Health Management Information Systems (HMIS/Strategic Information; Service Delivery & Human Resources for Health(HRH); and Community Systems Strengthening(CSS)*. The membership of the five HSS WGs was drawn from health partners, Non-State Actors and the rest of MOH. The five HSS WGs worked interactively and collaboratively with technical assistance throughout the proposal development process.

HSS WG Meetings: The HSS WG meetings were interactive and thematic in focus. Led by the HSS consultant, the five HSS WGs identified health system bottlenecks to achieving immunization outcomes, discussed related causal factors and explored plausible strategies and activities for addressing the identified health system bottlenecks. The bottlenecks were then validated through concurrent analytic literature review- hence all the bottlenecks are referenced. ***Consensus Workshop on Objectives and activities of the Gavi HSS 2016 Proposal:*** In order to build technical consensus on the objectives and activities proposed by the five HSS WGs, a bottleneck analysis at subnational and national level that involved interaction with district Health Offices , selected health facilities and key informants at national level and literature review, a three days' workshop in Masaka district where we developed the objectives and identified activities in all the components of EPI based on the bottleneck analysis and a two day consensus workshop was held in Jinja to refine the objectives and activities for the Gavi HSS 2016 proposal.

The Non-State Actors (CSOs): Like the health partners, the Non-State Actors were involved in the proposal development process right from the onset. The Non-State Actors active in the proposal development process were: UHF, JMS, MACIS, Theta, UNHCO, PNFPs (UCMB, UPMB, UMMB, UOMB) and PHPs.

Table 1: Summary of the process of Gavi HSS 2016 Proposal development, MOH/UNEPI Uganda

Proposal Development Milestone	Mode of Execution of the specific Milestone	Outcome of the specific Milestone / Phase	Responsibility Centre
1. Decision to apply for Gavi HSS Support by UNEPI/MOH Uganda	• The decision was initiated by the EPI TWG (MoH & HDP) meeting, in the context of continued need for additional HSS support for achieving immunisation outcomes • The NCC & HPAC meetings sanctioned the decision to apply for Gavi HSS Support	• Gavi HSS proposal in preparation: work-in-progress for submission to Gavi Secretariat on the 29th April 2016	**UNEPI**
2. Formation of HSS	• Formed in November 2015	• Monthly stakeholder-wide	**UNEPI**

[3] *EVM 2011*

	Working Group (WG)	• HSS WG headed by UNEPI but reporting to the NCC chaired by the DGHS, MOH	consultative meetings • Weekly HSS Working Group meetings	
3.	**Procurement of TA**	• HSS TA	• Alignment of Objectives and Activities • HSS proposal developed	**World Health Organisation (WHO)**
		• Costing TA	• Alignment of Activity costs • HSS costing developed	**Clinton Health Access Initiative (CHAI)**
4.	**Health System Building Block Specific WG Meetings**	• Five working groups formed according to the health system (HS) building blocks • Expected output of Objectives and Activities aligned with the HS building blocks	• Objectives and Activities in place	• **MoH** • **Stakeholders** • **HSS TA**
5.	**Individual Health System Building Block Specific WG Assignments with weekly updates**	• Individual assignments submitted to the UNEPI HSS Focal Person & the HSS TA for review and update	• Assignment outputs reviewed and updated for incorporation into the main proposal	• **UNEPI HSS Focal Person** • **HSS TA**
6.	**Consensus Workshop on Objectives and activities of the Gavi HSS 2016 Proposal**	• Consultative meetings • Bottleneck review of MoH policy, reports and review documents • Bottleneck Analyses at national & district levels (selection criteria: Good, Moderate, Poor EPI Performance)	• Identified bottlenecks affecting the health system and impacting negatively on immunisation service delivery, demand and uptake	• **UNEPI** • **HDP** • **HSS TA**
7.	**Costing of Activities & Development of the Budget**	• Costing TA procured by CHAI • WG leaders were tasked to give clearly quantified and qualified activities to ease costing • Focused activity specific discussions of cost elements were carried out for all the health system building blocks; this intensified in the consensus workshop	• Cost estimates and or cost elements of most activates added done during the consensus workshop	• **UNEPI HSS Focal Person** • **Costing TA** • **HSS TA** • **HSS WGs**
8.	**Development of the Performance Framework (PF)**	• Timing of activities was part of the assignment for all WGs • Timing of activities was refined in the Consensus Workshop	• Most activities timed by quarter and year during the consensus workshop	• **UNEPI HSS Focal Person** • **Costing TA** • **HSS TA** • **HSS WGs**
9.	**Contribution and Approval processes**	• Input by: - SMC: 13th April 2016 - EPI TWG: a continuous process - Top Management: 19th April 2016 - UNITAG: 19th April 2016 • Approval by: - HPAC: 20th April 2016 - Ministers (MOH & MOFP&ED): 26th April 2016	• Draft Proposal submitted according to schedule	• **MoH and UNEPI top management**
10.	**Completion of the proposal**	• Slated for 29th April 2016	• The Gavi HSS Proposal 2016 for Uganda to be accomplished in time for submission on the 29th April 2016	• **HSS TA** • **Costing TA** • **UNEPI HSS Focal Person**
11.	**Sourcing Signatures**	• To be done by the UNEPI HSS Focal Person	• Proposal signed ready for submission	• **MoH Top Management**
12.	**Final Approval**	• GoU commitment and Final Approval by Minsters MoH and MoFPED	• Proposal signed ready for submission	• **MoH Top Management**
13.	**Submission of the proposal**	• Portal population to start from 22nd April 2016 by the UNEPI HSS Focal Person, other WG members & the Consulting Teams	• Proposal to be duly submitted on the 29th April 2016	• **UNEPI HSS Focal Person**

Other Contributing Documents & Insights considered for this HSS proposal: The recommendations from Gavi Full Country Evaluation Report 2015 based on the findings on the performance of Gavi HSS-I were reviewed during the proposal development process to provide lessons learnt to inform future implementation of HSS activities. The current cMYP (2016-2020), HSDP (2016-2020) and findings of EPI Reviews were among the key documents reviewed during the proposal development to ensure alignment and overarching strategic objectives

How Gavi HSS-II relates to other on-going HSS-I interventions under MOH stewardship: Gavi HSS-II is well aligned, complementary and synergistic to other MoH HSS interventions funded by Global Fund for Aids,

Tuberculosis and Malaria Project (GFATMP), Health Systems Strengthening Project (HSSP) by World Bank (WB), African Development Bank (AFDB), Islamic Development Bank(IDB), Belgian Technical Corporation (BTC) and others; and the GoU capital investments and Primary Health Care(PHC) funding. Therefore GAVI HSS –II funding will be catalytic to the existing investment in HSS of the country.

3. Signatures

3a. Government endorsement

*Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment #2.***

We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.

Minister of Health (or delegated authority)

Name: **Hon. Dr. Elioda Tumwesigye (MP)**

Signature: ***Attached***

Date: *27th April 2016*

Minister of Finance (or delegated authority)

Name: **Hon. Matia Kasaija**

Signature: ***Attached***

Date: *29th April 2016*

3b. Health Sector Coordinating Committee (HSCC) endorsement

*Include HSCC official endorsement of the HSS proposal – **Mandatory Attachment #3 Attached***

Include a signature of each committee member in attendance and date.

Mandatory Attachment #3: HSCC Endorsement of HSS Proposal

We the members of the HSCC, or equivalent committee met on 20th April 2016 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	Title / Organisation	Name	Sign below to confirm:	
			Attendance at the meeting where the proposal was endorsed	Endorsement of the minutes where the proposal was discussed
Chair				
Co-Chair				
Secretary				
MOH members				
Development Partners				
CSOs				
WHO Country Office				
UNICEF				

Other				

4. Executive Summary *(Maximum 2 pages)*

Provide an executive summary of the application.

Strategy for Identification of Priority Bottlenecks

In order to identify bottlenecks that are a priority to address through this Gavi HSS support, all the five HSS TWGs were guided by a set of criteria that ensured the identified HSS bottlenecks are not only a priority but are respectively and logically linked to strategies, objectives and activities for the bottlenecks. The guiding criteria is included as an attachment.

HSS Bottlenecks Identified

Procurement / Logistics & Supply Chain Management (LSCM) Bottlenecks constraining effective vaccine management and endangering cold chain integrity of UNEPI: EVM 2014 still highlights bottlenecks which include inadequate cold storage capacity in District Vaccine Stores (DVS) in nearly 50% of districts with high likelihood of limiting their technical capacity to accommodate the traditional and newly introduced vaccines, inadequate biomedical technical capacity countrywide, obsolete EPI equipment, poor vaccine temperature monitoring, lack of technical capacity in forecasting. Other challenges include ttransport for distribution of vaccines and other essential medical commodities, non-adherence to distribution protocols of vaccines, no Standby electricity or power backup at many DVS, and weak EPI logistics management information system.

HMIS- Strategic Information challenges that weaken production of evidence for decision making in the health system: There is limited use of EPI data as evidence in decision-making from the point of data generation to other levels of the health system. Persisting poor data quality in UNEPI and main HMIS, lack of updated data collection tools and Monitoring Charts undermining completeness and reliability of data, unreliable EPI Denominators, weak VPD surveillance due to technical knowledge, inadequate occurrence of active surveillance and weak EPI Performance Monitoring at all levels of the health system

Service Delivery and Health Workforce bottlenecks that compromise quality, access and uptake of EPI and priority RMNCAH services: At the service delivery levels challenges still exist, these include: Inadequate outreaches with inadequate support supervision, only 40% of health units surveyed in 2014 had evidence of conducting outreaches, deficit in VPD / IDSR technical skills, lack of EPI micro-plans, low PCV uptake after introduction of the vaccine, lack of in-service training on current developments in EPI, an old EPI Prototype curriculumum that has not been updated to include the recent developments in immunization.

Health Financing and Stewardship constraints that limit availability of financial resource for immunisation:

Overall, the total government expenditure on Health averages about 8.5%, far below the Abuja declaration of 15%. This leads to inadequacy of funds for health system priorities and impaired fulfilment of government priorities, resulting in an equally high OOPE (38.4%), and balance of expenditure being met by donors (46.3%). Other challenges include slow flow of Funds from MOFPED to MOH, and from DHO to Health Facilities; off-budget donor support for districts by that has restrictive guidelines and do not align to district priorities, non-existent Fair & Sustainable Health Financing for majority of the population (*High OOPE, No risk-pooling or prepayment schemes for health services, exorbitant privately procured immunization services*, *weak regulation of health markets by the government*, the *immunization act enshrines the immunization fund which needs operationalization),* No pragmatic Oversight Visits by MOH Top Management to get contextual insights for strengthening program performance at sub-national / operational level, and weak evidence based EPI advocacy engagements across sectors and legislature.

CSS challenges that hinder community access to EPI and other priority RMNCAH services: There's low capacity of VHTs (30% had formal training) to multi-task in PHC service delivery, poor tooling and incentives / motivation. Due to the challenges experienced with the VHTs, a new CHEWs strategy is being adopted. Other CSS challenges include weak advocacy, communication and social mobilization for uptake of EPI services; lack of a fully functional CBHIS for generation and transmission of real time information.

Objectives for addressing the identified bottlenecks and improving immunisation outcomes

Medium Term goal 1: Service Delivery -HRH: To enhance equitable access to quality EPI and other priority RMNCAH services by target populations, including hard-to-reach populations, so as to increase uptake of EPI and other priority RMNCAH services by December

2021: The objective will focus on ensuring EPI commodities will reach the service delivery points. ***Specific objectives*** include: Strengthening outreach services to increase equitable access including hard-to-reach communities to quality EPI and other priority RMNCAH services; strengthening EPI focused supportive supervision for improving EPI service delivery quality and uptake of EPI services; updating the EPI curriculum for health training institutions to include new developments and technologies in the country's EPI / VPD program for improving EPI outcomes; and conduct operational researches on EPI service delivery to inform EPI service performance during the grant period. ***Budget for this objective:*** **12,152,796** **USD**

Medium Term goal 2: To strengthen the logistics and supply chain management system of UNEPI/NMS in order to improve the quality of stock management as well as efficiency of distribution of these essential commodities at all levels countrywide by December 2021: The aim of this objective is to improve the PSM/LSCM of the EPI commodities. ***Specific Objectives are:*** expansion of the cold and dry storage capacity for vaccines and related supplies at the National vaccine Store and sub-national stores to adequately accommodate all vaccines by 2021; Improve the efficiency of distribution of vaccines and related supplies at all levels; strengthen the quality management/safeguard mechanisms that ensure cold-chain integrity and vaccine potency from the port of entry at the airport (customs) to the point of distribution; implement the planned EPI Cold Chain Preventive Maintenance System for efficient maintenance of cold chain and other critical equipment while ensuring responsive remedial biomedical engineering support for EPI cold chain trouble-shooting anywhere in the country; and establish and operationalize an electronic Logistics Management Information System (LMIS) of the EPI vaccines and related supplies. ***Budget for this objective:*** **9,493,486** **USD**

Medium Term goal 3: To strengthen generation and utilization of routine and real time strategic health information (HMIS, IDSR & Surveys) on EPI and other priority health services for responsive management of these services at all levels of the health system by December 2021: The HMIS will be strengthened to guide evidence-based decision making. ***Specific Objectives:*** Building the capacity of District HMIS, EPI/VPD Surveillance & IDSR Focal Persons in M&E skills with emphasis on quality data management and data use for management decision making on performance improvement of EPI & other priority RMNCAH services; strengthen the EPI/VPD surveillance system at all levels of the health system, including community based VPD surveillance; and strengthen EPI Performance Monitoring and Tracking by the EPI M&E Unit to continue evidence generation using regular surveys and operational research.

Budget for this objective: **3,289,785** **USD**

Medium Term goal 4: Health Financing: To institute mechanisms for sustainable immunization financing so as to achieve predictable immunization financing for effective management of the immunization program by December 2021: This objective has two ***specific objectives*** that aim to address the challenge of financing the immunization program. To Operationalize the immunization fund so as to enhance sustainable financing for the immunization program in the grant period; To institute sustainable timely resource flow, timely accountability & increased transparency of financial management processes of the EPI program at national and sub national levels . ***Budget for this objective:*** **1,012,560** **USD**

Medium Term goal 5: CSS / Non-State Actors: To Enhance community demand for and uptake of quality EPI and other priority RMNCAH services so as to improve EPI and other health outcomes of the country by December 2021: This objective will focus on strengthening the community demand for and uptake of quality EPI services. ***Specific objectives*:** strengthening the quality of community based health services by diversifying the skills of CHEWs to make them more effective in delivery of integrated priority community health services, including EPI services; strengthening Communication and Social Mobilization for EPI to enhance demand for and uptake of EPI and other priority RMNCAH services; establish CBHIS to enable capture and transmission of real time data on community health and surveillance events in any part of the country. ***Budget for this objective:*** **2,380,583** **USD**

Medium Term goal 6: Stewardship and Programme management: To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI: This objective will focus strengthening program management and improving stewardship of the program. It has one ***specific objective:*** To strengthen Leadership & governance for sustainable, effective and efficient management of the EPI program at all levels of the health system. ***Budget for this objective:*** **2,268,890** **USD**

Implementation Arrangements, including Financial Management, Procurement, Coverage and Equity and M&E Setting

The Ministry of Finance Planning and Economic Development (MoFPED)

The management of the Gavi grant will be through existing GoU financial management structures and banked on the MoFPED holding account. Once requested by MOH, MoFPED transfers amount to Bank of Uganda (BoU)

Dollar account. At implementation, MoH requests Bank of Uganda to provide funds in a Uganda shillings currency. The Integrated Financial Management Information System (IFMIS) is the interface used for making financial transactions.

Sub-recipient management arrangements

Since 2007, the Principle Recipient (PR) sub-granted Local Governments and CSOs. The PR undertakes a pre-award assessment to ascertain existing capacity and identify areas of weakness, signs MoU with qualifying CSOs, undertakes capacity building, disburses grant funds and performs routine monitoring to ensure proper programmatic and financial accountability. The PR will be responsible for contracting the sub recipients. This will include sub recipient orientation and training on monitoring and reporting requirements as well as capacity strengthening on operational and crosscutting issues. All sub-recipients will then derive their work plans in line with the overall PR work plans

Coordination between the Principal Recipient and their respective sub-recipients

The PR shall ensure intensified monitoring to ensure that sub recipients adhere to SOP set by GAVI, conduct induction training, financial reporting, indicators and guidelines. Also PR is responsible for Quarterly validation of expenditures, internal audit as is required by GAVI, coordination and effective planning.

Coverage and Equity:

The implementation of the Gavi HSS grant will be equity focused targeting special geographic location, socio-economic status, gender and special population groups such as hard to reach populations.

M&E arrangements: The Gavi HSS grant will be monitored using multiple M&E approaches and structures, jointly agreed by UNEPI/MOH and the Gavi HSS grant implementing partners (IPs). The approaches will include: Regular Program Progress Assessments and Operational Support Supervision Reports; Programme Performance Reviews; Operational Researches; Conventional Evaluative Studies; Various Policy Level Oversight on the grant; Oversight by Global Health Initiatives (Gavi Alliance Geneva; Gavi FCE; GFATM & WB), MoH technical structures and other HSS supports.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
ABCE	Access, Bottlenecks, Costs, and Equity project
ACHS	Assistant Commissioner Health Services
AEFI	Adverse Effects Following Immunization
AIS	AIDS Indicator Survey
APR	Annual Progress Report
BCC	Behaviour Change Communication
BCG	Bacillus Calmette–Guérin vaccine
BTC	Belgian Technical Corporation
CBHIS	Community Based Health Information System
CDC	US Centers for Disease Control and Prevention
CES	Coverage Evaluation Survey
CHAI	Clinton Health Access Initiative
cMYP	Comprehensive Multi-year Plan
CRO	Country Responsible Officer (GAVI)
CRS	Catholic Relief Services
DBS	Dried blood spot
DFID	UK Department of International Development
DGHS	Director General Health Services
DHO	District health officer
DHS	Demographic and Health Survey
DoV	Decade of Vaccines
DPT/DTP	Diphtheria, pertussis, tetanus vaccine
DSS	Demographic Surveillance Site
DTP	Diphtheria, Tetanus and Pertussis
EAT	EPI Expenditure Tracking
EEA	EPI Expenditure Accounts
ELISA	Enzyme-linked immunoassay

EPI	Expanded Program on Immunization
EPITWG	EPI Technical Working Group
EVMA	Effective Vaccine Management Assessment
FCE	Full Country Evaluations
FCI	Fact-checking interview
FGD	Focus Group Discussion
FMA	Financial Management Assessment
FY	Fiscal Year
GBD	Global Burden of Disease
GOU	Government of Uganda
HB	Hepatitis B
HBc	Anti-hepatitis B core antigen
HBsAg	Hepatitis B surface antigen
HFS	Health Facility Survey
HH	Households
HHS	Household survey
Hib	Haemophilus influenzae
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HPV	Human papillomavirus Vaccine
HRR	Household Response Rate
HSS	Health Systems Strengthening
ICC	Interagency Coordinating Committee
IDB	Islamic Development Bank
IDRC	Infectious Diseases Research Collaboration of Uganda
IDSR	Integrated Disease Surveillance and Response
IEC	Information, education, and communication
IFMS	Integrated Financial Management System
IHME	Institute for Health Metrics and Evaluation
IPD	Invasive pneumococcal disease
IPV	Inactivated polio vaccine
IRB	Institutional Review Board
IRC	Independent Review Committee
ISO	International Organization for Standardization
ISS	Immunization Services Support
IU	International units
JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JSI	John Snow Inc.
KAP	Knowledge, Attitudes, And Practice
KII	Key informant interview
LC	Local Council
LCMS	Living Conditions Monitoring Survey
LIST	Lives Saved Tool
LR	Linear regression
MACIS	Malaria and Childhood Illnesses Secretariat
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Programme (Uganda)
MIS	Multiple Indicator Survey
MMR	Measles, Mumps, Rubella vaccine
MNC&AH	Maternal Neonatal Child & Adolescent Health
MOH	Ministry of Health
MoU	Memorandum of Understanding
MR	Measles-Rubella vaccine
MSD	Measles Second Dose
NCC	National Coordinating Committee (Uganda)
NCIP	Scientific & Technical Sub-Committee of National Committee for Immunization Practice
NGO	Non-Governmental Organization
NHA	National Health Accounts

UNITAG	Uganda National Immunization Technical Advisory Group
NMHCP	National Minimum Health Care Package
NMS	National Medical Stores (Uganda)
NSDS	National Service Delivery Survey
NVS	New Vaccine Support
OD	Optical Density
OECD	Organization for Economic Cooperation and Development
OP	Operational Plan
OOR	Out-of-range
PAED	Programme for Awareness and Elimination Of Diarrhoea
PATH	Program for Appropriate Technology in Health
PCV	Pneumococcal Conjugate Vaccine
PETS	Public Expenditure Tracking Survey
PI	Principle Investigator
PIE	Post-Introduction Evaluation
PIP	Program implementation plan
PHP	Private Health Practitioners
PNFP	Private Not For Profit
PPA	Principal Policy Analyst
PPDPA	Public Procurement and Disposal of Public Assets
PSU	Primary sampling unit
QC	Quality control
QSS	Quality, Safety, Standards
RCA	Root Cause Analysis
RFP	Request for Proposals
RT	Resource Tracking
SD	Standard Deviation
SHA	System of Health Accounts
SIA	Supplemental Immunization Activities
SMS	Short Messaging Service
SOW	Scopes of work
SVRS	Sample vital registration system
SWAp	Sector-Wide Approach
TA	Technical Assistance
Theta	Traditional & Modern Health Practitioners Together Against AIDS
TOC	Theory of Change
TOT	Training of Trainers
TT	Tetanus Toxoid
TWG	Technical Working Group
UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UHF	Uganda Health Federation
UMMB	Uganda Muslim Medical Bureau
UNCST	Uganda National Council of Science and Technology
UNEPI	Uganda National Expanded Programme of Immunisation
UNHCO	Uganda National Health Consumers' /Users' Organization
UNICEF	United Nations Children's Fund
UNMHCPs	Uganda National Minimum Health Care Package
UNPS	Uganda National Panel Survey
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
VA	Verbal Autopsy
VIG	Vaccine Introduction Grant
VPD	Vaccine Preventable Diseases
WB	World Bank
WG	Working Group
WHO	World Health Organization
XRP	Radiologically (X-Ray) Confirmed Pneumonia

PART B: BACKGROUND INFORMATION

6. Description of the National Health Sector *(Maximum 1 page)*

*Provide **Attachment #8**: NHSP or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

Uganda's Demographic Profile

Uganda is located in East Africa along the equator and has total area of 241,551square kilometers. Between 2002 and 2014, the population increased from 24.2 million to 34.9 million. This gives an average annual growth rate of 3.03%. The majority of the population (82%) live in rural areas[4].

Administrative Structure

Uganda is currently divided into 112 districts, 220 counties, 1261 sub-counties, 6,953 parishes and 59,092 villages). The village forms the smallest administrative unit.

Health Services Structure

The provision of health services in Uganda is managed through a central and decentralised system to the district local governments with the district and health sub-districts (HSDs) responsible for delivery and management of services at their levels.

Maternal and Child Health Indices

According to the 2011 UDHS, the MMR is estimated at 438 / 100,000 LB, the IMR at 54 / 1,000 LB, the under-5 MR at 90/1000 LB. 52% of children ages 12-23 months were fully vaccinated (UDHS2011), an increase of 6% from the 2006 UDHS. According to UDHS 2011, there is no notable difference between male and female vaccination coverage. Similar data is captured in the routine disaggregated HMIS data.

Uganda National Immunisation Program (UNEPI)

Immunisation services are provided nationwide and the MOH/UNEPI is responsible for policy, standards and priority setting, capacity building, coordinating with other Immunisation stakeholders and partners, resource mobilization, procurement of inputs (e.g. vaccines and injection safety materials), programme monitoring, and the provision of technical support supervision to the districts[5]**.** MoH/UNEPI has introduced new vaccines over 5 years which include PCV, HPV, IPV and plans to introduce Rotavirus vaccine in 2016.

Health Financing

The government's expenditure on health has been stable at about 8.6%, significantly below the Abuja Declaration of 15% of total annual government budget. The health sector is financed through government revenue and development assistance under the Sector-Wide Approach, termed the SWAp[6,7,8]. There is an improvement in availability of and access to Essential Medicines and Health Supplies (EMHS) from 43% in 2009/2010 to 63.8% in 2014/2015. With health infrastructure, physical access to health facilities (proportion of the population leaving within 5 km of health facility) is currently at 72% (HSDP 2015).

The is using the District Health Information System (DHIS)-2, which is an electronic web based reporting mechanism to ensure timely reporting for decision making. E-health has become a stronger area of focus, with the national e-health technology framework completed.

The health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, plus retention, motivation, and performance challenges. Efforts by the GoU and Partners have facilitated recruitment of much-needed staff increasing the proportion of approved posts from 56% in 2010 to 69% in 2013/14.

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[4] National Population and Housing Census 2014 pgs 8-15

[5] cMYP 2016 – 2020,pg 12

[6] HSDP 2015/16-2019/20 pages 77-79

[7] Vaccines and Immunization Financing review 2015 pgs 33-38

[8] EVM 2014,pg 18

According to the annual health report 72% of the districts have functional VHTs that are key link between the health service delivery and the community[9].

Despite improvement in the national immunization indicators, a review at sub-national level (particularly regional level) shows inequalities in service coverage and some impact indicators exist such as IMR.

7. National Health Sector Plan (NHSP) and relationship with cMYP *(Maximum 2 pages)*

Describe the relationship of the cMYP to the national health strategy.

*Provide: **Mandatory Attachment #8**: NHSP and **#11:** cMYP; and if available: **Attachment #18**: Joint Assessment of National Health Strategy (JANS); and **Attachment #19**: Response to JANS.*

The Health Sector Development Plan (HSDP 2015/16-2019/2020) hinges on the vision and mission of the National Health Policy II (NHP II), and the broad health sector objective of the National Development Plan II (NDP II). The HSDP (2015/16 – 2019/20) focuses to improve interventions across four cluster areas: Health Promotion, Disease Prevention and Community Health initiatives; Reproductive, Maternal, Child and Adolescent Health (RMNCAH); Communicable Diseases Control; and Non-Communicable Diseases prevention and control. The HSDP has four specific objectives, each outlining strategies for achieving it (Table 1).

Table 1: Objectives of the NHSDP 2015/16-2019/2020

Specific Objective of HSDP 2015/16-2019/2020	Strategic Interventions for achieving the specific objective
Specific Objective 1: To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services	Health promotion across the life course (RMNCAH and elderly)
	Provision of Non Communicable Disease Prevention and Control services
	Provision of Communicable Disease Prevention and Control Services
Specific Objective 2: To address the key determinants of health	Strengthen inter-sectoral collaboration and partnerships for effective implementation of the other cross-cutting issues
Specific Objective 3**:** To increase financial risk protection of households against impoverishment due to health expenditures	Establishment of systems for revenue generation
	Establishment of systems for risk pooling
	Establishment of systems for strategic purchasing of services
	Improve financial and procurement management systems
Specific Objective 4: To enhance the health sector competitiveness in the region and globally	Health Systems strengthening by addressing: Health governance & partnerships; Service delivery system; Health information & technology; Health financing; Health products and technologies; Health workforce; and Health infrastructure

Source: HSDP 2015/16-2019/2020

The current HSDP gives explicit focus on provision of sustainable, equitable and quality health services in the context of health promotion, and prevention & control of diseases, it also highlights fair and sustainable health financing as a component of broader health system strengthening. This blends with the vision, goal and mission of the NHP-II; the health sector objective of the NDP 2015-2020; and the goal of cMYP 2015-2020.

The cMYP (2016 – 2020)

The evidence base for the cMYP 2016-2020: The cMYP 2016 – 2020 was informed by the findings of: the Uganda Comprehensive EPI & Surveillance Review; Immunization Financing Review; PIE of Pneumococcal vaccine 2015; Effective Vaccines Management Assessment (EVMA, October 2014); GAVI Full country Evaluation (April 2015; Data Quality Self-Assessment (DQSA 2013; External Desk Review of The Status of Implementation of The Routine Immunization Improvement Plan for Uganda (February 2014), (see attached documents status of implementation of Coverage improvement plan 2014, review of annual work plan 2016); Meningococcal Risk Assessment 2014; and Cold Chain Equipment Inventory and Capacity Requirements for introduction of new vaccines in Uganda, 2014.

Table 2: Objectives of the cMYP 2016 -2020

Specific Objective of cMYP 2016-2020	Strategic Interventions for achieving the specific objective
Strategic objective 1: To increase and/or sustain	Strengthen and sustain high coverage of al l antigens through

[9] Annual Health report 2013/2014

coverage of all antigens across the duration of the cMYP	effective implementation of Reach E very Child/RED strategy
Strategic objective 2: To improve immunisation demand by reducing dropout rates	Improve immunisation demand through strengthening Advocacy, Communication and IEC
Strategic objective 3: To improve immunization equity by ensuring access and availability of vaccination across all districts with specific focus on gender, hard to reach and high risk communities	Improve Access and Equity Thro ugh Integration of services, SIAs and focused Targeting of High Risk Communities
Strategic objective 4: To accelerate introduction and integration of new vaccines and technologies in RI to reach high coverage in a sustainable manner	Accelerate and ensure effective and sustainable introduction of new vaccines and technologies
Strategic objective 5: To strengthen existing health systems and infrastructure to ensure efficient delivery of EPI program within the cMYP period	Strengthen AEFI surveillance and Integrate EPI surveillance into surveillance of other diseases (IDSR)

Source: cMYP 2016 - 2020

Alignment of cMYP 2016 -2020 with HSDP 2015/16- 2019/20

In addition to both cMYP and HSDP being strategic plans, albeit varying in programmatic scopes, their objectives align appropriately. The vision of the cMYP is to ensure that the Ugandan population is free from vaccine preventable diseases. The mission is to contribute to the overall HSSIP objective in reducing morbidity, mortality and disability due to vaccine preventable diseases.

The specific objectives 1 to 4 of the cMYP fit into the scope of specific objective 1 of the current HSDP. Further, the specific objective 5 of cMYP strongly feeds into specific objectives 3 and 4 of the HSDP, and inevitably into its specific objective 2 which provides an enabling environment for the overall health system functionality. This signifies that the priorities of cMYP and the HSDP are aligned, therefor achieving the objectives of cMYP which focus on RMNCAH and enhancing achievement of HSDP objectives. The key partners financing/funding the HSDP and cMYP, too, are relatively similar- both being financed by the GoU (from national revenues) in addition to being funded by development partners through various budget support and off budget development assistance packages[10,11] .

8. Monitoring and Evaluation Plan for the National Health Plan *(Maximum 2 pages)*

Provide background information on the country M&E arrangements.

How the National M&E Plan is implemented in practice

MOH Uganda has developed a complete M&E Plan for the HSDP 2015/2016 – 2019/20 (M&E Plan HSDP, January 2016). The goal of the M&E Plan is to contribute to the attainment of the HSDP 2015/16 - 2019/20 objectives and performance targets by providing a health sector-wide framework for regular, systematic tracking and documenting progress in the health sector performance.

The previous HSSIP (2010/11-2014/15) established the following mechanisms for M&E of health sector development interventions: operationalizing the DHIS-2 an electronic Health Facility web-based reporting mechanism; development of a Data Quality Assessment (DQA) manual; with support from Global Fund, 12 Regional Performance Monitoring Teams have been established to strengthen decentralized performance monitoring and surveillance as well as supporting performance management of health implementing agencies at all health system levels; and a Health Facility and community feedback and real time mechanism called mTRAC is operational in all the 112 districts.

Coordination of M&E activities in the health sector is done through the existing organizational structures of the health sector as detailed in the M&E of the HSDP 2010/11-2014/15 (Refer to ***Attachment #9***). Data analysis and synthesis have been designed to be carried out at all levels (national, district, health facility and community) to enhance evidence based decision making. However, data analysis, synthesis and utilization as evidence for decision-making is weak at sub-national levels. Analytical outputs that are produced for decision-making, program management, financial disbursements and global reporting include Annual Health Sector Performance Report,

[10] *cMYP, 2015 pgs 37-38*

[11] *HSDP 2015/16–2019/20 pgs XIV–XVI*

Annual Health Statistical Abstract, Annual Program / Project reports, Annual Report to National Planning Authority, Quarterly Progress Reports and Quarterly fiscal performance reports.
Service delivery data are packaged and displayed at the various levels using the HMIS formats already provided. Information is made publicly accessible through the MoH repository under the Resource Centre and MoH website, www.health.go.ug. The Health Promotion and Education Unit in the MoH packages information according to target audiences of various communication channels e.g. radio, T.V, video conferencing, tele-conferencing, newsletters, booklets, etc.
The MOH undertakes evaluation of the overall HSDP implementation as well as evaluation of specific programs, projects, policies and interventions in the health system under the GoU. The evaluations are commissioned by the MoH and conducted jointly by the MoH -Quality Assurance Department, country partners and international agencies. The MoH through the specific program / project managers is responsible for the design, management and follow-up of all program and project evaluations. All projects are required to budget for project evaluations and all project evaluations are conducted by external (non-MOH) evaluators to ensure independence. The value-for-money audits under the NHSDP are sanctioned by the Office of the Auditor General.

MoH in partnership with UBOS also conducts different periodic surveys such as UDHS 2011, AIDS Indicator Survey (AIS), Uganda Health Systems Assessment, National Health Accounts (NHA), Service Availability and Readiness Assessment (SARA), Non-Communicable Diseases Survey, and client Satisfaction Surveys. In the current HSDP, the following major surveys are planned: the UDHS-16, Aids Indicator Survey, NHA and Efficiency Analyses. The MoH undertakes disease surveillance under the; Integrated Disease Surveillance and Response (IDSR) framework. Each program identifies and plans all studies to be conducted in their respective M&E Plans.
Joint progress and performance reviews are part of programmatic governance mechanisms that help ensure transparency, accountability, constructive exchange of views and building consensus between partners for enhancing program performance effectiveness.
The Immunization programme is monitored using different mechanisms including regular Program Progress Assessments Reports, Support Supervision Reports; Joint Annual Programme Performance Reviews (JARs); Policy Level Oversight on the grant through top management support, Oversight by Global Health Initiatives (Gavi Alliance Geneva; Gavi FCE; GFATM & WB) & other HSS supports, including ADB; UNEPI/MOH Implementing Partners and MOH Technical Oversight Structures.

The Joint Annual Health Sector Review (JAR).

The annual performance review is conducted through the Joint Review Mission (JRM), a national forum organized by the MOH with support from partners that brings together all relevant stakeholders in the health sector. The review is focused on input, process, output and coverage indicators and targets specified in the annual plans and the NHSDP. Performance of the previous fiscal year is assessed, and actions and plans for the next year are determined.

Disparities between country administrative data and data from other sources

In 2014, there were disparities between country administrative data and coverage estimates from WHO/UNICEF. For example the administrative data reported DPT3 coverage at 102% while the WUENIC was 78%. This may be related to poor quality of numerator and denominators. In line with the recommendation of the DQSA of 2013, MOH and HDP agreed on a data quality improvement (DIT) plan for which implementation started in December 2014 and is still on-going. This is designed to provide supportive supervision and mentorship of health workers at district and health facility levels on data quality improvement and utilization. This is the basis of the data quality improvement interventions planned for in the Gavi HSS II grant application. Other interventions that have been planned for to complement the DIT interventions are mapping of target populations by the VHTs and Triangulation of population data to improve reliability of denominators using census, mapping, UDHS and WUENIC.

Independent Assessment of administrative data quality

MoH through the HMIS Resource Centre, with support from Gavi HSS I grant, conducts routine desk review of data quality in sampled districts. The methodology comprises of a combination of interviews, on-site observations and data reviews. The DQA teams comprise mainly of MOH staff from the HMIS Resource Centre and District Biostatistician,

The in-depth review of the routine administrative reporting system, required by Gavi at least once every five

years

WHO has developed a Data Quality Self-Assessment (DQSA) standard tool for evaluating different aspects of the immunization monitoring system at district and health facility level in order to determine the accuracy of reported numbers of immunizations and the quality of the immunization monitoring system. UNEPI with HDP, using the DQSA tool, carries out an assessment in order to assess the data accuracy and quality of immunization monitoring system in the country; the last assessment was done in 2013. The assessment findings have highlighted strengths. A similar guideline will be followed in implementing the DQS planned for in Gavi HSS grant 2017-2021.

Population-based survey to measure national vaccination coverage

The last coverage survey in the country was done in 2005. MOH and HDP have planned for EPI Coverage Survey to be conducted in 2016. A cross-sectional study with children aged 6-59 months and women who had a delivery during the last 0-11 months. The aim is to measure coverage, access of immunization services and ability of health care systems to ensure continuity of immunization services[12] in Uganda

Household surveys that have been conducted in recent years

Although a National Census was conducted in 2014, it did not include Immunization indicators. Uganda, however, through UBOS and MoH, conducts DHS once every five years Also planned for this year, is the Uganda Demographic and Health Survey.

*Provide **Mandatory Attachment #9:** National M&E Plan (for the health sector/ strategy)**,** as well as any sub-national plans, as relevant**.** If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment #16:** Data quality assessment report; and **Attachment #17:** Data quality improvement plan.*

***Pooled fund** applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

9. Alignment with existing results based financing (RBF) programmes (where relevant) (Maximum 1 page)

Indicate whether your country will align HSS support with existing results based financing (RBF) programmes.

*If yes, provide **Attachment #30:** Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.*

Uganda does not have a RBF program in place currently. Uganda has only implemented Result Based Financing (RBF) in pilots of varied nature, these include World Bank reproductive health voucher project, NU-Health RBF project, On-going CORDAID project. Currently, there are no existing RBF programmes to align with this HSS proposal. However, major steps for the preparation of the implementation of RBF are underway. Specifically, the Uganda National RBF Framework has been developed and is finalised[13]. The main objectives of the proposed National RBF program are:

1. To enhance the efficiency and quality of health services delivered to the population of Uganda while improving equitable access to these services.
2. To increase the strategic purchasing of cost effective services so as to contribute to significant reductions in morbidity and mortality

The main Principles of RBF implementation in Uganda include:

1. Promoting public-private partnerships with public, private not for profit (PNFP) and private health providers (PHP). PNFP and PFP providers will be eligible to provide services since they complement the provision of services by the public sector and by so doing increase access to health services.
2. Separation of the functions of regulation, purchasing, fund holding, verification and service provision. Although a purchaser provider split is recommended often with the involvement of independent purchasing agencies, we propose to use a combination of mainly government bodies with a separation of functions between the key

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[12] WHO, 2008, The EPI Coverage Survey. WHO/IVB/08.07

[13] Uganda National RBR framework

actors. Scaling up such a system is likely to be more sustainable than relying on independent agencies that would have to be paid huge sums of money. Oversight will however be provided by various committees that will include a multi-sectoral group of implementers. This mode of implementation will be monitored closely to identify bottlenecks, which will be addressed as soon as possible.

3. Autonomous management of services by health facilities. Under the decentralization policy, health providers are mandated to manage and deliver health services. They will be required to continue providing services under the government or institutional (PNFP) requirements except when there is a conflict with the RBF expectations in which case the DHMT should be alerted and the problem solved with advice from the regional RBF unit. The responsibility to hire and fire will however remain with the District Service Commission. All procurement will be done in line with the PPDA rules.
4. Transparency in the use of RBF funds through direct allocation of RBF funds to the health facilities and other entities and disclosure of the funds transferred.
5. Provision of RBF funds as an additional source of funds to the health facilities and other entities. It is therefore expected that the facilities and the district health teams will continue receiving the funds that they have previously received. However, some of these funds may eventually be provided using a PBF mechanism.

The detailed Uganda National RBF Framework is attached.

PART C: APPLICATION DETAILS

10. Health System Bottlenecks to Achieving Immunisation Outcomes *(Maximum 3 pages)*

*Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach **Optional Attachment 33:** Health system bottleneck analysis.=*

Please refer to the detailed Bottle neck analysis as attachment (BNA-GAVI HSS II Analysis_referenced_Uganda)

Key health system bottlenecks undermining improvement of immunisation outcomes at national and sub-national levels of the country

The health system bottlenecks identified and discussed are presented by specific health building blocks below. Also included in the attachments is a tabulated summary of health system bottlenecks and EPI equity trends for quick reference.

Service Delivery

Weak EPI Support Supervision coupled with inadequate outreaches

Only 40% of the health facilities surveyed in 2014 were found to be conducting outreach services and not all were conducting daily static services. This has been attributed to lack of transport for reaching the health facilities and inadequate funds for support supervision allowances. The PHC fund from MOFPED to districts is so thinly spread over many priority PHC services as to sufficiently cater for EPI services.

- ***Micro-plans non-existent in some districts***: consequently, micro-planning, and adequate implementation of the RED and REC strategies becomes hampered;

Procurement and Supplies Management (PSM) / Logistics & Supply Chain Management (LSCM)

Assessments and reviews conducted in 2014 and 2015 identified the following key bottlenecks that cut across the entire EPI supply chain from port of entry (Airport) to the service delivery level.

1. Inadequate cold storage capacity at District Vaccine Stores (DVS) and health facilities to accommodate traditional and new vaccines by 2020; - 12% of the 112 district vaccine stores and 35% of health facilities have inadequate cold storage capacity against 2020 needs and more capacity gaps expected with the more vaccine introduction.
2. Transport challenges affecting distribution of vaccines and other essential medical commodities especially within districts, including hard-to-reach areas
3. Persisting weaknesses in vaccines and EPI supplies stock management, including forecasting and quantification resulting in high wastage rates and stock outs.
4. Vaccine Temperature monitoring data not properly analysed and used for follow up action

5. Inadequate Cold Chain Technical Capacity to support sustainable maintenance of cold chain viability countrywide – only 40% districts with cold chain technicians.
6. Non-WHO Prequalified Fridges and other Cold Chain Equipment in the system that need replacement.
7. 10 DVSs do not have standby electricity or power backup (need standby generators)
8. The LMIS is not fully functional leading to data monitoring gaps on vaccine utilization and wastage tracking. Besides EPI Tools are at times lacking.
9. In 2014/15, 34% districts DPT1 coverage less than 80% (poor access) – need for expansion to improve coverage and equity and accessibility in hard to reach areas.

HMIS- Strategic Information

Equitable generation, access and transmission of strategic information has been strengthened; operationalizing DHIS-2, twelve Regional Performance Monitoring Teams strengthened and decentralized to conduct monitoring and surveillance countrywide and a community feedback mTRAC is operational in all the 112 districts. However there still exist gaps in the HMIS strategic information affecting data quality and utilisation.

- *Limited use of EPI data as evidence for decision-making at point of data generation and other levels of the health system*

The limited use of data for decision-making is due to lack of skills for analysis, interpretation, summarization, report writing and dissemination stemming from the lack of skills for analysis, interpretation, summarisation, report writing and dissemination.

- *Lack of updated EPI data collection tools and EPI Monitoring Charts undermining completeness, reliability of data as a result of unreliable and unpredictable funding.*

EPI monitoring charts were available in only 46% of health facilities, 40% of districts, and none at the national level[14].

- *EPI Denominators*

Even after the 2014 national census, some districts have continued to report coverage above 100%[15].
This may compel MOH/UNEPI to rely on pragmatic mapping at community level so as to obtain reliable denominator figures for specific population groups for supplies estimation.

- *VPD Surveillance*

Only 46% district Surveillance Focal Persons (SFPs) had correct knowledge of case definitions of VPDs, 54% had a list of active surveillance sites while guidelines for surveillance and AEFI were available in only 43%).

Health Financing

- *Total Government Expenditure on Health is low*

The overall government expenditure on health is 8.5% far below the Abuja Declaration recommendation of 15% hence inadequate to meet the actual resource need for effectively addressing the health system bottlenecks including PHC funds. Government per capita expenditure on health is about $8 or 15.3% of the $51 per capita; the difference being shared between donors (46.3%) and households/OOPE of 38.4%[16]. Furthermore the PHC fund has no specific proportion ring-fenced for immunization, yet immunization not only averts morbidities and mortalities from VPDs but also pertinent costs on households and the government.

Community System Strengthening (CSS)

- *Low capacity of CHWs / VHTs to multi-task in PHC service delivery including Poor Incentives, Motivation and Tooling*

In 2015, Uganda had a total of 179,175 CHWs (Village Health Teams- VHTs) that spanned the entire country. They are involved in several parallel activities not integrated into one PHC package and are poorly motivated. MOH has therefore come up with a policy to formalize the community based workforce by establishing the CHEWs (Community Health Extension Workers) who will be formerly employed civil servants. Through Gavi HSS-I, establishment of the CHEWs had begun through production of the CHEW Policy and Strategy and sensitization of stakeholders on CHEWs. This support will continue in form of co-funding unless there are no other partner

[14] Combined EPI Review 2014
[15] JRF 2015
[16] NHA 2012

supports. The strengthening of CHW (CHEWs/VHTs) performance will support the health system in many ways ranging from generating demand for EPI and other priority health services; improving access to health information; and providing real-time data/information to MOH and partners on health events/ actions in the health system countrywide[17].

- *Advocacy, Communication and Social Mobilization for routine EPI are still weak, resulting in low demand for and uptake of EPI services by the community*

The 2014 joint EPI review revealed that 89% of the health facilities had linkages with VHTs but only 49% of them communicated immunization and health matters through community leaders. Communication has been largely for accelerated immunisation activities and New Vaccine Introduction.

- *Community Based Health Information System is still at pilot stages in the country yet it would be crucial for generation and transmission of real time information*

Rolling out the CBHIS will improve generation of real time data/information while improving the timeliness of information flow from the community to the conventional HMIS, including community based VPD surveillance and allowing for defaulter tracking.

Stewardship- Leadership & Governance

- *Weak CSO Coordination, Collaboration and Oversight for EPI*

MOH collaborates with key players and partners through functional structures (HPAC, Top Management, EPI TWG, NCC, etc.) to ensure robust partnerships which entail evidence based/rational decision making, resource mobilization, transparency, accountability and focus on strategic directions. In addition there is an established office dedicated for Public Private Partnership for Health (PPPH) for coordination of CSO and other private-public partners for health however there are still exits gaps namely; lack of implementation guidelines and SOPs/tool kits facilitating CSOs.

- *Evidence based EPI advocacy engagements across sectors and the legislature is improving but needs strengthening*

The recently endorsed Immunization Act is a strong advocacy tool for MOH/UNEPI and her partner/CSOs. However, there is need to sensitize communities on the act and to follow up with Government commitments, enshrined in the Immunization Act e.g. establishment of the Immunization Fund[18].

Human Resource for Health

- *Human Resource Shortages in health facilities against MOH staffing norms*

Thirty nine (39%) of Districts reported >35% of health worker positions are vacant in the EPI review comparable to 32% reported in the NDPII. This leading to increased workload and inappropriate task shifting, usually to less trained cadres of staff[19,20]. Only 40% of districts have trained cold chain technicians, affecting logistics and cold chain management[21]. At national level, UNEPI staffing structure has not been changed since 1983 despite the increasing scope of work[14,22,23].

Coverage and Equity:

Despite marked improvements in coverage at national level, a review of coverage levels at sub-national level shows that inequalities in service coverage which impact immunisation indicators. Geographically, children living in Kampala are likely to receive full vaccination (63%), while those living in East-Central region are less likely to be fully vaccinated (39%)[24]. Social economic status among the population influence uptake of immunisation services. Mothers of secondary education (62%) compared to primary education (43%) and no education (38%) access

[17] Community Health Extension Workers Strategy in Uganda (2015/16- 2019/20)
[18] Immunisation Act 2016
[19] Uganda Combined EPI Review 2014, p 24
[20] NDPII 2015/16 – 2019/20 p33
[21] Ministry of Health, Human Resources for Health Bi-annual Report October 2014 – March 2015
[22] cMYP 2016-2020, p 21
[23] Uganda EPI Adapted Prototype Curriculum 2013
[24] UDHS 2011

immunisation services. There are regional variations in female independent decision making; 24% in Eastern region to 79% in Kampala[25].

***Pooled fund** applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.*

11. Health system bottlenecks to be targeted through Gavi HSS support *(Maximum 2 pages)*

Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.

Strategy for Identification of Priority Bottlenecks

In order to identify bottlenecks that are a priority to address through this Gavi HSS support, all the five HSS TWGs were guided by a set of criteria that ensured the identified HSS bottlenecks are not only a priority but are respectively and logically linked to strategies, objectives and activities for the bottlenecks. Special focus was on the districts coverage and equity considering full vaccination, geographical barriers and social-economic disparity to be given emphasis in the implementation. The guiding criteria can be found in the attachments. The health system building blocks were aggregated into five groups: whereas PSM, HMIS/Strategic Information and CSS remained as standalone blocks because of their unique health system strengthening demands, HRH was combined with Service Delivery because of their inalienable nature while Stewardship (Leadership & Governance) was combined with Health Financing because of the intricately related nature of bottlenecks in these blocks- in the case of Uganda.

Service Delivery and Health Workforce bottlenecks that compromise quality, access and uptake of EPI and priority RMNCAH services:

1. Weak EPI Support Supervision
2. Inadequate outreaches
3. Human Resource Technical Skill Deficits in VPD / IDSR surveillance
4. Micro-plans non-existent in some districts
5. Low PCV uptake after promising introduction of the vaccine
6. Lack of in-service training of health professionals on current developments in EPI;
7. The Pre-service EPI Prototype Curriculumum for training health professionals has not been updated to include the recent developments in immunization

Capacity building of the Human Resource for Health on quality immunization service delivery and micro-planning and operationalization of outreach immunization services will translate into reaching the unreached communities with quality immunization services

8. Ensuring vaccination coverage and equity in high risk population: 37 Districts with problems in access were identified by DPT1 (<90%), 16 districts with Geographical barriers, 47 districts categorised as special population(7 Nomadic, 15 Urban poor, 25 resistant groups).

Procurement / Logistics & Supply Chain Management (LSCM) Bottlenecks constraining effective vaccine management and endangering cold chain integrity of UNEPI:

1. Inadequate cold storage capacity in District Vaccine Stores (DVS) in nearly 50% of districts with high likelihood of limiting their capacity to accommodate the traditional and newly introduced vaccines
2. Transport challenges in distribution of vaccines and other essential medical commodities within most districts, including a few hard-to-reach areas
3. Non-adherence to distribution protocols of vaccines and other EPI commodities from port of entry (Entebbe Airport) to the operational (district and health facility) levels
4. Persisting weaknesses in EPI stock management, including lack of competence in forecasting and quantification of EPI and other Medical commodities
5. The quality of Vaccine Temperature Monitoring is does not meet the minimum EVMA acceptable standards in the entire EPI supply chain: right from the NVS/NMS at national level , the DVS at district level up to health facility level.
6. Inadequate Biomedical Technical Capacity to support sustainable maintenance of cold chain integrity countrywide
7. Non-WHO Prequalified Fridges and other Equipment still being used in the EPI cold chain
8. No Standby electricity or power backup at many DVS (District Vaccine Stores)
9. Weak LMIS: EPI logistics data quality does not meet the minimum EVMA acceptable standards; inadequate vaccine

[25] Coverage and equity analysis in the context of HSS for sustainably achieving desired immunization outcomes

utilization and wastage tracking; lack of EPI Tools & Guidelines for traditional & new vaccines

The challenges related to maintenance have been prioritized in HSS II with more innovative ways to improve maintenance at sub national level by leveraging the existing regional biomedical structure to bring maintenance services closer to districts in need of skilled cold chain technicians.
Uganda aims to address the cold chain gaps above in order to increase vaccine availability, accessibility to immunization services and thus enable improved coverage and equity.

HMIS- Strategic Information challenges that weaken production of evidence for decision making in the health system:

1. Limited use of EPI data as evidence for decision-making at point of data generation and other levels of the health system
2. Persisting Poor Immunization Data Quality
3. Lack of updated EPI data collection tools and EPI Monitoring Charts undermining completeness and reliability of data
4. Protractedly unreliable EPI Denominators
5. VPD Surveillance has several challenges ranging from technical knowledge gaps to inadequate occurrence of active surveillance.
6. Weak EPI Performance Monitoring at all levels of the health system

The limited availability of tools, use of data for decision-making mainly stems from the lack of skills for analysis, interpretation, summarization, report writing and dissemination and has resulted in delayed use of data for action. Addressing these bottlenecks will allow for routine monitoring of data and timely corrective action.

Health Financing that limit availability of financial resource for immunisation:

1. Low Total Government Expenditure on Health
2. Slow flow of Funds from MOFPED to MOH, and from DHO to Health Facilities
3. Off-budget support for districts by Health Development Partners has restrictive guidelines that sometimes do not align to district priorities
4. Resource constraints impair fulfilment of vaccine co-financing obligations by GoU
5. Intensive Immunization Events (NIDS & SIAs)
6. Non-existent Fair & Sustainable Health Financing for majority of the population:
    - *High out-of-pocket expenditure*
    - *No risk-pooling or prepayment schemes for health services*
    - *Exorbitant privately procured immunization services*
    - *Weak regulation of health markets by the government*
    - *The Immunization Act enshrines the Immunization Fund which needs operationalization*

Constructive advocacy engagements to improve financial performance of the country is key to ensure *GoU / MOH support to EPI interventions, Ring-fencing EPI funds released to MOH through MOFPED* and *exploring realistic mechanisms of establishing fair and sustainable health financing that is appealing to the populace countrywide to avoid interruption in the service delivery and ownership.*

CSS challenges that hinder community access EPI and other priority RMNCAH services

1. Low capacity of CHWs / VHTs to multi-task in PHC service delivery which demands such skill versatility
2. Weak capacity of CHWs to multi-task, poor tooling, incentives/motivation of CHWs
3. Advocacy, Communication and Social Mobilization for EPI are still generally weak, resulting in low demand for and uptake of EPI services by the community
4. Community Based Health Information System is still at pilot stages in the country yet it would be crucial for generation and transmission of real time information

Immunization services in Uganda largely depends on community linkages to service delivery and strengthening the performance of community systems to enhance access and uptake of EPI services in all communities as well as strengthening *advocacy communication and social mobilization for EPI services* must be prioritized.

Stewardship and Program management constraints

1. No pragmatic Oversight Visits by MOH Top Management to get contextual insights for strengthening program performance at sub-national / operational level
2. Inadequate evidence based EPI advocacy engagements across sectors and the legislature needs strengthening

***Pooled fund** applicants are not required to complete this question.*

12. Objectives of the NHSP and application *(Maximum 2 pages)*

Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or

specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in ***Attachment #6*** *- Detailed work plan, budget and gap analysis.*

Pooled fund *applicants are* *not* *required to prepare separate objectives, rather to list the key objectives from the NHSP, including ones relevant to immunisation.*

The Overall Goal of Uganda's Gavi HSS 2016/17 – 2020/21: ***The overall goal of Uganda's GAVI HSS 2016 proposal is to strengthen the health system so as to enhance sustainably responsive and equitable delivery of quality EPI and other priority RMNCAH services for improvement of immunization and RMNCAH outcomes countrywide by 2021***

Uganda's theme for the Gavi HSS 2016 Proposal is: Gavi HSS driving sustainably responsive, equitable & quality EPI services for better immunization outcomes

A strategic or medium term planning approach has been used to develop Uganda's Gavi HSS II proposal. Therefore, to address the priority health system bottlenecks identified from analyses of the respective health system building blocks, Medium Term Goals and corresponding set of Specific Objectives have been formulated for achieving each of these medium term goals. In this regard:

- ***The medium term goals*** (each of which will cover the entire strategic period/the grant period of five years) will synergistically contribute to achieving the country's overall goal for this Gavi HSS project.
- ***The specific objectives:*** each of the medium term goals of the proposal has a number of inter-related and or inter-dependent specific objectives that are envisaged to synergistically contribute to achieving this particular medium term goal.

This proposal, therefore, presents five medium term goals intently designed to provide remedial solutions to the priority bottlenecks identified in the respective health system building block.

Table 3: Objectives proposed for this Gavi HSS grant

Service Delivery and HRH Combined Block	
Medium Term Goal 1: Service Delivery-HRH	**To enhance equitable access to quality EPI and other priority RMNCAH services by target populations, with emphasis on hard-to-reach populations, so as to increase uptake of EPI and other priority RMNCAH services by December 2021**
	The focus of Strategic Objective 1 is to enhance access of all target populations to quality EPI and RMNCAH services in the entire country. There are four specific objectives and each is linked to a health system and or EPI outcome.
Specific Objective 1.1: ***To strengthen outreach services to 112 districts so as to increase equitable access of target populations to quality EPI and other priority RMNCAH services, with emphasis on hard-to-reach communities / poorly performing districts in the entire grant period***	The activities under this objective will strengthen integrated outreach services at health facility level so as to increase equitable access of target populations, including hard-to-reach communities, to quality EPI and other priority RMNCAH services. The intermediate results will be: ***increased access to immunization and other priority health services, increased knowledge of communities on immunization services, and increased uptake of immunization services***
Specific Objective 1.2: ***To strengthen EPI focused supportive supervision in order to improve the quality and uptake of EPI services in 112 districts in the grant period***	This objective aims at strengthening existing but weak EPI focused supportive supervision for improving EPI service delivery quality and uptake of EPI services. The envisaged results will include ***increased knowledge and skills of health professionals on EPI and other aspects of health service management and improved quality of services provided***
Specific Objective 1.3: To update the EPI curriculum for health training institutions (in the first half of the grant period) to include new developments and technologies in the country's immunization program for improving EPI outcomes	Through this objective, the EPI curriculum for health training institutions will be updated to include new developments and technologies in the country's EPI / VPD program for improving EPI outcomes. The outcomes include ***improved service quality and increased knowledge and technical skills of health professionals in EPI and immunization***
Specific Objective 1.4: ***To conduct operational researches on EPI service delivery to inform EPI service performance during the grant period***	This objective will ***improve availability of quality evidence for management decision making on improving the Red/Rec strategy. It will also contribute to better micro-planning at health facility and district levels.***
PSM_LSCM Block	
Medium Term Goal 2: PSM/LSCM	**To strengthen the logistics and supply chain management system of UNEPI/NMS in order to improve the quality of stock management as well as efficiency of distribution of these essential commodities at all levels countrywide by December 2021**
	Strategic Objective 2 is set to improve the performance of both the supply chain and cold chain of EPI in the country. Five specific objectives will contribute to achieving this strategic objective

Specific Objective 2.1: ***To expand the cold and dry storage capacity for vaccines and related supplies at the National Vaccine Store and sub-national stores to adequately accommodate all vaccines by 2021***	The specific objective will aim at expanding the cold and dry storage capacity for vaccines and related supplies at the National Vaccine Store and Sub-national stores to adequately accommodate all vaccines through 2021, and beyond. This specific objective will lead to ***improvement of EPI and other medical stock management at CVS and DVS levels in the context of increasing volumes of EPI and other medical commodity stocks.***
Specific Objective 2.2: ***Improve the efficiency of distribution of vaccines and related supplies at all levels***	The specific objective aims at strengthening the already largely good transportation and delivery of vaccines and other medical commodities. While the small vehicles will deliver vaccines and other medical commodities to locations that need small trucks, ***the boats will serve hard to reach fishing communities on the mentioned islands.***
Specific Objective 2.3: ***To strengthen the quality-safeguard mechanisms that ensure sustainable cold-chain integrity and vaccine potency from the port of entry at the airport (customs) to the point of distribution in the entire cold chain system***	The specific objective will strengthen the quality safeguard mechanisms that ensure cold-chain integrity and vaccine potency from the port of entry at the airport (customs) to the point of distribution. Vaccine temperature management has been rated poorly by both EVMA 2011 & 2014. This objective should be able to ***contribute greatly to improving quality of not only temperature management but other aspects of effective vaccine management- hence improvement of vaccine potency.***
Specific Objective 2.4: ***To implement the EPI Cold Chain Preventive Maintenance plan (in all the 14 health regions) for efficient maintenance of cold chain and other critical equipment while ensuring responsive remedial biomedical engineering support for EPI cold chain trouble-shooting anywhere in the country***	The implementation / operationalization of the EPI cold chain preventive maintenance plan is the aim of this objective so as to have an efficient and effective cold chain system that will ensure availability of potent vaccines. The outcome seen will be ***improved cold chain integrity, hence vaccine potency***
Specific Objective 2.5: ***To establish / operationalize an electronic Logistics Management Information System (LMIS) of the EPI vaccines and related supplies in all the 112 districts in the grant period***	This objective will ensure establishment and operationalization of an electronic Logistics Management Information System (LMIS) of the EPI vaccines and related supplies. Results expected will include ***readily available data on cold chain and other logistics, as well as availability of evidence for decision making, and improved responsiveness to cold chain integrity challenges- hence overall improvement in effective vaccine management and sustainable availability of quality vaccines.***
HMIS Strategic Information Block	
Medium Term Goal 3: HMIS / Strategic Information	**To strengthen generation and utilization of routine and real time strategic health information (HMIS, IDSR & Surveys) on EPI and other priority health services for responsive management of these services at all levels of the health system by December 2021**
	Strategic Objective 3 emphasis is availability of quality HMIS data at all levels of the health system; availability of real time data from the community level up to policy level; and evidence-based facilitated decision making- all these will be achieved through the four specific objectives of this health system building block.
Specific Objective 3.1: ***To build the capacity of 112 District HMIS Focal Persons, 112 District EPI/VPD Surveillance Focal Persons & 14 Regional IDSR Regional Focal Persons in M&E skills with emphasis on quality data management and data use for management decision making on performance improvement of EPI & other priority RMNCAH services by the end of the grant period***	The focus of this activity will be to build capacity of Health workers on quality data management and data use for management decision making for performance improvement of EPI & other priority RMNCAH services. Following implementation, results of this objective will include: ***readily available quality data at source and in the rest of the health system; increased use of e-health mechanisms for improving availability of data at source of generation and elsewhere.***
Specific Objective 3.2: ***To strengthen the EPI/VPD surveillance system in all the 14 health regions of the country, with emphasis on sustainable community based VPD surveillance***	The aim of this objective is to strengthen the EPI/VPD surveillance system at all levels of the health system, including community based VPD surveillance. The main results from this objective will be ***improved integrated IDSR surveillance with focus on VPD surveillance at operational and community levels.***
Specific Objective 3.3: ***Strengthen EPI performance monitoring and tracking by the EPI M&E Unit to continue evidence generation using regular surveys and operational research in the grant period***	This objective will Strengthen EPI Performance Monitoring and Tracking by the EPI M&E Unit to continue evidence generation using regular surveys and operational researches. Results that will be obtained will include: ***readily available data on EPI performance- hence improvement in evidence based decision making.***
Specific Objective 3.4: ***To strengthen/adapt LMIS of the EPI program equipment, commodities and other supplies so as to improve the quality of inventory management and the overall strategic information of the EPI program at the centre and the districts in the grant period***	This objective aims at strengthening LMIS of the EPI/VPD and other essential medical commodities. Expected results will include ***improved overall EPI commodity stock management, readily available data for effective management of EPI commodity stocks, and good stock quality in all vaccine/medical stores countrywide.***

Health Financing Block	
Medium Term Goal 4: Health Financing:	**To institute mechanisms for sustainable immunization financing so as to achieve predictable immunization financing for effective management of the immunization program by December 2021** This Strategic focus of this objective is establishment of sustainable immunization financing for achieving predictable immunization financing and therefore better program performance. This strategic objective is linked to the Immunization Act and Immunization Fund directly and implicitly through three specific objectives presented below.
***Specific Objective 4.1:** To operationalize the immunization fund so as to enhance sustainable financing for the immunization program of the country in the grant period*	The objective aims at, Establishing sustainable financing for the immunization program of the country. This will lead to ***sustainable immunization financing of the EPI and immunization program***
***Specific Objective 4.2:** To institute sustainable timely resource flow, timely accountability, & increased transparency of financial management processes of the EPI program at national and sub-national levels*	This objective will aim at instituting timely resource flow and increased transparency and accountability in financial management processes of all immunization funds/finances. The results envisaged under this specific objective will include ***timely disbursement of financial resources at all governance levels, improved availability of funds for EPI, and improved transparency and accountability for immunization financial resources.***
Community Systems Strengthening (CSS)	
Medium Term Goal *5:* Community Systems Strengthening	***Enhance community demand for and uptake of quality EPI and other priority RMNCAH services so as to improve EPI and other health outcomes of the country by December 2021*** The CSS strategic objective aims at increasing community demand for immunization services, which will in turn drive uptake of the same services- hence improvement of immunization outcomes at population level through three specific objectives.
***Specific Objective 5.1:** To strengthen community based health services by conducting comprehensive registration of target populations, and increasing sensitization / mobilization of communities for sustainable uptake of EPI and other priority RMNCAH services*	Currently there is a transition of CHWs (VHTs), who are voluntary health workers, to GoU employed CHEWs (Community health extension workers). This objective will build on the HSS I activities of sensitizing stakeholders on this transition- which lays the ground for selecting and training the CHEWs. Nevertheless, the currently available VHTs will continue to carry out community mobilization through two of the activities under this objective. ***Registration/Mapping of EPI target populations will be accomplished countrywide. This will provide an important database for MOH, HDPs and other line ministries.***
***Specific Objective 5.2:** To strengthen Communication and Social Mobilization for EPI services to enhance and sustain demand for and uptake of EPI and other priority RMNCAH services at national and sub-national levels*	The aim of this objective is to strengthen Communication and Social Mobilization for EPI so as to enhance demand and uptake of EPI and other priority RMNCAH services. Results expected from this objective are: ***strong community participation, increased community demand for and uptake of EPI/VPD and other priority health services; improved use of high impact media for social mobilization and sensitization for EPI and other health actions.***
***Specific Objective 5.3:** To establish Community Based Health Information System (CBHIS) to enable capture and transmission of real time data on community health and surveillance events in any part of the country*	A Community Based Health Information System (CBHIS) will be established to enable capture and transmission of real time data on community health and surveillance events in any part of the country. The anticipated results include ***availability of real time data right from community level; improved responsiveness of the health system stewardship to emerging or identified health events / demands; quality decisions at community, operational and policy levels due to availability of evidence.***
Medium Term Goal 6: Stewardship & program management:	***To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI*** The objective aims is to strengthen the program oversight and management to ensure equitable immunisation services and accountability
***Specific Objective 6.1:** To strengthen Leadership & governance for sustainable, effective and efficient management of the EPI program at all levels of the health system*	Leadership and governance of the Immunisation program will be strengthened under this objective for effective and efficient management of the EPI program. The results that will be achieved should include ***improved MOH oversight of the entire health system, improved performance of the EPI program, including strengthened partnerships***.

13. Description of activities *(Maximum 3 pages)*

Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in ***Attachment #6*** *- Detailed budget, gap analysis and work plan.*

Pooled fund *applicants are not required to complete this table, but should provide relevant sub-sections of the NHSP focusing on immunisation, including the annual work plan, activities and budget****; Attachment #34:*** *Pooled Fund Annual Work plan and Budget (AWPB****)*** *and related Terms of Reference*

Table 4: Activities proposed for this Gavi HSS grant[26]

The selection of the HSS activities put into consideration other partner technical and financial contribution through the Gavi PEF CTA to support the EPI health system. *The numbering of the activities follows the numbering of activities in Attachment #6. The selected activities are key to achieving the specific objective*

Objectives Activities	Linkage to Immunization Outcomes
Medium Term Goal 1: Service Delivery -HRH: To enhance equitable access to quality EPI and other priority RMNCAH services by target populations, including hard-to-reach populations, so as to increase uptake of EPI and other priority RMNCAH services by December 2021	
Specific Objective 1.1: To strengthen outreach services in 112 districts so as to increase equitable access of target populations to quality EPI and other priority RMNCAH services, with emphasis on hard-to-reach communities/poorly performing districts in the entire grant period	
Activity 1.1.3: Deploy the Central EPI Team to designated health facilities to supervise the integrated child health days in the 14 regions covering 112 districts	This activity will achieve three immunization purposes: to strengthen Central EPI oversight at the operational level; and will provide opportunity for health facility and district officials to be mentored by the Central EPI teams. The combination of operational level and central/MOH level EPI officials in this supervision will create a synergy to better performance at operational level countrywide.
Activity 1.1.4: Support the district to carryout outreaches, supply of vaccines and logistics, micro-planning and cold-chain maintenance in 112 districts	This activity deals with provision of Gavi top-up funds to supplement the inadequate PHC funds to districts / health facilities for EPI and other PHC services.
Specific Objective 1.2: To strengthen EPI focused supportive supervision in order to improve the quality and uptake of EPI services in 112 districts in grant period	
Activity 1.2.3: Six-members of the DHT in 112 districts to conduct quarterly EPI mentorship of health facility immunization teams on Immunization in Practice (IIP)	IIP is mentorship based. The DHTs will conduct mentorship to health facility staff on EPI service delivery, including latest practices in EPI. This will improve the knowledge and quality of EPI service delivery.
Activity 1.2.6: Procure 68 vehicles for program management and District Health Offices that did not receive vehicles in Gavi HSS I for support supervision & distribution of logistics to the LLHUs	Transport availability to districts solves many challenges faced at operational level. Vehicles purchased will be utility vehicles which are multi-purpose in design- for transportation of health workers for supervision, outreaches; transportation of EPI and medical supplies, as well as aiding referral of patients.
Specific Objective 1.3: To update the EPI curriculum for health training institutions (in the first half of the grant period) to include new developments and technologies in the country's immunization program for improving EPI outcomes	
Activity 1.3.1: Orient the 450 tutors of health training institutions (nursing, clinical officers and medical laboratory) including teaching staff in medical schools on the updated EPI Prototype curriculum	This activity builds on activity for updating the EPI Prototype Curriculum to include new developments in EPI. Tutors oriented will utilize the updated curriculum for better imparting of knowledge on EPI. Enabling Health professionals to qualify with good knowledge and skills in EPI practice.
Specific Objective 1.4: To conduct operational researches on EPI service delivery to inform EPI service performance during the grant period	
Activity 1.4.1: Conduct a programme review of RED/REC integration strategy evaluation in 18 ***randomly selected*** districts each with 12 teams in	Review of the RED/REC strategy aims at finding out factors driving good and bad performance of the strategy. The review will therefore furnish recommendations for improvement of practice if

[26] The numbering of the activities follows the numbering of activities in Attachment #6. The selected activities are key to achieving the specific objective

25% of the health facilities each taking 14 days which includes report writing and a one day dissemination workshop	the RED/REC strategy for improving EPI coverage and eventually outcomes.
Activity 1.4.2: Map schools in health facility catchment areas to improve outreach coverage and uptake of priority RMNCAH services (e.g. HPV, Tetanus etc.)	Mapping of schools in the catchment areas of health facilities is a priority in relation to the introduced HPV vaccine in the country. The schools are the main areas where most of the target population is found.
The Medium Term Goal 2: PSM/LSCM: To strengthen the logistics and supply chain management system of UNEPI/NMS in order to improve the quality of stock management as well as efficiency of distribution of these essential commodities at all levels countrywide by December 2021	
Specific Object 2.1: To expand the cold and dry storage capacity for vaccines and related supplies at the National Vaccine Store and sub-national stores to adequately accommodate all vaccines by 2021	
Activity 2.1.4: Construct 30 district medical stores (of floor area 180 square meters) for vaccines and dry commodity storage in 30 districts without DVS	Lack of DVS predisposes districts to vaccine stock outs, vaccines wastage and loss of potency. Stock outs result in low uptake, missed opportunity and dropouts from EPI services.
Activity 2.1.6: Contribute 20% of the USD 10,760,228 to cater for co-financing of the Cold-chain Equipment Optimization (CCE OPT) budget	HSS budget co-financing 20% from CCE Optimization budget ensures CCE-Optimisation for the country is achieved as planned. This will optimise quality CCE equipment in EPI, hence a boost to cold chain performance and quality vaccines.
Specific Object 2.3: To Strengthen the quality-safeguard mechanisms that ensure sustainable cold-chain integrity and vaccine potency from the port of entry (at the airport/customs) to the point of distribution in the entire cold chain system	
Activity 2.3.1: Train 14 teams (of three people) to be Regional TOTs in efficient management of vaccines/EPI commodities and other essential medical supplies with emphasis on quantification, forecasting, Vaccine Tracking and Vaccine Temperature Monitoring.	The 14 teams of trainers will cover all the 14 health regions and their respective clusters of districts. Each region will have a team of trainers/mentors in EVM and will improve the EVM in the entire country. Hence vaccine availability (minimal incidences of stock outs), good EPI stock quality and assured vaccine potency as immediate dividends.
Activity 2.3.3: Train 10 customs / ports of entry personnel and 10 NMS staff for two days in proper handling of vaccines.	This will minimise incidences of improper / poor handling of vaccines by officials at the port of entry (Entebbe Airport), as well as vaccine truck drivers who distribute vaccines countrywide.
Specific Object 2.4: To implement the EPI Cold Chain Preventive Maintenance plan (in all the 14 health regions) for efficient maintenance of cold chain and other critical equipment while ensuring responsive remedial biomedical engineering support for EPI cold chain trouble-shooting anywhere in the country	
Activity 2.4.1: Train 112 DCCTs and 14 Regional Biomedical / CCTs in basic maintenance of the cold chain and other crucial medical equipment in order to ensure sound cold chain integrity in each district.	This activity will provide continuous monitoring of CCE, including notifications for repair of DVS. Rather than attend only to CCE trouble shootings, the combination of the central, regional and district cold chain technicians will ensure that remedial actions are taken in time, and cold chain integrity in the country is sound at all times.
Activity 2.4.4: Carryout central and regional planned preventive maintenance and supervision	As above.
Specific Objective 2.5: To establish/Operationalize an electronic Logistics Management Information System (LMIS) of the EPI vaccines and related supplies in all the 112 districts in the grant period	
Activity 2.5.1: Pilot and roll out an electronic LMIS integrating stock management, CCE inventory and storage temperature at programmatic and operational levels (design the LMIS system and tools, test/pilot the functionality of the system and roll-out the system)	The e-LMIS will be designed to provide updates on EPI and medical commodity stocks, CCE and other equipment inventory, equipment status updates and linkage with other e-health establishments (especially those under HMIS management).
Activity 2.5.2: Train programmatic and operational level users /officials in LMIS	The trained personnel will man the e-LMIS system.
The Medium Term Goal 3: HMIS / Strategic Information: To strengthen generation and utilization of routine and real time strategic health information (HMIS, IDSR & Surveys) on EPI and other priority health services for	

responsive management of these services at all levels of the health system by December 2021	
Specific Object 3.1: To build the capacity of 112 District HMIS Focal Persons, 112 District EPI/VPD Surveillance Focal Persons & 14 Regional IDSR Focal Persons in M&E skills with emphasis on quality data management and data use for management decision making on performance improvement of EPI & other priority RMNCAH services by the end of the grand period	
Activity 3.1.1: Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	This activity will facilitate the trained DITs to continue operational / district level mentorship of health workers at district in quality data management and utilization of EPI data for decision making at points of use and in various levels of the health system. Trained teams from National level will visit all districts to conduct mentorship and supportive supervision at district level and together with DITs from the district level, conduct mentorships at all health facilities in each district. This is expected to create a momentum for passion to use evidence based decisions to address identified weakness of data use for decision making at sub-national level (addressed in activities and result chains section)
Activity 3.1.5: Conduct a National DQSA	DQSA assesses the quality of HMIS and other data in the health system. This will improve HMIS as well as EPI specific data quality including quality of evidences gathered on EPI performance.
Specific Object 3.2: To strengthen the EPI/VPD surveillance system in all the 14 health regions of the country, with emphasis on sustainable community based VPD surveillance	
Activity 3.2.2: Conduct 2-day annual National Joint Review meetings with regional VPD/HMIS management teams on EPI performance, including VPD/EPI Surveillance performance	This review meeting will identify bottlenecks or good practices. Hence remedial actions to EPI challenges or scaling up of good practices.
Activity 3.2.7: Update, print and distribute surveillance guidelines (flipcharts10,400) and Case Investigation Forms for VPDs (10,400 copies for polio, 10,400 copies for measles and 10,400 copies for NNT and 10,400 copies AEFI	Lack of updated EPI tools at many health facilities has been an EPI performance bottleneck. This activity will address the bottleneck.
Specific Object 3.3: To strengthen EPI Performance Monitoring and Tracking by the EPI M&E Unit to continue evidence generation using regular surveys and operational research in the grant period	
Activity 3.3.2: Conduct EPI Coverage Survey	The country has not had EPI coverage survey for a long while. The coverage survey will partly contribute to improvement of data on EPI coverage which has relied a lot on administrative data. Results from the survey will strengthen design of better EPI interventions for performance improvement
Activity 3.3.4: Conduct End Term Evaluation of Gavi HSS in 2021	The end term evaluation will gauge the performance of this Gavi HSS grant. The findings will point to where EPI/health system investments should be focused and guidance to future Gavi grants.
Specific Object 3.4: To strengthen/adapt LMIS of the EPI program equipment, commodities and other supplies at the Centre and the district so as to improve the quality of inventory management and the overall strategic information of the EPI program in the grant period	
Activity 3.4.1: Procurement of ICT equipment to support electronic data management for EPI data: 77 Computers, 112 Internet Modems, annual internet data bundles, 2 Photocopier, 2 Scanners, backup systems, 15 Laptops for UNEPI Staff to allow uptake of electronic systems and utilization of data at both national and district/HF levels.	The procurement will support to electronic data management, transmission and feedback.
The Medium Term Goal 4: Health Financing: To institute mechanisms for sustainable immunization financing so as to achieve predictable immunization financing for effective management of the immunization program by December 2021	

Specific Object 4.1: To Operationalize the immunization fund so as to enhance sustainable financing for the immunization program in the grant period	
Activity 4.1.1: Conduct a cost effectiveness study for immunization/the unit cost of a fully immunized child	This is cornerstone activity that will determine how Immunization Fund regulations should be formulated, and how the EPI Sustainability Plan should be designed. It also informs the nation on the unit cost of immunizing a child fully.
Activity 4.1.3: Develop regulations for operationalizing the Immunization fund	The regulations for operationalizing the Immunization Fund will enable progress implementation of the fund. This may lead to sustainable financing of immunization.
Specific Object 4.2: To institute sustainable timely resource flow, timely accountability & increased transparency of financial management processes of the EPI program at national and sub national levels	
Activity 4.2.2: Hold an induction meeting on the Comprehensive EPI Financial Management Operational Manual	The induction meeting is to enable the operational and policy officials to understand the Comprehensive EPI Financial Management Operational Manual. This will generate faster flow of EPI funds, transparency, good accountability
Activity 4.2.5: Conduct external and internal audits for all running Gavi grants in EPI/HSS	This activity will enforce routine monitoring of financial management standards. This will improve financial management practices.
The Medium Term Goal 5: Community Systems Strengthening / Non-State Actors: To Enhance community demand for and uptake of quality EPI and other priority RMNCAH services so as to improve EPI and other health outcomes of the country by December 2021	
Specific Object 5.1: To strengthen community based health services by conducting comprehensive registration of target populations, and increasing sensitization/mobilization of communities for sustainable uptake of EPI services and priority RMNCAH services	
Activity 5.1.1: Provide funds to CSO to conduct mobilisation and follow up at village level	This activity will ensure the Non-State Actors involved in EPI activities fasten the process of mobilizing target populations for uptake of EPI services, especially now that new vaccines are being introduced.
Activity 5.1.2: Support CHWs (VHTs/CHEWS) to conduct mobilization and registration of the target population in their catchment areas	This activity will ensure CHWs/VHTs enhance mobilization of target populations for uptake of EPI services, especially now that new vaccines are being introduced.
Specific Object 5.2: To strengthen Communication and Social Mobilization for EPI services to enhance and sustain demand for and uptake of EPI and other priority RMNCAH services at national and sub national levels	
Activity 5.2.1: Carryout Communication Needs Assessment (once in the first year of the grant period)	Communication Needs Assessment will inform MOH and partners on how best to design community mobilization for uptake of EPI services
Activity 5.2.2: Provide funds to conduct comprehensive mapping of private health facilities in the 112 districts so as to include all private practitioners in the EPI Communication loop and the HMIS system	MOH and district do not have updated databases of private health practitioners. This activity will help district and national health system levels to have updated database of private health practitioners; include them in the EPI communication loop and HMIS system, and provide avenues for managing them better.
Specific Object 5.3: To establish Community Based Health Information System (CBHIS) to enable capture and transmission of real time data on community health and surveillance events in any part of the country	
Activity 5.3.1: Integrate the Family Connect & CHMS (e-health systems/ e-tools)	This is the activity for creation of the e-health health system for establishment of the Community based health information system
Activity 5.3.3: Train users of the CBHIS tools that feed into the e-health CBHIS	The users trained are officials who will operate / run the CBHIS.
Medium Term Goal 6: Stewardship and Program Management: To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI	
Specific Object 6.1: To strengthen Leadership & governance for sustainable, effective and efficient management of the EPI program at all levels of the health system	
Activity 6.1.1: MOH Top Management to conduct	This activity serves to strengthen MOH stewardship by ensuring

annual oversight visits to all the 14 health regions to provide oversight support to the region and their respective cluster of districts	MOH Top Management get contextual realities of the 14 health regions and their cluster of districts. This will improve responsiveness to health system demands, including EPI sub-systems.
Activity 6.1.7: Create a MOH/UNEPI/CSO led coordination platform / forum for regular updates on Non-State Actors' participation in EPI interventions	There is currently no MOH led coordination platform for Non-State Actors. This activity will ensure the Non-State Actors involved in EPI activities are well organized for good performance in their interventions.

14. Results chain *(Maximum 4 pages)*

*Complete the **Results Chain** using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.*

*Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org*

***Pooled fund** applicants are not required to complete this template, but must provide a a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP*

Table 5: The Results Chain

Objectives and Key Activities	Intermediate Results	Immunization Outcomes
***Medium Term Goal 1:** Service Delivery: To enhance equitable access to quality EPI and other priority RMNCAH services by target populations, including hard-to-reach populations, so as to increase uptake of EPI and other priority RMNCAH services by December 2021*		
Specific Objective 1.1:** To strengthen outreach services in 112 districts so as to increase equitable access of target populations to quality EPI and other priority RMNCAH services, with emphasis on hard-to-reach communities/poorly performing districts in the entire grant period* ***Key Activities 1. Deploy the central EPI team to the designated health facilities to supervise integrated Child Days in the 14 regions covering 11 2 districts 2. Support the district to carryout outreaches, supply of vaccines and logistics, microplanning and cold-chain maintenance ***Related Key Activities Indicators*** 1. Number of districts in which the central level team have supervised the planned Child Health Days 2. Number of Districts supported through Gavi top up funds to carry out outreaches	***Intermediate Results:*** *1. Increase in access (of community) to EPI services* *2. Increase in uptake* ***Related Key Intermediate Results Indicators*** *1. %age of under ones receiving BCG* *2. Number of surviving infants who received Penta1* *3. Number of surviving infants who received Penta3* *4. Number of surviving infants who received MCV1* *5. Percentage point difference between Penta 3 national administrative coverage and survey point estimate*	***Immunization Outcomes:*** *1. Increased immunization coverage* *2. Decreased dropout rates* ***Immunization outcomes Indicators*** *1. % of districts with ≥80% DTP3 coverage* *2. % point drop out between DTP1 and DTP3 coverage* *3. % of surviving infants receiving 3 doses of DTP-containing vaccine* *4. % of surviving infants receiving first dose of measles containing vaccine* *5. Difference in DTP3 coverage between lowest and highest wealth quintile* *6. Percentage of districts with Pentavalent 3 coverage ≥ 50% and <80%* *7. Percentage of districts or equivalent administrative area with Penta3 coverage greater than 95%* *8. Penta 3 coverage amongst males and females* *9. Penta3 coverage difference between the children of educated and uneducated mothers/care-takers*
Specific Objective 1.2:** To strengthen EPI focused supportive supervision in order to improve the quality and uptake of EPI services in 112 districts in grant period* *Key Activities* 1. Six-members of the DHT in 112 districts to conduct quarterly EPI mentorship of HF immunization teams on Immunization in Practice (IIP) 2. Procure 68 vehicles for District Health Offices & MoH that never received for support supervision & distribution of logistics to the LLHUs ***Related Key Activities Indicators 1. Number of districts in which the DHT has conducted quarterly EPI Mentorship of Health Facility immunization teams on IIP 2. Number of vehicles procured for Districts Health Offices that did not receive vehicles in the Gavi HSS1 grant	***Intermediate Results:*** *1. Improved quality of services* *2. Increased uptake* ***Related Key Intermediate Results Indicators*** *1. % of EPI service users satisfied with the perceived quality of services* *2. Increase in number of under ones receiving DPT1*	
Specific Objective 1.3:** To update the EPI curriculum for health training institutions (in the first half of the grant period) to include new developments and technologies in the country's immunization program for improving EPI outcomes* ***Key Activities 1. Orient the 450 tutors of health training institutions (nursing, clinical officers and medical laboratory) including teaching staff in medical schools on the updated EPI prototype curriculum ***Related Key Activities Indicators*** 1. Number of Tutors of health training institutions oriented on the updated EPI prototype curriculum	***Intermediate Results:*** *1. Increase in EPI knowledge* ***Related Key Intermediate Results Indicators*** ***1.** % of newly qualified midwives/Nursing Professionals who are knowledgeable on new developments in EPI (new vaccines, switches and other new technologies)*	
Specific Objective 1.4:** To conduct operational researches on EPI service delivery to inform EPI service performance during the grant period* ***Key Activities 1. Conduct a programme review of RED/REC integration strategy evaluation in 18 randomly selected districts each with 12 teams in 25% of the health facilities each taking 14 days which includes report writing and a one day dissemination workshop 2. Support mapping of schools in health facility catchment areas to improve outreach coverage and uptake of priority RMNCAH services (HPV, Tetanus etc.) ***Related Key Activities Indicators*** 1. A programme Review of RED/REC integration strategy evaluated	***Intermediate Results:*** *1. Availability and use of valid/documented evidence on integration of RED/REC with RMNCAH services* ***Related Key Intermediate Results Indicators*** *1. Documented evidence from reports used during annual planning to improve strategy and results*	
***The Medium Term Goal 2:** PSM/LSCM: To strengthen the logistics and supply chain management system of UNEPI/NMS in order to improve the quality of stock management as well as efficiency of distribution of these essential commodities at all levels countrywide by December 2021*		
Specific Object 2.1:** To expand the cold and dry storage capacity for vaccines and related supplies at the National Vaccine Store and sub-national stores to adequately accommodate all vaccines by 2021* ***Key Activities 1. Construct 30 district medical stores (of floor area 180 square meters) for vaccines and dry commodity storage in 30 districts without DVS	***Intermediate Results:*** ***1.** Increase in cold storage capacity f in the 30 districts without DVS* ***Related Key Intermediate Results Indicators***	***Immunization Outcomes:*** *1. Reduction in stock outs of vaccine/EPI Commodity* *2. Improved vaccine potency* ***Immunization outcomes Indicators***

Specific Objectives / Key Activities	Intermediate Results	Outcomes
2. Contribute 20% of the USD USD 11,267,155 to cater for co-financing of the CCE OP budget ***Related Key Activities Indicators*** 1. Number of district medical stores (of floor area 180 square meters) constructed in 30 districts without DVS 2. Amount of USD funds contributed to the total budget of CCEOP	*1. % increase in cold storage capacity in the 30 districts without DVS*	1. % of districts reporting any vaccine/antigen stock out 2. % of districts with ≥80% DTP3 coverage 3. % point drop out between DTP1 and DTP3 coverage 4. % of surviving infants receiving 3 doses of DTP-containing vaccine 5. % of surviving infants receiving first dose of measles containing vaccine 6. Difference in DTP3 coverage between lowest and highest wealth quintile
Specific Object 2.3: ***To Strengthen the quality-safeguard mechanisms that ensure sustainable cold-chain integrity and vaccine potency from the port of entry (at the airport/customs) to the point of distribution in the entire cold chain system*** ***Key Activities*** 1. Train 14 teams (of three people) to be Regional TOTs in efficient management of vaccines/EPI commodities and other essential medical supplies 2. Train 10 customs / ports of entry personnel and 10 NMS staff for two days in proper handling of vaccines. ***Related Key Activities Indicators*** 1. Number of ToT teams of three trained in efficient management of vaccines 2. Number of customs/ports of entry personnel and NMS staff trained n proper handling of vaccines	**Intermediate Results:** *1. Improvement in quality of vaccine management/handling (Improvement in proper vaccine management/handling) at ports of entry/during transportation* ***Related Key Intermediate Results Indicators*** *1. Number of observed/reported incidences of poor handling of vaccines at ports of entry/during transportation*	
Specific Object 2.4: ***To implement the EPI Cold Chain Preventive Maintenance plan (in all the 14 health regions) for efficient maintenance of cold chain and other critical equipment while ensuring responsive remedial biomedical engineering support for EPI cold chain trouble-shooting anywhere in the country*** ***Key Activities*** 1. Train 112 District (DCCTs) and fourteen Regional Biomedical / Cold Chain Technicians in basic maintenance of the cold chain and other crucial medical equipment 2. Conduct central and regional planned preventive maintenance and supervision ***Related Key Activities Indicators*** 1. Number of DCCTs trained in basic maintenance of the cold chain and other crucial medical equipment 2. Number of central planned supervision visits conducted	**Intermediate Results:** *1. Improved cold chain integrity at central and district levels* ***Related Key Intermediate Results Indicators*** *1. % of cold chain equipment operating within WHO recommended temperature ranges (National level)* *2. Number of cold chain trouble-shootings timely resolved by the central team* *3. Effective Vaccine Management Score at national level (composite score)*	
Specific Object 2.5: ***To establish/Operationalise an electronic Logistics Management Information System (LMIS) of the EPI vaccines and related supplies in all the 112 districts in the grant period*** ***Key Activities*** 1. Pilot and roll out an electronic LMIS integrating stock management, CCE inventory and storage temperature at programmatic and operational levels (design the LMIS system and tools, test/pilot the functionality of the system and roll-out the system) 2. Train programmatic and operational users/officials and officials in LMIS ***Related Key Activities Indicators*** 1. Number of districts with operational LMIS 2. Number of districts with trained programmatic/ operational users/officials of LMIS	**Intermediate Results:** *1. Improved quality of stock management* ***Related Key Intermediate Results Indicators*** *1. Number timely orders* *2. Number of timely deliveries* *3. Number of DVS with readily available Vaccine/EPI Commodity stock data*	
The Medium Term Goal 3: HMIS / Strategic Information: To strengthen generation and utilization of routine and real time strategic health information (HMIS, IDSR & Surveys) on EPI and other priority health services for responsive management of these services at all levels of the health system by December 2021		
Specific Object 3.1: ***To build the capacity of 112 District HMIS Focal Persons, 112 District EPI/VPD Surveillance Focal Persons & 14 Regional IDSR Focal Persons in M&E skills with emphasis on quality data management and data use for management decision making on performance improvement of EPI & other priority RMNCAH services by the end of the grand period*** ***Key Activities*** 1. Support Data Improvement Teams (DITs) to conduct Follow – up mentorships of Health Workers in Data quality Improvement of EPI/HMIS program at all levels in Districts 2. Conduct a National DQSA in the second half of the grant period ***Related Key Activities Indicators*** 1. % of districts in which DITs are supported to follow-up mentorships of Health Workers in Data Quality improvement of EPI/HMIS and DIT mentorship has occurred 2. National DQSA conducted in 2019/20 and report produced	**Intermediate Results:** *1. Improved quality of data* *2. Availability of documented evidence on data quality* ***Related Key Intermediate Results Indicators*** *1. Data quality Index at district level and health facility levels*	**Immunization Outcomes:** *1. All management/policy decisions backed by quality/sound evidence-base* **Immunization outcomes Indicators** *1. % of districts with ≥80% DTP3 coverage* *2. % point drop out between DTP1 and DTP3 coverage* *3. % of surviving infants receiving 3 doses of DTP-containing vaccine*
Specific Object 3.2: ***To strengthen the EPI/VPD surveillance system in all the 14 health regions of the***	**Intermediate Results:**	

country, with emphasis on sustainable community based VPD surveillance ***Key Activities*** 1. Conduct two-day six-monthly National Joint Review meetings with regional VPD/HMIS management teams on EPI performance, including VPD/EPI Surveillance performance 2. Update, print and distribute surveillance guidelines (flipcharts10,400) and Case Investigation Forms for VPDs (10,400 copies for polio, 10,400 copies for measles and 10,400 copies for NNT and 10,400 copies AEFI (WHO to receive the funds directly from GAVI Alliance) ***Related Key Activities Indicators*** 1. Number of two - day annual National Joint Review meetings with regional VPD/HMIS management teams on EPI performance and surveillance **2.** Number of each surveillance tools (Polio, Measles, NNT, AEFI, flip charts] updated, printed and distributed to districts by type	*1. Increase in number of agreed EPI performance action plans developed* *2. Availability of surveillance tools at the health facility* ***Related Key Intermediate Results Indicators*** *1. Number of agreed EPI performance action plans developed* *2. % of Health facilities with readily available updated surveillance tools by type*	*4. % of surviving infants receiving first dose of measles containing vaccine*
Specific Object 3.3: ***To strengthen EPI Performance Monitoring and Tracking by the EPI M&E Unit to continue evidence generation using regular surveys and operational research in the grant period*** ***Key Activities*** 1. Conduct EPI Coverage survey in 2020/21 2. Conduct End Term Evaluation for Gavi HSS in 2020/21 ***Related Key Activities Indicators*** 1. EPI Coverage surveys conducted in 2020/21 and report produced *2.* End Term Evaluation for Gavi HSS II grant conducted in 2020/21	**Intermediate Results:** *1. Findings from EPI coverage survey used in annual reviews and planning to improve actions and results* ***Related Key Intermediate Results Indicators*** *1. Number of peer reviewed publications (policy briefs, Journal articles, presentations, media talk shows) related to the Coverage reports*	
Specific Object 3.4: ***To strengthen/adapt LMIS of the EPI program equipment, commodities and other supplies at the Centre and the district so as to improve the quality of inventory management and the overall strategic information of the EPI program in the grant period*** ***Key Activities*** 1. Procurement of ICT equipment to support electronic data management for EPI data: 77 Computers, 112 Internet Modems, annual internet data bundles, 2 Photocopier, 2 Scanners, backup systems, 15 Laptops for UNEPI Staff to allow uptake of electronic systems and utilization of data at both national and district/HF levels. ***Related Key Activities Indicators*** 1. Number districts with functioning internet	**Intermediate Results:** *1. Availability of ICT equipment improving electronic data management quality at all planned health service delivery points* ***Related Key Intermediate Results Indicators*** ***1.*** *% of data files meeting set quality criteria (timeliness and completeness)*	
The Medium Term Goal 4: ***Health Financing: To institute mechanisms for sustainable immunization financing so as to achieve predictable immunization financing for effective management of the immunization program by December 2021***		
Specific Object 4.1: ***To Operationalise the immunization fund so as to enhance sustainable financing for the immunization program in the grant period*** ***Key Activities*** 1. Conduct a cost effectiveness study for immunization/the unit cost of a fully immunized child 2. Develop regulations for operationalizing the Immunization fund ***Related Key Activities Indicators*** 1. Cost Effectiveness study for immunization to determine the unit cost of fully immunizing a child conducted and a report written 2. Regulations for operationalizing the immunization fund developed	**Intermediate Results:** *1. Immunization fund board instituted* ***Related Key Intermediate Results Indicators*** *1. Immunization board in place and operational*	**Immunization Outcomes:** *1. Sustainable immunization financing in place* **Immunization outcomes Indicators** *1. % increase in immunization funds at National level from all sources* *2. % of districts with ≥80% DTP3 coverage* *3. % point drop out between DTP1 and DTP3 coverage* *4. % of surviving infants receiving 3 doses of DTP-containing vaccine* *5. % of surviving infants receiving first dose of measles containing vaccine*
Specific Object 4.2: ***To institute sustainable timely resource flow, timely accountability & increased transparency of financial management processes of the EPI program at national and sub national levels*** ***Key Activities*** 1. Hold an induction meeting on the comprehensive EPI financial management operational manual 2. Conduct external and internal audits of all running Gavi grants in EPI/HSS. ***Related Key Activities Indicators*** 1. Number of users/officers inducted on the comprehensive EPI financial management operational manual 2. Number of external audits conducted during the life of the Gavi HSS II grant 3. Percent utilisation of GAVI HSS annual budget for the reporting period	**Intermediate Results:** *1. Increase in number of officers practising instituted EPI financial management guidelines* *2. Increased in quality financial and programmatic accountability (by individuals and districts)* ***Related Key Intermediate Results Indicators*** *1. % of districts submitting quality accountabilities* *2. % individual officers submitting quality financial and programmatic accountability*	

The Medium Term Goal 5: Community Systems Strengthening / Non-State Actors: To Enhance community demand for and uptake of quality EPI and other priority RMNCAH services so as to improve EPI and other health outcomes of the country by December 2021

Specific Objectives and Key Activities		Intermediate Results		Immunization Outcomes
Specific Object 5.1: ***To strengthen community based health services by conducting comprehensive registration of target populations, and increasing sensitization/mobilization of communities for sustainable uptake of EPI services and priority RMNCAH services*** ***Key Activities*** 1. Provide funds to CSO to conduct mobilisation and follow up at village level 2. Support the CHEWS /VHTs to conduct mobilization and registration of the target population in their catchment areas ***Related Key Activities Indicators*** 1. Number of CSOs provided with funds to support mobilization and follow - up at village level **2.** Number of VHTs supported to conduct mobilization and registration of the target populations in their catchment areas	→	**Intermediate Results:** *1. Increased number of districts where CSOs conduct mobilization and follow up at village level* *2. Increased number of districts supported to mobilize and register the target population* ***Related Key Intermediate Results Indicators*** **1.** *Number of districts where CSOs conduct mobilization and follow up at village level* *2. Increased number of districts supported to mobilize and register the target population*	→	**Immunization Outcomes:** *1. Increased immunization coverage* *2. Decrease in dropout rates* **Immunization outcomes Indicators** *1. % of districts with ≥80% DTP3 coverage* *2. % point drop out between DTP1 and DTP3 coverage* *3. % of surviving infants receiving 3 doses of DTP-containing vaccine* *4. % of surviving infants receiving first dose of measles containing vaccine* *5. Difference in DTP3 coverage between lowest and highest wealth quintile*
Specific Object 5.2: ***To strengthen Communication and Social Mobilization for EPI services to enhance and sustain demand for and uptake of EPI and other priority RMNCAH services at national and sub national levels*** ***Key Activities*** 1. Provide funds to Conduct comprehensive mapping of private health facilities in each district of all the 14 health regions **2.** Sensitize communities on the Immunization Act (radio spots) ***Related Key Activities Indicators*** 1. Number of districts to which funds are provided to conduct comprehensive mapping of private health facilities 2. Number of stations that run radio spots run on the immunization act 2016	→	**Intermediate Results:** *1. Availability of a comprehensive database of private health facilities and practitioners in MoH* *2. Increased knowledge on the immunization act* ***Related Key Intermediate Results Indicators*** *1. Number of districts for which a comprehensive database for private health facilities and practitioners exist* *2. % of clients knowledgeable about the immun. act 2016*		
Specific Object 5.3: **To establish Community Based Health Information System (CBHIS) to enable capture and transmission of real time data on community health and surveillance events in any part of the country** ***Key Activities*** 1. Integrate the Family Connect & CHMS (e-health systems/ e-tools) 2. Train users of the CBHIS tools that feed into the e-health CBHIS ***Related Key Activities Indicators*** 1. Family Connect & CHMS (e-health systems/ e-tools) Integrated into a functional e-health system driven CBHIS 2. Number of users of the integrated e-health driven CBHIS trained		**Intermediate Results:** *1. An e-health driven integrated CBHIS Operational in districts* *2. Improved quality of CBHIS data* ***Related Key Intermediate Results Indicators*** *1. % of districts from which complete and timely CBHIS data are submitted*		
Medium Term Goal 6: Stewardship and Program Management: To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI				
Specific Objective 6.1: **To strengthen Leadership & governance for sustainable, effective and efficient management of the EPI program at all levels of the health system** ***Key Activities*** 1. MoH Top management conduct annual oversight visits to all the 14 health regions to provide oversight support to the regions and their respective cluster of districts. 2. Create a MOH/UNEPI/CSO led coordination platform / forum for regular updates on Non-State Actors' participation in EPI interventions ***Related Key Activities Indicators*** 1. Number of regions to which MoH top management conduct annual oversight visits. **2.** Number of update meetings held by MOH/UNEPI/CSO coordination platform/forum on Non-State Actors' participation in EPI interventions	→	**Intermediate Results:** *1. Availability of documented evidence by MoH Top Management on contexts of health system performance of EPI in the Country* *2. Availability of valid/documented agreed action plans for improvement of Non-State Actors' performance in EPI interventions* ***Related Key Intermediate Results Indicators*** *1. Number of documented evidence by MoH Top Management on contexts of health system performance* **2.** *Number of agreed action plans for improvement of Non-State Actors' performance in EPI interventions*		**Immunization Outcomes:** *1. Management/policy decisions backed by sound evidence-base* **Immunization outcomes Indicators** *1. % of districts with ≥80% DTP3 coverage* *2. % of surviving infants receiving 3 doses of DTP-containing vaccine* *3. Difference in DTP3 coverage between lowest and highest wealth quintile*

Impact statement:
The Gavi HSS Grant II will contribute to achievement of health related Impacts stated in the Health Sector Development Plan 2015/16 - 2019/20: Reduction in Under five mortality rate from 90 (per 1,000) in 2011 to 64 (per 1,000) in 2021.

Impact Indicator:

- Under five mortality rate (at the end of the Gavi HSS grant in 2021)

Assumptions:

1. The epidemiological pattern of diseases remains the same during the grant period
2. The population growth rate remains as projected
3. Gavi Alliance will approve the grant application and disburse the funds to the Country according to the agreed schedule
4. MoH will have the necessary complementary resources to support implementation of the grant
5. The high political will is sustained and even improves during the grant implementation period
6. The economic environment remains stable so as not to create a huge difference between conditions/assumptions under which the grant was developed and conditions under which it will be implemented
7. No major civil strife in any part of the country and the Great Lakes Region

,15. Monitoring and Evaluation (M&E) *(Maximum 2 pages)*

Provide a description of how HSS grant performance will be monitored.

The Gavi HSS grant will be monitored using multiple M&E approaches and structures, jointly agreed by UNEPI/MOH and the Gavi HSS grant implementing partners (IPs). The approaches employed will include: *Regular Program Progress Assessments and Operational Support Supervision Reports; Programme Performance Reviews; Operational Researches; Conventional Evaluative Studies; Various Policy Level Oversight on the grant; Oversight by Global Health Initiatives (Gavi Alliance Geneva; Gavi FCE; GFATM & WB) & other HSS supports, including ADB; UNEPI/MOH Implementing Partners and MOH Technical Oversight Structures.*

I. Regular Program Progress Assessments and Operational / Implementation Reports

Overall, the implementation progress of Gavi HSS 2016 grant will be monitored through the following two M&E frameworks- with clear performance indicators tracked through analysis of related quality data:

- ***The Overarching M&E Framework for the whole Grant:*** the Overarching / Main M&E framework for the entire grant will be maintained and overseen by UNEPI/MOH. The performance indicators used in this framework and that of the IPs (where relevant) will be the same ones used by the NHSDP 2015/16-2019/20;
- ***The IP specific M&E framework: this*** specific M&E framework will be tailored for monitoring the performance of the Gavi HSS grant IP using the performance indicators specific to assigned objectives and corresponding activities. The IPs of this HSS grant will be predominantly the CSOs recognized by MOH PPPH Office and UNEPI: MACIS, UHS, UNACOH, FPHP and PNFPs- each responsible for implementing a set of activities in the work plan.

The specific M&E mechanisms used for monitoring grant implementation progress are the following:

1. ***Quarterly Implementation Progress Reports***: for UNEPI/MOH and IPs, and shared with Gavi Alliance as instructed by Gavi Alliance reporting guidelines;
2. ***Annual Implementation Progress (Review) Reports:*** for UNEPI/MOH and IPs, and shared with Gavi Alliance as instructed by Gavi Alliance reporting guidelines;

Annual programme performance reviews that will be used to monitor the grant will include: the Joint Appraisal Reviews (JARs) for EPI and in-country Annual Regional Reviews ARRs- of the 14 health regions). Joint appraisal reviews will be an intensive and comprehensive exercise that will draw participation from Gavi Alliance - Geneva, in Country Health Development Partners and other EPI partners. The reviews will involve desk reviews and field work /contextual project findings using the already established guidelines of Gavi Alliance. The Joint nature of the reviews will ensure that all areas of relevance to EPI and priority RMNCAH not supported by both Gavi Alliance and other partners are integrated since they play synergistic roles in strengthening EPI performance. The JAR report together with other related reports to Gavi Alliance will form the basis for HLRP decisions on the nature of future country support from Gavi Alliance.

The in-country Annual Regional Reviews (ARRs) will include: IDSR, Cold Chain by UNEPI and an independent assessment of the Cold Chain Integrity by Joint Medical Stores (JMS). While IDSR reviews will follow the existing mode of review, the Cold Chain Assessment by UNEPI and that by JMS are new initiatives which will use new mutually agreed /owned guidelines (of MOH proposed by JMS). The ARRs reports, too, will clearly specify areas that require improvement to enhance the grant's effectiveness and efficiency. Each ARR will include interactive feedback meetings that will draw participation of different EPI constituencies in the country.

II. ***Procurement Reports:*** Procurement of some items will be handled managed by the MOH PPDA Delegated Procurement Committee, while procurement of all transport and cold chain equipment in the grant will be done through UNCEF's supply division. To obtain monitoring data from these entities, MoH/UNEPI will, in collaboration with partners develop, agree on and share reporting guidelines; all related documents will be shared with Gavi Alliance.

III. Conventional Evaluative Studies and Operational Researches

- ***Conventional Evaluative studies*** in this grant will include: the EPI Coverage Survey, the EVMA Study, Cold Chain

Inventory Assessment, Data Quality Self-Assessment, Data Quality Audit and Health Facility Assessment. These studies will be implemented using standard protocols. Technical Assistance, when needed, will be sought from Health Development Partners. These studies will identify key strengths and bottlenecks in implementation progress of the project- with respect to projected outputs and outcomes. This will not only facilitate taking timely corrective measures in the course of implementation of the Gavi HSS grant but also identifying potential good practices and innovations. Reports of all the evaluative studies will be shared in various forums- as planned. This will foster constructive partner / stakeholder engagement, hence involvement in the HSS grant implementation- thereby promoting ownership of achieved results by all stakeholders. Timelines and responsibility centres of the studies are as indicated in the grant work plan.

- ***The Operational Researches*** that will be conducted during the life of the grant will include: KAPB Study, Costing Study to establish the cost of fully immunizing a child in Uganda and the Temperature Monitoring Study. With Technical Support from Health Development Partners, the studies will be implemented using established scientific methods. Based on the findings, the studies will furnish recommendations on specific areas of good performance as well as rather weak areas that need further improvement for effectiveness and efficiency. Each study will be planned to include interactive feedback meetings (e.g. validation or consensus meetings) that draw participation of different constituencies of all EPI stakeholders in the country.

IV. *Oversight Mechanisms*

Monitoring through oversights will be carried out using two main oversight structures, i.e. MOH/GoU and relevant Global Health Initiatives (GHI).

- ***Monitoring through MoH/GoU:***
    - The status of grant implementation progress reports will be presented to the MOH based Gavi Technical Coordination Committee (TCC), NCC and EPI TWG. These reports will also be consolidated in the quarterly reports and shared with Gavi Alliance- Geneva.
    - The reports of the routine support supervisions by teams from different levels of the health system to the lower levels will complement the progress reports.
    - ***Annual Top Management Regional Oversight Visits:*** at policy level, monitoring and supportive oversight will be conducted through oversight visits to the 14 health regions. These visits are envisaged to understand the contextual health dynamics and provide strategic support to the DHO, DLG (district local governments), other stakeholders and communities in form of policy directions, government support and priming on health rights and responsibilities therein. After every visit, a national feedback meeting will be held to obtain feedback and policy guidance to the sector as well as generate consensus on matters that may require attention of government, HPAC and the Parliamentary Social Services Committee.
    - ***Other key policy oversight structures:*** Health Policy Advisory Committee (HPAC) meetings; Top Management Meetings (TMM); Senior and Middle Management (SMM) Meetings; Annual National EPI Stakeholders' meetings; and regular reports by Health Development Partners. HPAC meetings will be used to monitor and provide policy advice to the MOH arising from JARs and other reports that must be presented to TMM and SMM prior to submission to HPAC, thence to Gavi Alliance - Geneva.
- ***Monitoring through GHIs***

Monitoring of the Gavi HSS grant will also be done through oversight by the Global Health Initiatives and other key international health development agencies; i.e. Gavi Alliance, GFATM, UN family (WHO, UNICEF, UNAIDS, WB), CHAI, PATH, USAID and Full Country Evaluation. The MoH/UNEPI will work with partners to ensure that mechanisms for sharing health information in the country are clear, mutually agreed upon and predictable to all parties. This way, GHI and health development partners will track performance of immunization hence HSS grant.

V. ***The Annual EPI stakeholders meeting***

This draws participation from all EPI stakeholders including districts, regions, MoH and the HDP. EPI performance will be shared and consensus will be sought on strategies for performance improvement in the subsequent implementation period of the grant. Additionally, HDPs including PATH, CHAI, WHO, UNCEF and MCHIP will conduct independent or joint supervisions on EPI and other health interventions at district level - related reports will be shared for joint deliberations.

16. PBF Data verification option	
Choose which data verification option to be used for calculating the performance payments.	
Data verification option	**Select ONE**
Use of country administrative data	☐
Use of WHO/ UNICEF estimates	☑
Use of surveys	☐

PART D: WORK PLAN, BUDGET AND GAP ANALYSIS

17. Detailed workplan, budget narrative and gap analysis *(Maximum 3 pages)*

Complete ***Mandatory Attachment #6: Detailed work plan, budget and gap analysis,*** *which can be accessed at the online country portal.*

Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.

Once the budget template and financial gap analysis has been completed, provide a ***budget and gap analysis narrative*** *here.*

Table 6 provides a summary of the budget for the HSS proposal. The proposed activities require a total of $30,599,998 for the period of 5 years. Of this total, the first objective (service delivery) takes up 39.7%, while PSM take the second largest share of 31.3%. Together, these two areas take nearly 71% of the total HSS budget. The remaining objectives take up relatively smaller percentages, with HMIS taking 11.3%, health financing 0.9%, community systems 7.6% and program management 9.3%. Furthermore, out of the total budget of $30.59 million, about 24% will be required in the first year (2017), and the remaining will be evenly spread over the remaining 4 years (with an average of about $5.83 million per year).

The proposal objectives presented in Table 6 are highly summarised and made up of many activities, whose details are presented in the Excel Budget Template (attached to this proposal), and also in the detailed costing tool (that has been uploaded as an additional document for reference).

Table 6: summary of budget for the HSS proposal (USD)

HSS Proposal Objectives	2017 (USD)	2018 (USD)	2019 (USD)	2020 (USD)	2021 (USD)
1. Enhance equitable access to quality EPI and other priority MNCH services by target populations, including hard-to-reach populations, so as to increase uptake of EPI and other priority MCNH services	4,215,567	2,779,687	1,607,373	1,761,497	1,788,673
2. Strengthening the logistics and supply chain management system of UNEPI/NMS in order to improve the quality and efficiency of stock management of EPI/VPD and other essential medical commodities at all levels countrywide	1,248,895	1,480,678	2,921,926	1,962,675	1,961,146
3. Strengthen generation and utilization of routine and real time strategic health information	679,847	738,364	515,688	770,373	743,543

4. To strengthen the MOH/UNEPI stewardship to effectively deploy constructive engagements for achieving sustainably predictable immunization financing with the prospect of attaining self-sufficiency in the country's immunization financing	112,303	41,996	41,996	41,996	41,996
5. Enhance community demand for and uptake of quality EPI and other priority MNCH services so as to improve EPI and other health outcomes of the outcomes	420,620	257,631	211,373	710,615	710,374
6. Program management To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI	602,767	531,644	531,644	582,844	584,267
Total	**7,279,999**	**5,830,000**	**5,830,000**	**5,830,000**	**5,829,999**

Table 7 provides a summary of the financial gap analysis. The total resource need is estimated from the cMYP. Resources available were provided by all partners who support immunization activities in Uganda. Based on these, we have a total financial gap of nearly $200 million over the 5-year period (2017 – 2021). In this HSS proposal we request for funding of $30.59 million over the same period, which is about 15.3% of the total financial gap.
Table 7 also shows that "service delivery" has the largest financial gap (which makes 57.8% of the total financial gap for the 5-year period). Program management has a financial nearly 17% of the total financial gap.

Table 7: Summary of Financial Gap analysis

	Service delivery	**PSM**	**HMIS**	**Health financing**	**Community**	**Program Management**	**TOTALS**
Resource needs (from cMYP)	119,249,970	19,386,371	31,077,234	2,253,431	2,337,361	33,981,457	**208,285,824**
Available resources	3,729,110	313,273	2,270,298	286,078	1,585,629	118,321	**8,302,709**
Financing GAP	115,520,860	19,073,098	28,806,936	1,967,353	751,732	33,863,136	**199,983,115**
Amount requested in the HSS proposal	**12,152,796**	**9,493,486**	**3,289,785**	**1,012,560**	**2,380,583**	**2,268,890**	**30,598,100**
% financial gap	57.80%	9.50%	14.40%	1.00%	0.40%	16.90%	

Pooled fund *applicants are not required to complete the work plan, budget and gap analysis template. Instead, specific information on the sector wide annual work plan and budget should be provided.*

18. Sustainability *(Maximum 2 pages)*

How the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion.

Staff in the UNEPI to ensure that all priorities are followed up; staff hired are incorporated into main government structure. The Ministry of Health UNEPI programme has been having challenges with ensuring adequate HR capacity in the past. However, in this strategic period, the Government of Uganda has endeavored to fill critical HR posts in UNEPI to ensure smooth implementation and stewardship of EPI activities in Uganda. These include the post of the Programme Manager, Deputy Programme Manager, Senior Medical Officer and cold chain engineer amongst others. These have been substantiated in the current strategic period and included on the government role. This action will ensure programmatic sustainability as well as ensuring sustainability of achievements are given timely follow-up of critical actions that have often been hampered by high turn-over of staff due to inter alia job insecurity.

The Country has developed and is implementing a National Human Resources for Health Strategic Plan 2005/2020 that will guide recruitment and comprehensive maintenance of health workers to fill the needed HR posts in the sector. MOH is committed to filling the HRH posts and advocacy efforts with the MoFPED are ongoing in this regard to ensure that funds are availed for the wage bill within the MTEF. As these critical posts are filled and capacity for health workers is built it is anticipated that this will strengthen UNEPI programmatic sustainability beyond the life of the Grant.

With regard to motivation of staff, the sector has developed and is to implement RBF framework that will guide remuneration of health workers based on their performance. As RBF is scaled up, bonuses or salary top-ups will be used to motivate health workers and encourage retention especially in hard to reach areas. This will help reduce the high attrition of staff (whose capacity will have been built) thereby contributing to programmatic sustainability.

Sustainability of important innovations like the LMIS will be achieved chiefly because the LMIS is going to be anchored as a module in DHIS 2. Since the DHIS 2 is already rolled out to sub-national level (Health Centre IVs) this will greatly enable the LMIS to be rolled out and maintained as updates to the DHIS 2 are made. In addition, strategic partnerships with other partners in the sector will be explored to ensure further updates of the LMIS are maintained in all districts beyond this grant.

The implementation of the newly finalized and endorsed CHEWs Strategy will be critical for ensuring programmatic sustainability of activities related to community health and the CBHIS. The strategy includes curriculum development and training of CHEWs in, amongst other technical competence areas, effective utilization of the CBHIS for generation of quality real time data and other needed information for timely management decision making. Therefore UNEPI will partner with other stakeholders in the sector to ensure successful implementation of the CHEWs Strategy.

How the government is going to ensure financial sustainability of the results achieved by the Gavi grant after its completion

The GoU has successfully finalized its Health Financing strategy 2015-2025. The strategy clearly articulates the government's plans for ensuring increased fiscal space for health, reducing OOPs and increasing financial risk protection. Chief among the strategies are heightened evidence-based advocacy for increased government financing for health, development of National Health Insurance Scheme that will ensure prepayment for health services with likelihood of reducing household OOPS, and increased aid effectiveness ensuring predictability and harmonization of donor funding for health. These actions will facilitate increasing availability of financing for immunization in Uganda.

As a key government priority for health, GoU in March 2016 enacted the Immunization Act. This act provides for, inter alia, the Immunization Fund which will enable a buffer to be designed to avoid any shocks in the supply of immunization services while providing opportunity for MOH/UNEPI to plan with foresight for the growing vaccine demand and schedule. The creation of this fund provides for ring-fencing of funds that specifically focus on immunization in Uganda. The country is yet to develop regulations for the newly formed act and fund including the sources of financing for the fund. The country will endeavor to conduct a study exploring funding sources for the immunization fund. Following this, concerted evidence based advocacy efforts will be implemented to ensure that credible funding sources are identified for the fund. This will greatly ensure financial sustainability for immunization program in Uganda.

The EPI programme has secured a vote function in MOFPED; this eases the accountability and monitoring of funds voted for the immunization program. This will support the programme to increase its transparency within the Ministry of Finance, and enable forging better understanding of how and when immunization funds are utilized to

achieve the National Health Goals and key performance indicators. The EPI programme has realized the importance of strong accountability practices for improving transparency and efficiency while further garnering support of local finance institutions.

The country's steps to reduce further reliance on Gavi funding for recurrent costs and requests recurrent activities

Investment in Human Resource for Health

GoU-MOH is largely self-sufficient in human resource generation for manning the health and other markets of the country's economy; this is contained in the National Human Resource for Health (HRH) plan27. To strengthen this effort, part of the Gavi HSS grant will facilitate the HR technical capacity which include; capacity enhancement across health system levels on priority areas of need, potentiate crucial strategies (data quality improvement, EVM, the RED/REC strategy including mapping of target communities/populations enhancing coverage and equitable access). Implementation of the HRH plan will sustain this effort.

HSS Investment with Recurrent Expenditure Nature	MOH/UNEPI-GoU Sustainability Measure
The CCE Investments	MOH/UNEPI has developed a comprehensive CCE Preventive Maintenance Plan (CCE PMP). Implementation of this plan will ensure sustainable maintenance of CCE countrywide. MOH/UNEPI will vote funds for the CCE PMP in the budget of every financial year to supplement initial investment support of Gavi HSS. Once the Immunization funds become operational in the next five years, sustainability of the CCE PMP will be further consolidated
Traditional & New Vaccines	The vote function secured by the EPI programme in MOFPED will ease negotiation for and ring-fencing of immunization funds- and broader understanding (by MOFPED and the other arms of the government) of immunization program demands. MOH/UNEPI and partners with whom they successfully advocated for the Immunization fund, are making further advocacy strategies for operationalizing the immunization vote in addition to fast tracking establishment of the immunization fund. These actions are envisaged to secure adequate funding for the traditional vaccines (in the short and medium terms) and for the new vaccines (in the medium and long term). The private sector, which is part of the NCC, is showing promising commitments for resource mobilization in collaboration with MOH/UNEPI.
Motor Vehicles (trucks, motor cycles and boats)	GoU/MOH/UNEPI are going to assume full responsibility for fueling and maintenance of all types of vehicles going to be procured through Gavi HSS support; the GoU/MOH/UNEPI acknowledge their role and responsibility in this. MOH will induct local governments towards their inherent responsibility to secure, utilize and maintain the vehicles appropriately at operational levels
Services to Special Populations and HTR areas	Through the UNHCR integration policy, MOH/UNEPI and UNHCR will cost share provision of all key immunization inputs for provision of immunization services of the same standard to refugees in UNHCR settlements
HRH (especially the District Cold Chain Technicians /DCCTs and the Biomedical Engineers / Technicians)	District Cold Chain Technicians have been identified for each district. Although currently the DCCTs are being paid through Gavi HSS funds, MOH and the Ministry of Public Service are in the process of regularizing establishment of the DCCTs as conventional civil servants on government payroll. Hence, all districts will have sustainably salaried DCCTs to provide CCE maintenance and general management.
Printing Expenditures	With prospects of continued good performance of the economy, government hopes to improve resource flow to the health sector. MOH has in the last one year been discussing how to improve health financing- improving the health financing fiscal space and how to sustain that in the medium and long term. Hence, there is a possibility of

[27] National Human Resource for Health plan

	GoU/MOH increasingly becoming responsible for all the operational recurrent expenses
Surveys (HH & Routine surveys), Reviews, Operational Research costs	As above
CHWs (VHTs & CHEWs)	Government has a new strategy to improve the community level workforce using CHEWs (Community Health Extension Workers. This cadre will undergo training for one year, and will be on government civil service payroll (MOH Chew Strategy, 2015). In order to improve effectiveness and quality of community based health services, stakeholders are discussing ways of ensuring co-existence of VHTs and CHEWs.

Summary of the country's policy and approach to sustainability

The country has an enabling policy environment that will ensure sustainability. The National vision 2040 sets the vision for transformation from a peasant society to a low middle income society. The economic and social transformation that will accompany this provides an enabling long term environment for sustainability. In addition, the NDP II, the National Health Policy II, HSDP 2015-2020, the immunization policy and the CMYP provide an enabling policy environment for ensuring oversight of coordination and implementation of efforts towards sustainability of the programme and financial sustainability.
The Immunization Act 2016, the Local Government Act 1997 that provides for establishment and functionality of the decentralized health system, the Public Finance Management Act (2015) all provide an enabling and enforceable legal environment for implementing actions geared towards financial and programmatic sustainability for immunization.

***Pooled fund** applicants are required to provide existing documentation that addresses sustainability. List which documents have been provided and reference the relevant sections.*

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

19. Implementation arrangements *(Maximum 2 pages)*

The planned implementation arrangements

The Gavi grant will be managed within the existing government of Uganda management structures.

The Permanent Secretary (PS) of MoH will provide oversight in the implementation of the GAVI supported HSS. The PS with support from the Commissioner of Health Services (CHS) for Planning will be responsible for managing the implementation of the GAVI HSS support.

HPAC will monitor progress in the implementation of GAVI HSS support and provide technical guidance. It will receive progress reports and make appropriate recommendations. Through the Sector Budget Working Group (SBWG), HPAC will ensure that GAVI HSS funds are being used as efficiently and equitably as possible, and aligned to the agreed policy priorities

The MoH provides overall stewardship of the health sector working in a coordinated manner with key sector players. The different stakeholders have been brought together under a variety of mechanisms and structures. Uganda has a working Sector wide Approach (SWAp) and the Public Private Partnership for Health. These structures exist in a dynamic environment and have evolved as appropriate. GAVI HSS activities just like other activities will be coordinated under SWAp arrangement. The following Officers/offices will be responsible for the following:

1. The Under Secretary (Finance and Administration) will be responsible for the preparation of annual financial reports, arranging audits of the GAVI HSS finances and organising training of accounting courses and transport management.
2. The CHS (Planning) will provide leadership and coordination in the implementation of GAVI HSS and also

responsible for Annual Performance Review (APR) including monitoring annual implementation plans and producing sector reports.

3. The CHS (Clinical Services) will provide technical guidance.
4. The UNEPI Programme Manager will be responsible for the overall management (including technical supervision) of EPI services at national and sub-national levels.
5. The Desk Officer in the Ministry of Finance, Planning and Economic Development will monitor budget performance and participate in Midyear and annual Reviews.
6. The WHO and UNICEF representatives will provide technical support on a regular basis.
7. The CSO representatives will also form part of the implementation partnership.

The organogram below (Figure 1) illustrates the oversight functions of GAVI Grant.

Sub-recipient management arrangements

Since 2007, the PR has sub-granted Local Governments, CSOs, CBOs and Hospitals. The PR undertakes a pre-award assessment to ascertain existing capacity and identify areas of weakness, signs Memoranda of Understanding with qualifying CSOs, undertakes capacity building, disburses grant funds and performs routine monitoring to ensure proper programmatic and financial accountability. The PR will be responsible for contracting the sub recipients. This will include sub recipient orientation and training on monitoring and reporting requirements as well as capacity strengthening on operational and crosscutting issues. All sub-recipients will then derive their work plans in line with the overall PR work plans

Coordination between the Principal Recipient and their respective sub-recipients

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

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

Partner Engagement Framework-Country Tailored Approach (PEF CTA)

Health development Partners such as WHO, UNICEF and WB will be directly involved in deliverables of the HSS grant through the PEF CTA. The grant PEF CTA activities have been included in the overall grant planning and budgeting process. The accrued results will be reported along with GoU Gavi outputs targeting improving immunisation coverage, equity and HSS in the country.

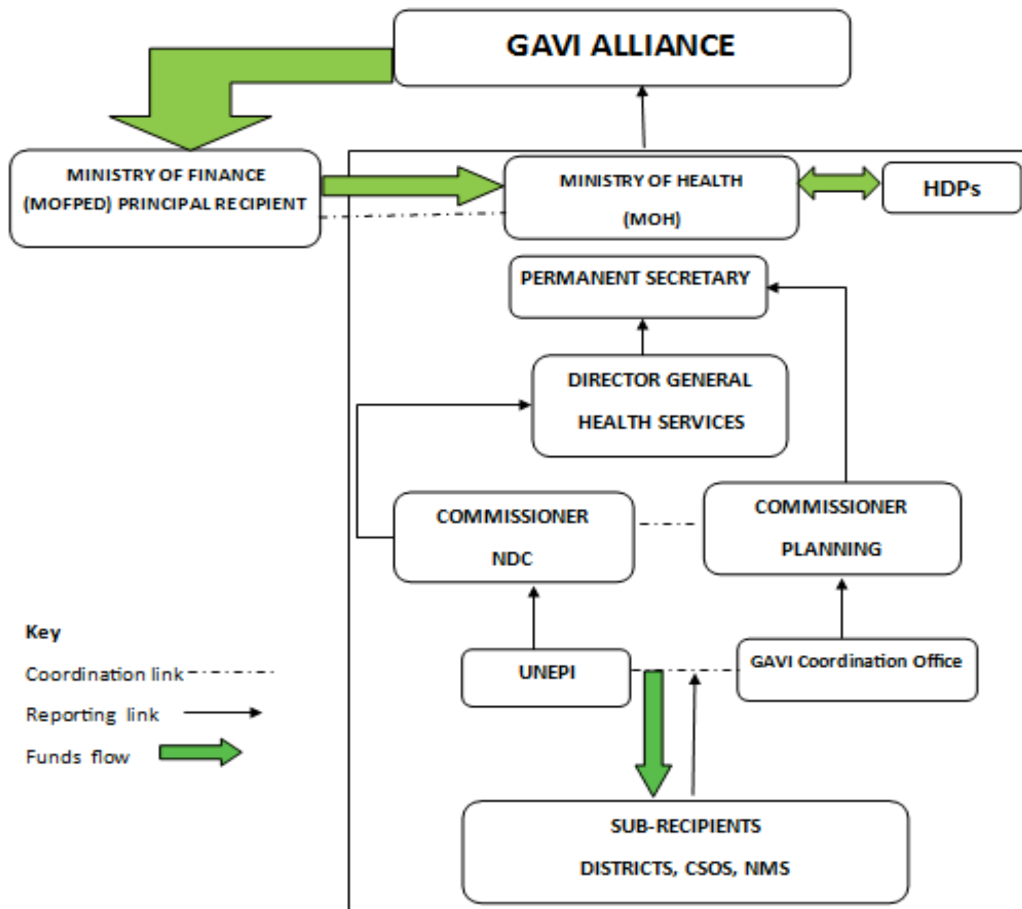

Figure 1

Pooled fund *applicants are required to provide documentation of the implementation arrangements of the sector wide mechanism, if appropriate. List which documents have been provided and reference the relevant sections.*

20. Involvement of Civil Society Organisations (CSOs) *(Maximum 2 pages)*

How CSOs (Non State Actors) will be involved in the implementation of the HSS grant.

Civil Society Organizations also referred to as Non state actors are strong partner to the Ministry of Health efforts in improving service delivery and demand creation. The Non state actors / CSO are coordinated by Ministry of Health through the Private Public Partnership for Health (PPPH) Coordination office. The CSO's are directly involved in advocacy, programme management and monitoring implementations, of immunization service delivery. The CSO's are located both at central and district level. CSO's Coalitions exist under different umbrellas all with a primary focus on immunization. During the implementation of the 2017-2021 HSS life span, the CSO's will be harnessed towards support of immunization service delivery at all levels of the Health system.

Among the CSO's umbrella's working with Ministry of Health include; Uganda Health Foundation(UHF) which has UHF, UCMB,UPMB,UMMB,UOMB, Traditional and Modern health Practitioners together against aids(THETA), all under one umbrella, Malaria and Childhood Illness NGO network secretariat (MACIS), Uganda National Health Consumer's Organization(UNHCO) and Private Health Practitioners.

The CSO's will be involved in civil society engagement, strengthening MoH immunization Programme, collaboration with the communities an advocacy arm in extending immunization services further in the

communities ,demand creation and ownership. Among key activities identified for scale up include.

- Mobilization and follow-up
- Inclusion of both private and public health practitioners in immunization
- Mobilization of resource persons such as religious and cultural leaders
- Support scale up of a family connect and Community Health Management Systems (CHMS) - e-health systems/ e-tools

How Inter Religious Council (IRC) will be involved in the implementation of the HSS grant.

Religion in Uganda permeates the entire country reaching most hard to reach areas. According to Census report 2014, approximately 98% of the population belongs to a religion. Faith based organizations in Uganda are organized under one body, the Inter Religious Council of Uganda (IRCU) composed of the Roman Catholic Church, Anglican Church, Uganda Muslim Supreme Council, Orthodox Church, Seventh-Day Adventist Church, Uganda Action Network and Born Again Faith. The IRCU is divided in 13 operational regions covering the entire country. Non for Profit Health facilities that are owned by faith based institutions account for 43% of the national health system. Religious organizations have a cadre of trained religious leaders who interface with the population on a daily basis as they undertake their pastoral duties and during religious events. This therefore makes religious leaders important in mobilization for health service uptake. They will be sensitized on immunization and involved in conducting advocacy and mobilization for immunization services.

Pooled fund *applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.*

21. Risks and mitigation measures *(Maximum 2 pages)*

If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Uganda does not have a separate Health Sector Risk Assessment. However the table below high lights MoH/UNEPI stakeholder's analysis of the risks.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Table 8: Risk Analysis Table

Description of risk *** Internal risk ** External risk**	***PROBABILITY (high, medium, low)***	***IMPACT (high, medium, low)***	***Mitigation Measures***
Medium Term Goal 1 (Service Delivery): To enhance equitable access to quality EPI and other priority RMNCAH services by target populations, including hard-to-reach populations, so as to increase uptake of EPI and other priority RMNCAH services by December 2021			
Institutional Risks: • Accessibility to EPI and RMNCAH services (poor health seeking behaviour; distribution of Service Delivery [SD] points affecting equity of access; HTR areas / populations)* • Inadequate management competences – affecting planning, coordination & Implementation (quality)* • Allocative inefficiency (Inequitable resource allocation regardless of prevailing circumstances) or undue regard to environmental variations*	• Low • Medium • Medium	• Medium • Medium • • High	1. Improve outreach service delivery with focus to hard to reach and populace equity 1. Advocate for more Infrastructure at SD levels through cold chain expansion. Human resource recruitment and technical capacity building in areas of skill deficits 1. Evidence based implementation to guide institutional planning. Conduct planning and adequate resource allocation 2. Advocate for increased equitable GoU financing for health system interventions
Fiduciary Risks: • Weak planning that aligns and harmonizes Local Government & Central Government strategic and operational plans leading to delays in financial disbursements • Impairment of performance due to irregular or delayed disbursements of funds • Exchange rate volatility • Irregular and insufficient remuneration / compensation of health workers for services delivered coupled with disproportionate remunerations- which have resulted into staff demotivation*	• Medium • Medium • Low • Medium	• High • High • Low • Medium	1. Strengthen planning mechanisms that aligns and harmonizes the two governance levels 2. Track flow of funds from MOH to HFs via DHOs to inform MOFPED and MOH to get remedial actions to financial flow bottlenecks 3. Institute proactive financial management, including alignment of disbursements with recipient (DHOs/HFs) operational plans 4. Advocate for MOFPED to keep co-financing funds in USD to avert unpredictable foreign exchange rates 5. Device innovative ways of providing equitable incentives

Operational Risks: • Inequitable distribution of Cold chain equipment at service delivery level* • High staff turnover especially in hard to stay and hard to leave districts*	• Medium • Medium	• Medium • High	1. Expand the availability of CCE to deserving health facilities points to be supported by the CCE OP 2. Devise innovative ways of providing incentives to serving health workers, e.g. salary top-ups, hardship allowances, career development opportunities, etc.
Programmatic Performance Risks: • Inflexible fund utilization guidelines that restricts operational resource deployment options*	• Low	• Medium	1. Engage Global initiatives to discuss favourable options to current reprogramming / re-allocation processes
Overall Risk Rating for Strategic Objective 1	Medium	Medium	
Medium Term Goal 2: **To strengthen the logistics and supply chain management system of UNEPI/NMS in order to improve the quality of stock management as well as efficiency of distribution of these essential commodities at all levels countrywide by December 2021**			
Institutional Risks: • Delays in procurement processes in Civil Works, CCE and Services*	• Medium	• Medium	1. Ensure adherence to the approved procurement plan 2. Hire a procurement specialist to handle all Gavi HSS related procurements Timely implementation of M&E actions
Fiduciary Risks: • Delays in financial disbursements * • Inadequacy of PHC funds for Cold Chain Maintenance works at district level*	• Medium • Medium	• High • High	1. Align all interventions with global, regional, national and sub-national plans 2. Enforce the EPI Financial Management Protocol / Guidelines 3. Disburse Gavi funds directly to health facilities 4. Develop a rational formula for allocation of Gavi funds to districts 1. Advocate for ring-fencing of 20% of PHC funds for EPI activities 2. Advocate for operationalization of the Immunization Fund
Operational Risks: • Inadequate capacity in cold chain maintenance at district level due to lack of DCCTs*	• Medium	• Medium	1. Advocate for DLGs to fill the DCCT gaps 2. Build capacity of Regional Biomedical Equipment Team to effectively carryout intra-regional cold chain support supervision
Programmatic and Performance Risks: • Mal-alignment of Gavi Alliance Financial Year with that of MOH/GoU (affects disbursements, implementation, accountability & co-financing obligations) • Uncertainty of financial sustainability due to expanding EPI program budget (attributed to new vaccine introductions) **	• Medium • Medium	• Medium • High	1. Advocate to Gavi Alliance to align disbursements with MOH/GoU Fiscal Years 1. Advocate for operationalization of the Immunization Fund 2. Advocacy to establish viable options for equitable and sustainable health financing in the country
Overall Risk Rating for Strategic Objective 2	***Medium***	***Medium/High***	***(1:1)***
Medium Term Goal 3: **To strengthen generation and utilization of routine and real time strategic health information (HMIS, IDSR & Surveys) on EPI and other priority health services for responsive management of these services at all levels of the health system by December 2021**			

Institutional Risks: • Untimely and quality electronic data transmission system**	• Medium	• Medium	1. Mentorship of health workers in data management, analysis, utilization and feedback 2. Support integration of the piloted innovative e-heath approaches with DHIS 2 for capture of data from lower (community) level 3. Long term plan to extend the the electronic data transmission system to lower levels
Fiduciary Risks: Non anticipated			
Operational Risks: • Discrepancies in EPI strategic information (Inadequate data collection tools, Discrepancy in denominator, Un validated data ,Inadequate knowledge on data management and utilization mainly at health facility level)**	• Medium	• Medium	1. Strengthen the Data quality Improvement plan and conduct DQSA 2. Conduct quarterly review meetings as planned 3. Maximize use of community based health information system/Household mapping to improve denominator estimates 4. Conduct regular valid surveys(Coverage survey, EVMA)
Programmatic and Performance Risks: Not anticipated			
Overall Risk Rating for Strategic Objective 3	***Medium***	***Medium***	
Medium Term Goal 4: Health Financing: To institute mechanisms for sustainable immunization financing so as to achieve predictable immunization financing for effective management of the immunization program by December 2021			
Institutional Risks: • Reliance on donor funding which is unpredictable • Competing Government priorities which may cause volatility to allocation to Health sector	• High	• High	1. Advocate for increased government funding for immunization 2. Implement the immunisation fund including ring fencing the fund
Fiduciary Risks: • Financial flows across governance levels • *Off budget financing by donors to districts*	• Medium Medium	• Medium • Medium	1. Coordination and resource pooling
Operational Risks:*Non anticipated*			
Programmatic and Performance Risks: Non anticipated			
Overall Risk Rating for Strategic Objective 4	***Medium***	***Medium***	
The Medium Term Goal 5: **CSS/Non State Actors: To Enhance community demand for and uptake of quality EPI and other priority RMNCAH services so as to improve EPI and other health outcomes of the country by December 2021**			
Institutional Risks: • Weak organizational structure of CSO's	• Medium	• Medium	1. Support PPPH office with a desk officer for better coordination CSO's
Fiduciary Risks: Non anticipated			
Operational risks: • Many CSO's have been established requiring clear knowledge of their responsibilities to align to Health priorities *	• Medium	• Medium	1. MoH leading the coordination of the CSO's into one umbrella
Programmatic and Performance Risks:	• Medium	• Low	1. Mandatory reporting as requirement for accessing grant

• Weak monitoring and reporting system(lack of quality reports) *			funds
Other Risks: *Non anticipated*			
Overall Risk Rating for Strategic Objective 6	***Medium***	***Medium***	
The Medium Term Goal 6: ***To strengthen MoH oversight function so as to enhance effectiveness, efficiency and sustainability of EPI***			
Institutional Risks: • Weak top management involvement in program management*	***Medium***	***Medium***	1. Top management involvement in district supervision
Fiduciary Risks: *Adherence to accountability guidelines**	***Low***	***Low***	2. Hold an induction meeting on the Comprehensive EPI Financial Management Operational Manual
Operational risks: Non anticipated			
Programmatic and Performance Risks: Non anticipated			
Other Risks:			
Overall Risk Rating for Strategic Objective 5	***Low***	***Low***	

Pooled fund *applicants are required to provide any risk mitigation plan under the sector wide/ pooled funding mechanism.*

22. Financial management and procurement arrangements

The proposed budgetary and financial management mechanisms for the grant

The Ministry of Finance, Planning and Economic Development (MoFPED) is the Principal Recipient (PR) of GAVI funds (like it is the case of all monies received by the Government of Uganda (GoU)), according to Article 153 (1) of the Constitution of The Republic of Uganda of 1995 and the Public Finance and Accountability Act of 2003.

The MOH /Health Planning Department (HPD) coordinate the preparation of GAVI HSS at Central and Local Government Level in line with the Health Sector Strategic and Investment Plan (HSSIP). The Local Government activities are embedded in the Local Government work plans.

The Ministry of Health vote under the GoU budgetary arrangement is Vote 014 and the GAVI Projects is capture as Project 1141 : "Gavi Vaccines and HSSP" with clearly indicated outputs.

The MoFPED maintains a GAVI specific bank account (USD account) in BoU as a 'Collection Account' where all the funds from GAVI alliance are disbursed. The name of the account is the Global Alliance for Vaccines Initiative Health Systems Strengthening (GAVI HSS) Grant.

Two additional GAVI designated project bank accounts are operated by the MoH in the BOU.

- When funds are received by the MoFPED collection account, they are transferred to the GAVI US Dollar account (GAVI Vaccines Fund USD Account) on request by the PS (MoH) to PSST (MoFPED).
- The Uganda shillings account (GAVI Vaccines Fund UGX) is then used for payment of transactions in local currency for GAVI supported activities to all Sub Recipients (SR) including but not limited to local governments.

Funds disbursed to local governments are transferred from the MoH GAVI UGX account directly to the District General Collection bank accounts (receipt of which is confirmed in writing by the local government accounting officers to the MoH).

The main constraints in the health sector's budgetary and financial management system

The Government of Uganda (GoU) has put in place institutional arrangements for planning and budgeting with the aim of improving public expenditure management. The budget process is characterized by relative transparency and openness and broad participation. Planning and budgeting arrangements in place include the Sector Wide Approaches (SWAps), the medium-term expenditure framework (MTEF), the Poverty Action Fund (PAF), the fiscal decentralization process, the National Development Plan (NDP), and Budget Framework Papers (BFPs).

Among the budgetary challenges faced by the health sector are off-budget funds especially considering that Ministry of Health (MoH) has insufficient information to track and monitor their use. The efficiency of these funds remains questionable as their allocation may not be fully aligned towards health sector priorities. The continuous decrease in external funds reflected in the MTEF has created challenges of unpredictability and continues to be a big constraint to comprehensive planning and prioritization at both national and district levels.

In terms of financial management, the health sector follows the Public Finance and Accounting the Public Finance Management Act 2015. This is supported by other guidelines such as Treasury Accounting Instructions, Circular Standing Orders, and National Audit Act. These regulations are comprehensive to ensure that there is transparency and accountability in the utilization of public resources.

Internal financial control systems have also been established in public health institutions to deal with financial risk including management of financial records and budgetary controls, assigning responsibilities, defined reporting channels, performance appraisals and review systems.

Accounting and administrative controls such as the approval and control of documents and quality through performance indicators and performance statistics are in place. These controls aim at encouraging compliance with policies and procedures, prevention and detection of fraud, promotion of timely accountability, and accuracy and completeness of records.

Financial management systems within the health sector are comprehensively defined. Systems for planning, supervision, monitoring, and service management exist. However, their adequate utilization at the different levels this leave room for improvement. As a result, the quality of outputs from these management systems can be further improved.

There is still a major challenge with reporting at the district level manifested through delays in reporting and sometimes submission of poor quality reports. Accounting officers of health institutions are responsible for maintaining efficient and transparent systems of financial management and internal controls, ensuring that financial and other resources are used for the purpose for which they were voted, and managing and controlling commitments and expenditures within the approved budgets introduction of the Output Budgeting Tool (OBT).

Accounting officers sign performance contracts in order to deliver agreed upon outputs, particularly linking work plans and procurement plans to the cash flow. Linkage of work plan and procurement plans to the cash flow addresses delays in procurement; low absorptive capacity issues and promote timely reporting. Delays in reporting and delivery of outputs are attributed to factors such as lack of commitment and less than optimal attitude towards work. This situation usually creates serious challenges for the decentralized health service delivery since releases are tied to timely submission of performance reports on a quarterly basis.

Government of Uganda introduced an Integrated Financial Management System (IFMS), a fiscal and financial management information system for government that bundles all financial management functions into one suite of applications. IFMS assists the government and MoH to initiate, spend and monitor the budget, to initiate and process payments, and to manage and report on financial activities. It is a core component of financial management systems reforms which promotes efficiency, security of financial data, management and comprehensive financial reporting.

Although the IFMS helped MoH in terms of central control, monitoring and evaluation of expenditure and reporting systems, challenges of the system still exist. Access to the IFMS is still limited at sub-national level due to insufficient access to computers and the occasional systems unavailability. Ideally, realization of the full benefits of the IFMS, hinges on ensuring that all transactions are captured on real-time basis. Extension of the IFMS system has therefore been a major point of focus. However, in cases where the User departments are geographically dispersed e.g. health facilities, the MoFPED is faced with the prospect of substantially increased costs for the communication and information infrastructure required. In such cases, the MoFPED have had to opt for a manual data transmittal as a stop-gap measure.
Additionally, IFMIS configuration is somewhat rigid leaving no room for customisation of individual project financial reporting needs. As such, in case of Gavi Project, Ministry has had to revert to Excel spread sheet financial reporting which is not password enabled.

The MoH provides a separate program for funding of internal audits within its budget. Internal audit reports are submitted to the Audit Committee of Health Sector on technical matters and administratively to the Accounting Officers. The purpose, authority and responsibility of internal audit is formally defined in a charter, consistent with the standards of Professional Practice of Internal Auditing from Institute of Internal Auditors, and the national laws, rules and regulations.

Internal audits aim at identifying and evaluating significant exposures to risk and contribute to the improvement of financial risk management, and evaluating the efficiency and effectiveness of existing financial control systems. They also assess and make recommendations for improving the governance process in

accomplishment of objectives. The Uganda Health Sector Strategic and Investment Plan (HSSIP) recommended training in value for money auditing for internal auditors in order to further improve on their performance. External financial audits of all public accounts of Uganda Government and projects co-funded by the GoU and development partners are carried out by Auditor General's office on an annual basis. The auditing of all GoU funds and Donor support funds is done in accordance with GoU procedures and regulations as stipulated in the Public Finance Act and more specifically the National Audit Act 2008, as well as other donor specific procedures. Previous external audits have identified various gaps including; • Delays in preparation of comprehensive procurement plans and non-compliance to some procurement regulations • Lack of proper guidelines for prioritization and standardization of the infrastructural developments undertaken in Local Governments and regional referral Hospitals • Expiry of slow moving drugs and perpetual stock deficiency of essential drugs at health facilities coupled with poor drug storage facilities and untimely disposal of expired medical drugs.
*Complete the **Budgetary and Financial Management Arrangements Data Sheet** (below) for each organisation that will directly receive HSS grant finance from Gavi.*
*Provide **Mandatory Attachment #7**: Detailed two-year Procurement Plan Attached*
***Pooled fund** applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement*

Table 9: Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	**Mr. Keith Muhakinizi** Permanent Secretary and Secretary to Treasury Ministry of Finance, Planning and Economic Development. Plot 2-12, Apollo Kaggwa Road P.O. Box 8147, Kampala Tel: +256 41 4707 000 Email: finance@finance.go.ug
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance.	HSS1 Grant US$19,242,000 (Ends on June 30th 2016) ISS Grant: **US$** 2,649,520 (Completed) VIG Grants - PCV: US$1,372,000 HPV:US$1,336,980 IPV: US$1,356,500 (Completed) In respect to GAVI HSS (US$19,242,000) that is still on-going, there have been issues of delay implementation especially on procurements. No reported cases of misuses

• For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	or thefts. Delayed audit reports for the commencement year of the project were also a reported issue. Two Audit Reports have had a qualified opinions related to delayed accountabilities from districts.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Ministry of Health Top Management (Membership: All three Ministers, Permanent Secretary, Director General of Health Services, all Directors and Commissioners of Health Services and Heads of autonomous health agencies), Chaired by Minister of Health, is the Overall decision Making Organ of the Ministry of Health. Health Policy Advisory Committee (HPAC Members: Development Partners, Permanent Secretary, Director General of Health Services, Directors and Commissioners, and representatives of Civil Society Organisations), Chaired by Permanent Secretary). Both HPAC and Top Management provide overall oversight of the fund implementation. The Gavi Technical Coordination Committee (Membership: EPI Manager, Asst. Commissioner of Budget and Finance, Gavi Project Coordinator, Head of Procurement and Disposal Unit, Asst. Commissioner of Accounts, Ministry of Finance Desk Officer, representatives of WHO and UNICEF, DFID, Coordinator of Gavi). The committee is appointed by the Permanent Secretary and chaired by Asst. Commissioner of Budget and Finance. It provides technical oversight and advises the PS on implementation of the Grant. UNEPI is the overall grant implementer, administratively assisted by the Project Coordination office. UNEPI staff are permanent staff of MoH headed by the EPI Manager. The Coordination office is headed by a Permanent Staff of MoH assigned additional duties by PS. The Coordination Office reports to GTCC on a monthly basis and on day to day work, it reports to PS.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	MoH Planning and Policy Department is responsible for overall Planning and Budgeting. UNEPI with assistance from Gavi Coordination Office is obligated to provide GAVI HSS costed work-plans to Planning Department for inclusion into the National Budget.
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	MoH budgeting process starts in September of each Financial Year with Local Government Budget Conferences, working on indicative planning figures provided by Ministry of Finance. After collecting plans from local government and agencies, National Health Sector Budget conferences are held in December where all plans and budgets are input into the National Budget Estimates using Output Based Tool (OBT). The Sector Wide Budget Committee Budget Committee chaired by Commissioner Planning is responsible

	for the final Health Sector Budget. In March, Minister of Health presents the Ministerial Policy Statement to Parliament for debate and approval. The Financial year starts on July 1st and ends on June 30th.
7. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	Ministry of Health Maintain 2 Accounts (Dollar and Uganda Shillings Account). Ministry of Finance maintain dollar Holding account where Gavi disbursed Grants are first deposited and letter on transferred to Bank of Uganda Dollar Account until when requested for conversion by MoH. MoH PS is the Principal signatory to MoH Shilling Account. All transactions in Uganda are conducted in Uganda Shillings.
9. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Gavi Funds shall be transferred to the Central Bank called Bank of Uganda.
10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	Gavi Grants shall have an exclusive account in Bank of Uganda.
11. Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES (It is planned that funds shall be disbursed to Local Governments – Districts (DLGs), Regional Referral Hospitals (RRHs), Civil Society Organisations and Services Providers. Funds to both DLGs and RRHs are disbursed upon requisition by UNEPI and approved by MoH PS on a quarterly Basis. Accountability is made to Accounting Officers, and MoH receives copies of accountabilities. Funds for to Service providers only disbursed after service provided. There are no cash transactions. All funds to implementers are electronic using IFMS.)
Procurement	
12. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	All procurement in Uganda shall be done using the Uganda Public Procurement and Disposal Act and Regulations (PPDA). However, upon request by MoH some specialised procurements especially cold chain and vaccines are procured by UNICEF.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Not all. Some will be procured by UNICEF
14. What is the staffing arrangement of the organisation in procurement?	Ministry of Health has the Procurement and Disposal Unit (PDU). It is headed by a Principal Procurement Officer. Under him are Senior and Procurement officers. This is responsible for procurements in the sector. There is an appointed Procurement Committee that approves procedures of procurement. However, under this grant, a request of a Procurement Specialist is made in order to have a full time staff to

	coordinate Gavi procurements. He/she shall report to Head PDU
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES (Any dissatisfied bidder applies to Accounting Officer (PS) for administrative review. PS investigates and give feedback to complainant. In case he/she is not satisfied, application is made to Public Procurement and Disposal of Public Assets Authority. If further dissatisfied, he/she lodges a complaint to PPDA Tribunal. At any stage, a complainant can appeal to Courts of law or complain to IGG for investigation)
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES (Channels for dispute resolutions include; Mutual agreement and consent, Arbitration, and lastly are Courts of Law)
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	Parliament of Uganda is responsible for receiving and considering Financial Report from all Ministries and Agencies of Government. PS is MoH Accounting Officer reporting to Parliament on annual Basis. Within the Ministry, monthly, quarterly and annual financial reporting is made to PS. All financial reports are prepared through Asst. Commissioner of Accounts and submitted to PS. At local governments, all financial reporting is made to the Chief Administrative Officer (CAO) who finally reports to Parliament.
19. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	Ministry of Health has been using and will continue using Integrated Financial Management Information System (IFMIS) for Gavi financial transactions. While this system shall continue to be used, under this grant, we have proposed to purchase NAVISION accounting software to complement IFMIS especially in financial reporting.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Within MoH and Regional referral hospitals, accountability is made to Permanent Secretary. Within Districts, reports are made to Chief Administrative Officer who submits a copy to Ministry of Health.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES (There is an Internal Audit Division headed by Asst. Commissioner of Internal Audit, other staff include Senior Internal Auditors, and Internal Auditors. They sometime co-opt internal auditors from other government departments once on a special audit exercise. However, they are few in

	number. In this HSS, we have proposed to hire an extra internal auditor for Gavi funds who will report to Head of Internal Audit at MoH)
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[28]	YES (Usually Auditor General contracts a private firm)
25. Who is responsible for the implementation of audit recommendations?	Ministry of Health

[28] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.