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Prospective Country Evaluation Uganda

2018 ANNUAL COUNTRY REPORT

Commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund

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Abbreviations

ACT	Artemisinin-based Combination Therapy
ARV	Antiretroviral therapy
CCM	Country Coordinating Mechanism
CEP	Country Evaluation Partner
CHEW	Community health extension workers
DFID	Department for International Development
DHIS	District Health Information Software
DHOs	District Health officers
FCE	Full Country Evaluation
GEP	Global Evaluation Partner
GoU	Government of Uganda
HMIS	Health Management Information System
IDPs	Internally Displaced Persons
IDRC	Infectious Diseases Research Collaboration
IFMs	Integrated Finance Management System
IHME	Institute for Health Metrics and Evaluation
KII	Key informant interview
LLINs	Long lasting insecticide-treated bed nets
MARP	Most at Risk Persons
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
mRDTs	Malaria rapid diagnostic tests
MSM	Men who have sex with men
MTEF	Medium Term Expenditure Framework
NFM	New funding model
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NSP	National Strategic Plan
PAAR	Prioritized Above Allocation Request
PCE	Prospective Country Evaluation
PEPFAR	US President's Emergency Plan for AIDS Relief
RSSH	Resilient and Sustainable Systems for Health
SOMREC	School of Medicine Research and Research and Ethics Committee
STC	Sustainability, Transition and Co Financing
TASO	The AIDS Support Organization
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UGX	Uganda Shillings
UHC	Universal health coverage
UMRSP	Uganda Malaria Reduction Strategic Plan
UNCST	Uganda National Council of Science and Technology
USAID	United States Agency for International Development
USD	United States Dollars

Executive Summary

Introduction

The Prospective Country Evaluation (PCE) is an independent evaluation of the Global Fund commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). The PCE is designed to evaluate how Global Fund policies and processes play out in country in real time and provide high quality, actionable, timely information to national program implementers and Global Fund. This report provides an overview of setting up the PCE platform in Uganda, progress to-date and highlights early findings from the initial evaluation phase covering October 2017 – February 2018, which focused on the funding request and grant-making process for Global Fund's 2017-2019 application cycle.

Establishing the PCE in Uganda

The Infectious Diseases Research Collaboration (IDRC) is the evaluation partner conducting the PCE in Uganda, supported by IHME and PATH as Global Evaluation Partners (GEPs). In this first phase of the evaluation, emphasis was put on stakeholder mapping and engagement. The purpose of stakeholder engagement was to introduce the objectives of the PCE, solicit evaluation priorities, and better understand individual and organizational views of the Global Fund business model (from grant development through to grant implementation) and associated challenges. The evaluation team created a directory of Global Fund country stakeholders, attended various stakeholder meetings, made presentations, and sought buy-in from several stakeholders. After a series of stakeholder consultations and finalization of evaluation questions, the evaluation team developed and submitted the evaluation protocol for ethical review and obtained approval in December 2017. Further still, the evaluation team convened a 10-member high-level advisory board selected based on their independent nature and vast knowledge and expertise to provide supportive oversight, monitoring progress, advocacy, and review of reports prior to dissemination.

Methods

The first six months of the PCE drew upon process evaluation methods utilizing multiple data sources including Key Informant Interviews (KIIs), process tracking, document review, and non-participant observation of various meetings. To allow systematic synthesis and interpretation of findings related to the funding request and grant-making processes, an evaluation framework with key propositions (hypotheses) was developed and specific questions were then designed to address each proposition. The evaluation team extracted relevant information and data from document review and observation notes into the "PCE analysis matrix", an Excel file organized by proposition. The evidence from all process evaluation data sources were later condensed into evidence tables and subsequently developed into emerging findings statements, which were ranked based on the robustness and strength of the available evidence.

The Global Fund Business Model in Practice in Country

The 2017-2019 funding request and grant-making process was perceived as largely transparent and inclusive as well as better coordinated and managed compared to previous application cycles. Over time, the country has amassed significant capacity, experience, and expertise to develop well-aligned, strong funding requests that meet Global Fund requirements with minimum or no support from foreign expatriates. Clear guidance and a stated resource envelope also facilitated the application process especially the funding request, although the grant making process was perceived unclear as stakeholders were not sure who should have participated in this process and what exactly is discussed during this process.

Translation of Global Fund Strategy and Policy in Country

The 2017-2022 strategy focused on addressing resilient and sustainable systems for health (RSSH), key

and vulnerable populations, gender and human rights, and how the sustainability, transition, and co-financing (STC) policy translates at country level. Generally, there was strong participation of key and vulnerable populations, and gender and human rights constituencies in the 2017-2019 funding request development compared to the previous funding cycle**.** Based on Global Fund requirements for co-financing, the country demonstrated the needed commitment to meet the counterpart funding for the three disease programs. However, there was unclear guidance regarding RSSH and catalytic components of the funding request. There is an opportunity to provide explicit guidelines about RSSH and address concerns with implementing these activities.

Limitations

A major limitation of this first phase of the evaluation is that it has been retrospective in nature since the PCE launched after many of the funding request and grant-making processes had already been completed. As such, data collection heavily relied on KIIs, which can be prone to recall, and respondent bias. To ensure robustness, findings were triangulated across multiple data sources (interviews, observations and document review), and within KII data findings were triangulated across stakeholder groups.

Conclusion

The Global Fund's new funding model is progressively streamlining and differentiating grant application and approval processes in-line with the country context. This contributed to timely submission of funding requests with the aim of limiting significant delays into the implementation period. The successes of the 2017-2019 funding cycle were likely achieved through a combination of: (1) changes to grant development process; (2) a strong and supportive Country Team, which helped advise and kept the funding request and grant-making on track; and (3) overall better country preparedness (in terms of gathering the necessary evidence) as well as experience and capacity of in-country stakeholders for Global Fund processes. To further maximize the impact of Global Fund efforts against malaria, HIV and TB, there is need for harmonizing Global Fund policy documents so that they are better aligned with the countries policies and priorities.

CHAPTER 1: Introduction

1.1 Background

The Global Fund Prospective Country Evaluation (PCE) is an independent evaluation of the Global Fund commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). The PCE aims to evaluate the Global Fund's business model, investments, and impact. Through generating evidence in real-time, the PCE will inform global, regional, and country stakeholders and accelerate progress towards meeting the Global Fund's Strategic Objectives. These objectives are to:

1. Maximize impact against HIV, TB and malaria
2. Build Resilient and Sustainable Systems for Health
3. Promote and Protect Human Rights and Gender Equality
4. Mobilize Increased Resources

The TERG selected eight countries for the PCE: Cambodia, Democratic Republic of the Congo, Guatemala, Mozambique, Myanmar, Senegal, Sudan, and Uganda. As one of three Global Evaluation Partners (GEPs), the PATH-IHME consortium is working in Uganda with the Infectious Diseases Research Collaboration (IDRC) as the Country Evaluation Partner (CEP). The PCE consortia were competitively selected based on the quality of their proposal, including technical approach, expertise and qualification, and country expertise as well as cost proposal. The proposals included suggested CEPs. IDRC was part of the technical proposal development together with IHME and PATH, offering rich contextual knowledge given the vast experience in Malaria and HIV/TB research in Uganda and most importantly the experience with the Gavi Full Country Evaluation, which employed similar methods for evaluating complex systems, processes, and impact.

This report describes the PCE design, progress made to-date, early findings for the PCE in Uganda, preliminary recommendations based on the findings, and plans for 2018. As detailed later in the report, the first phase of the evaluation focused on the funding request and grant-making process for the 2017-2019 Global Fund application cycle.

1.2 Establishing the PCE at country-level

The project commenced in May 2017 with a five-month inception phase. During this phase, the PCE team together with global partners carried out a number of activities to establish the PCE in Uganda. Activities included stakeholder mapping and individual stakeholder consultations, gaining an understanding of the information landscape (both epidemiological and financial), planning and completion of a stakeholder evaluation workshop, developing the theory of change to guide the evaluation, and drafting of country-specific evaluation questions.

During the first six months of the evaluation phase, the PCE continued with country stakeholder mapping and engagement, as well as developed and submitted protocols for ethical review, which were approved in December 2017. Further, the team established an advisory board, began acquiring secondary data for resource tracking analysis, conducted a GEP-CEP analysis workshop, and collected data on the funding request and grant-making processes.

Stakeholder engagement

The country-level stakeholder mapping and engagement were early priorities for establishing the PCE platform. The purpose of stakeholder engagement was to introduce the objectives of the PCE, solicit evaluation priorities, and better understand individual and organizational views of the Global Fund business model (from grant development through grant implementation) and their associated

challenges. This involved creating a directory of Global Fund country stakeholders, attending various meetings as non-participant observers and making presentations to several stakeholders. A total of fourteen meetings were attended during the first phase of the evaluation. The meetings were used as an opportunity to seek stakeholder buy-in and trust, collect data through non-participant meeting observation, and seek access to secondary data and relevant documents. The evaluation team also made presentations on PCE progress.

Process of exploring and agreeing on the key evaluation questions for the country

After a series of stakeholder consultations and meetings during the inception phase, preliminary evaluation questions were developed. An iterative process followed between the Global Evaluation Partners and the Country Evaluation Partner to refine the questions and map them back to the Global Fund's strategic objectives. Preliminary questions were grouped into broad themes, each with numerous sub-questions embedded. The team also examined where the questions fit into the Theory of Change, to ensure the proposed questions were relevant to the Global Fund business model, and determined where the questions aligned with four key thematic areas of interest: partnerships, value for money, country ownership, and sustainability. During the first six months of the evaluation phase, the PCE focused on five evaluation questions related to the funding request and grant application/grant-making process, three of which are rated high priority.

Protocol development and Institutional Review Board approval

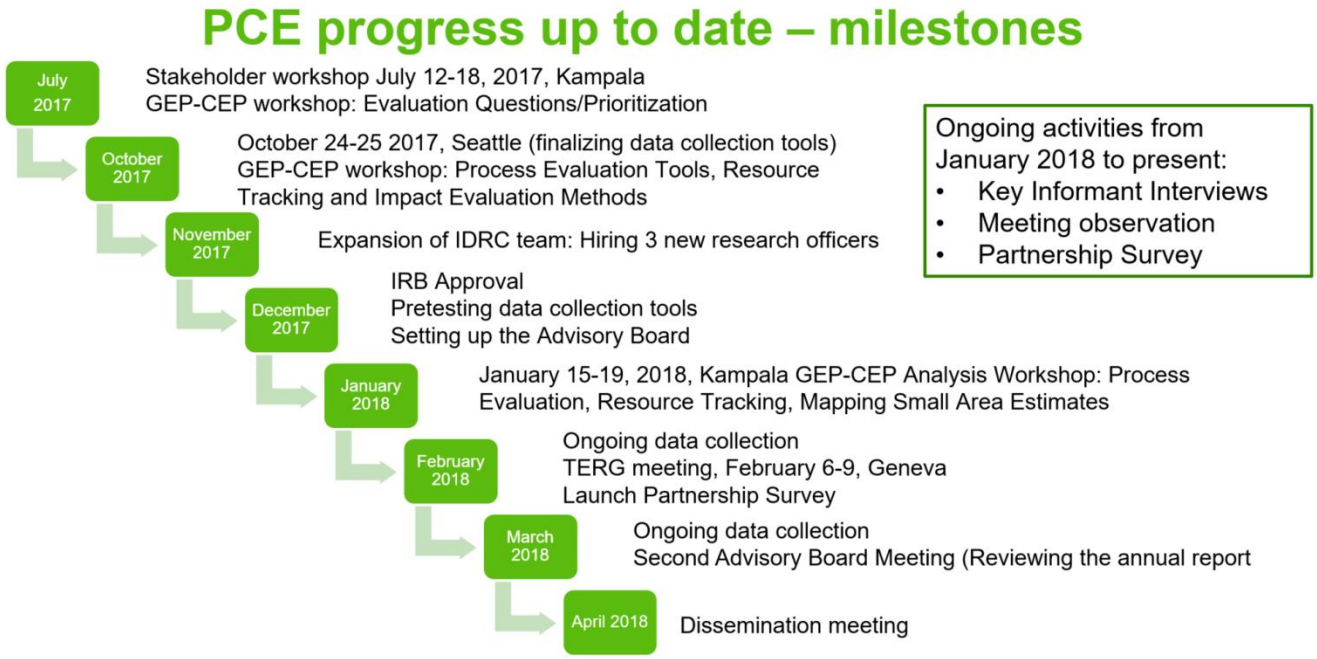
After a series of stakeholder consultations and finalization of evaluation questions, the evaluation team developed and submitted the evaluation protocol for ethical review to two Institutional Review Boards, namely School of Medicine Research and Research and Ethics Committee (SOMREC) and the Uganda National Council of Science and Technology (UNCST). Approvals for the protocol were obtained from both in mid-December 2017.

Formation of the Advisory Board

Given the similarities between the Global Fund PCE and Gavi Full Country Evaluation (FCE) evaluation approaches, IDRC formed a joint Advisory Board between the two projects with the aim of providing supportive oversight, monitoring progress, advocacy, and reviewing reports prior to dissemination. A team of 10 high-level country partners and opinion leaders were selected based on their independent nature and vast knowledge and expertise in the areas of HIV/AIDS, malaria, TB, immunization, health systems, quantitative and qualitative research, evaluation, and policy. The first advisory board meeting was held on 13 December 2017 in Kampala, Uganda. The objectives of the meeting were to orient members to the PCE and FCE evaluations, receive input from the members on the evaluations, discuss a way forward, and review and discuss expected Terms of Reference. The Terms of Reference for the advisory board were revised and have been shared with the board. In summary, the roles of the advisory board are aimed at facilitating implementation of the evaluation, ensuring that the activities of the evaluations have the potential to contribute to informing and strengthening all programs, and advocating for the use of findings and implementation of recommendations.

1.3 Progress to date

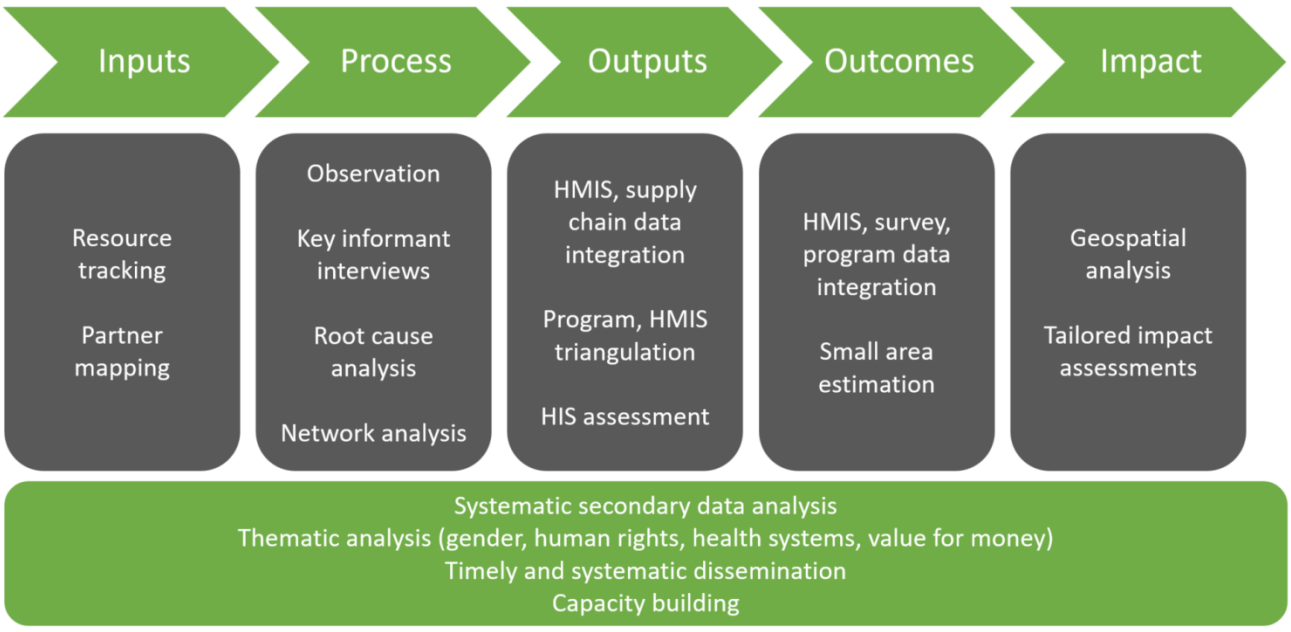
Figure 1: PCE progress to date



CHAPTER 2: Evaluation framework and methods

The PCE is utilizing an evaluation framework to prospectively track and measure the four Global Fund strategic objectives for 2017-2022. The framework provides a conceptual model describing the processes and causal mechanisms that lead from investments and inputs to outputs and coverage, outcomes and eventually impact on the three diseases (Figure 2).

Figure 2: Key evaluation components across the full results chain



As depicted in Figure 2, the PCE employs a mixed methods approach using multiple data sources including key informant interviews (KIIs), process tracking (process maps, document review, and non-

participant observation), root cause analysis, network analysis, resource tracking, and visualization and analysis of routinely collected health management information systems (HMIS) data and other existing sources. The study population for impact assessment includes the general population of Uganda at risk of, or affected by AIDS, TB or malaria. Data used to inform quantitative analyses include HMIS, household surveys, national program data, and data tracking budgets and expenditures from Global Fund, Government of Uganda (GoU), and other development partners. The PCE is designed to use distinct yet complementary data sources in combination with one another wherever possible.

Methods and Analytic Approach – Funding Request and Grant Making

For this phase of the evaluation, the PCE focused on key evaluation questions around the funding request and grant-making processes shown in Table 1 below. The approach to answering these questions has been through utilizing key informant interviews (KIIs) to explore issues in-depth and to fill in any information gaps emerging from the meeting observation and document review. This approach will be supported by complementary quantitative analyses where possible, such as using resource tracking methods to assess budget allocation.

Table 1: Uganda's priority evaluation questions for the funding request and grant-making process

	EVALUATION QUESTIONS	SUB-THEMES	ToC Areas	Theme	Global	UGA
Funding Request, Grant Application & Making	1. What is the nature and role of partnerships between Global Fund and in-country stakeholders participating in the grant application and making processes?	•Partnership structure and strength of ties	Strategic enabling environment			X
	2. How does the decision-making process determine Global Fund investment priorities, program split, and resource allocation?	•Drivers of priority setting •Reprioritization / reprogramming •Changes in priorities •Documenting priorities •Alignment between GF and country priorities •Achieving compromise •Financial gap analysis •Stakeholder / community engagement in decision process	Grant application & making			X
	3. To what extent are expected implementation bottlenecks anticipated and planned for in the grant application and making phase?	•Procurement challenges •Contractual delays	Grant application & making			X
	4. What barriers and facilitators have been experienced in negotiating co-financing commitments, as compared to previously?	•Use and application of STC policy for co-financing •Level of co-financing commitments versus actuals •How effective is the STC policy in stimulating co-financing? •Domestic resource mobilization for ATM	Inputs (policies); Grant application & making; Institutions			X
	5. How effectively are key and vulnerable populations considered, defined, and addressed in the grant application and making process (across program areas)?	•Definition of key and vulnerable populations, and strategies for reaching •How much money is devoted to key and vulnerable populations •Level of involvement of key and vulnerable constituencies in application	Inputs (policies); Grant application & making			X

Questions considered across countries to address a strategic objective – proposed by IHME/PATH or drawn from the Global Fund Request for Proposal

Prioritization of Evaluation Questions: **High** **Med** **Low**

Thematic Area Symbols Key:

Partnership | Country ownership | Sustainability, co-financing, transition | Value for money

To allow systematic, efficient synthesis and interpretation of findings related to the funding request and grant-making processes, an evaluation framework with key propositions (hypotheses) was developed and country specific questions were then designed to address each proposition. These also helped to

determine which data to collect, by what method, and the approach to analysis. The propositions include:

1. Changes in the grant application and review process enabled a more efficient and streamlined process, reduced transaction costs, and allowed more time to be spent on grant implementation and program quality compared to previous application processes.
2. A transparent, inclusive and country-led process was in place during grant development to confirm the country allocation, program split, funding request approach and Principal Recipient (PR) selection. Country dialogue was ongoing, including through grant-making.
3. There is a stronger focus on sustainability, transition and co-financing (STC) compared to previous funding cycles and application processes.
4. There is a stronger focus on key and vulnerable populations, human rights and gender compared to previous funding cycles and application processes.

The evaluation sub-questions per proposition are indicated in the evaluation framework in Annex III.

Data from document review, observations, and KIIs formed the basis for the process evaluation of the funding request and grant making processes. As of March 2018, the team conducted 19 KIIs, reviewed 42 documents, and observed 17 meetings, as indicated in Table 2. Given the prospective nature of the PCE, data collection is still ongoing.

For KIIs, respondents were purposively sampled based on their expertise/experience, unique familiarity with a critical component of the Global Fund funding request or implementation process, as well through referral. They included AIDS, TB, malaria and health systems stakeholders at the national levels, such as individuals responsible for, or working within Global Fund policies, funding requests, and/or grant implementation.

Table 2: Process evaluation data sources

Data Source	No.	Description
Meeting Observations	17	Principle Recipients, Ministry of Health Malaria, TB, and HIV teams, Civil Society Organizations, CCM grant negotiation, Finance and Procurement Joint Oversight and Committee, Partner Coordination for Malaria Stakeholders, Resource Mobilization Committee, CT with Stakeholders, Launch of Global Fund Grants, CCM end-of-year retreat, CT Guidance on Transitioning to New Grants, CT guidance on Catalytic funding grant, CCM program oversight committee meeting, CCM Finance and Procurement Committee.
Document Review	42	Funding requests and related files, national disease strategies, newspaper articles, CCM (performance framework and improvement plan, eligibility and performance assessment), TRP reviews, Allocation letter and associated memos, OIG audit reports, Global Fund iLearn modules, and more.
KIIs	19	Stakeholders from the Ministry of Health, Ministry of Finance, CCM, technical and development partners, non-governmental organizations, Civil Society Organization s, and the funding request writing team.

Analytic Approach

The PCE uses the framework method, the recommended analytic technique for applied policy research, to organize document review, observation, and KII data by key thematic areas and stakeholder group.

The framework method is a form of thematic analysis of qualitative data useful for organizing and summarizing data within a structure that allows for analytic comparisons across groups, by thematic area.(1,2) During November-December 2017, the evaluation team extracted relevant information and data from document review and observation notes into the "PCE analysis matrix," an Excel file organized by proposition and sub-question (rows) and stakeholder groups (columns), with tabs for data organization by funding request type: malaria and TB/HIV. This initial approach helped identify data gaps and additional areas to probe during KIIs.

A joint GEP-CEP analysis workshop was held in Kampala in mid-January 2018 to review the emerging findings and assess data robustness and strength of evidence to support each finding. During this workshop, detailed evidence tables were created, pulling in data from the document review, observations, and KIIs conducted by that point in time. This process has continued as more information has come in. The evidence tables include succinct summaries of participant responses for each stakeholder group plus document or observation data where applicable. These tables were used to assess patterns of convergence and divergence in the data, and ultimately to determine emerging finding statements. Robustness was rated according to three criteria: triangulation, fact vs. perception, and quality of the data.

> **Triangulation:** refers to the breadth of qualitative and quantitative data sources (e.g., surveys, documents, KIIs, etc.) Greater triangulation across multiple sources equates to more robust findings.
>
> **Fact versus perception:** Complements triangulation in that fact-based information generally requires less triangulation to be considered robust. It is noted that many evaluation questions are largely perception-based, however, these can still be considered robust findings if supported by well-triangulated data across stakeholders. Fact-based information can be drawn from document review, observations, and fact-checking interviews.
>
> **Quality of the data**: High-quality data contribute to greater robustness. Several indicators of quality in qualitative data were used, including recentness (for example timing of KII relative to the topics discussed to minimize recall bias); conditions of an interview or group discussion (includes rapport with the respondent, appropriate pacing, interruptions, appropriate level of privacy for interview, balanced as opposed to one-sided group discussions); and degree of proximity to topic or event in question (first hand observation by the evaluation team or a respondent's first-hand experience participating in the funding request or grant making process vs. second-hand information).

The evidence tables include a few notes qualitatively assessing each robustness dimension for the evidence related to each sub-question. Considering the robustness dimensions, a strength of evidence rating was assigned using a four-point scale as a general guide for ranking findings and describing the rationale behind the ranking (Table 3). The ranking process helped identify which findings needed additional triangulation and validation, particularly if rated as a "3" or lower. The evaluation team underwent a validation process, which included adding additional data to the evidence tables and reassessing the overall finding statement, robustness and strength of evidence.

Table 3: Strength of evidence 4-point scale

Rank	Rationale
1	The finding is supported by multiple data sources (good triangulation) which are generally of decent quality. Where fewer data sources exist, the supporting evidence is more factual than subjective.
2	The finding is supported by multiple data sources (good triangulation) of lesser quality, or the finding is supported by fewer data sources (limited triangulation) of decent quality but perhaps more perception-based than factual.
3	The finding is supported by few data sources (limited triangulation) and is perception based, or generally based on data that are viewed as being of lesser quality.
4	The finding is supported by very limited evidence (single source) or by incomplete or unreliable evidence. In the context of this prospective evaluation, findings with this ranking may be preliminary or emerging, with active and ongoing data collection to follow-up.

CHAPTER 3: The Global Fund business model in practice in country

The Global Fund Strategy 2017-2022 is committed to increasing flexibility of the business model, which entails improving country experiences of accessing funds through simplifying and differentiating ways of applying for and approving grants.(3) For the 2017–2019 funding cycle, the Global Fund introduced changes to the funding request, review, grant-making and approval process with the intention of simplifying and improving the efficiency and experience of accessing funding and enabling greater time to spent implementing the grants.(4) Additionally, the Secretariat also enhanced templates with the aim to simplify and reduce the number of documents required for the funding request and grant-making process.

During the 2017-2019 application cycle, Uganda submitted two funding requests during Window 1, both undergoing full review (as it was not eligible for program continuation review or tailored review). Full review is the application process most like the New Funding Model (NFM) introduced in 2014. While Uganda's overall allocation amount increased in the 2017-2019 cycle, there were differences by disease area (Table 4), with increases in the malaria allocation but decreases in the TB allocation. In November 2017, grants totaling $465 million were signed in the following amounts: TB grant US$22,406,578; HIV/AIDS grant US$255,956,719; and Malaria grant US$186,693,747. This represents a US$44.1 million (10.5%) increase over the previous allocation of US$421 million (for 2014-2016 application cycle).

Table 4. Comparison of allocation amounts 2014-16 vs. 2017-19 application cycle (USD) (5,6)

Application Cycle	HIV/AIDS	Tuberculosis	Malaria	HSS	Total
2014–2016	245,349,423	23,228,582	142,059,768	10,352,743	420,990,516
2017–2019	255,632,244	21,101,922	188,322,878	Not specified*	465,057,044
Percent Change	4.2%	-9.2%	32.6%		10.5%

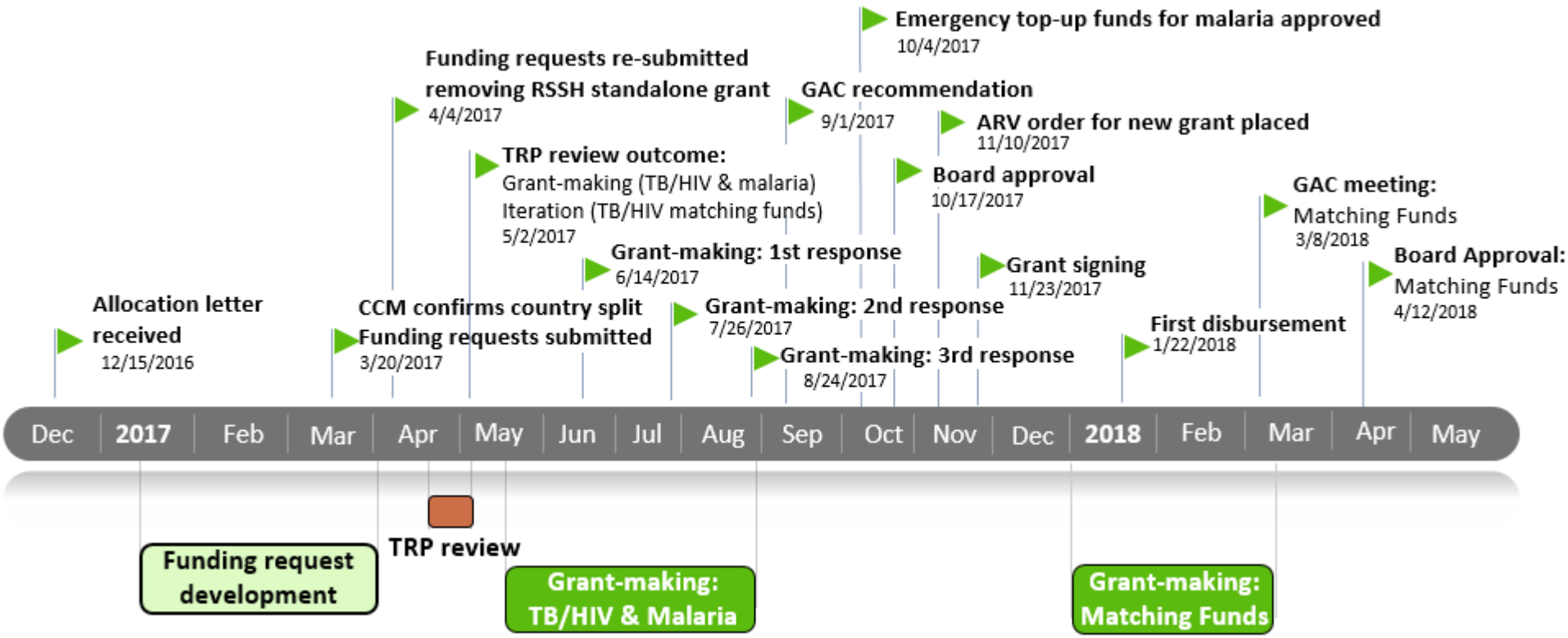
*Unlike in the 2014 allocation letter, there was no specified amount allocated for HSS in the 2016 allocation letter

PRs from both the public and non-public sectors implement the Global Fund grants in Uganda, including the Ministry of Finance, Planning and Economic Development (MoFPED) (executing entity) with the

Ministry of Health (MOH) (implementing entity), and The AIDS Support Organization (TASO), a local Non-Governmental Organization (NGO).

The funding request and grant-making was characterized by country-level processes including country dialogue, priority setting, grant writing, CCM board review, submission to TRP, grant-making and grant-signing. The application cycle took 11 months from mid-December 2016, when the allocation letter was received, to the grant signing in mid-November 2017 (Figure 3). Two months later, in mid-January 2018, the first funds were disbursed.

Figure 3: Timeline for Uganda's funding request and grant-making phase for the 2017-2019 application cycle.



Findings on the funding request and grant-making process in Uganda

Finding 1. Compared to previous Global Fund applications, the 2017-2019 funding request development process in Uganda was better guided, managed and coordinated.

Robustness: (*Ranking = 1) .The finding is supported by multiple data sources, including a mix of factual evidence from documents (timeline data; TRP reviews) and perception-based evidence from key informants. Due to the closeness of key informants to the funding request development process and broad agreement from majority of the key informants, the quality of interview data is considered high.*

The majority of in-country stakeholders perceived the recently concluded application as having been well streamlined and better coordinated than previous cycles. Several stakeholders including the PRs, disease program managers and the CCM were instrumental in steering the 2017-2019 application process. The CCM played a significant role in managing, designing, and developing the country funding applications, including convening all stakeholders, especially for the country dialogue, coordinating the writing process and teams, engaging the Country Team, and overseeing the review process of the application.

> *"…also the participants appreciated CCM's effort in terms of engagement, facilitation and coordination." (KII, Key populations)*

> *"In terms of involvement, this time it was superb, and for this I give 100% marks to CCM." (KII, Civil society)*

Key informants also noted that there was increased involvement and guidance from the Country Team from the beginning of the application cycle. Their guidance was perceived positively because they gave insights into Technical Review Panel (TRP) expectations, which then improved the overall funding request. As illustrated by the following quote, the CT helped ensure alignment of the funding request with Global Fund objectives, utilization of language that is appropriate and consistent with Global Fund terminology, and overall support to present a strong application:

> *"The Country Teams were very helpful especially in prioritization and grant writing because they were aware of what would sell to Global Fund and what would not… it was critical to get Global Funds insights..." (KII, Government)*

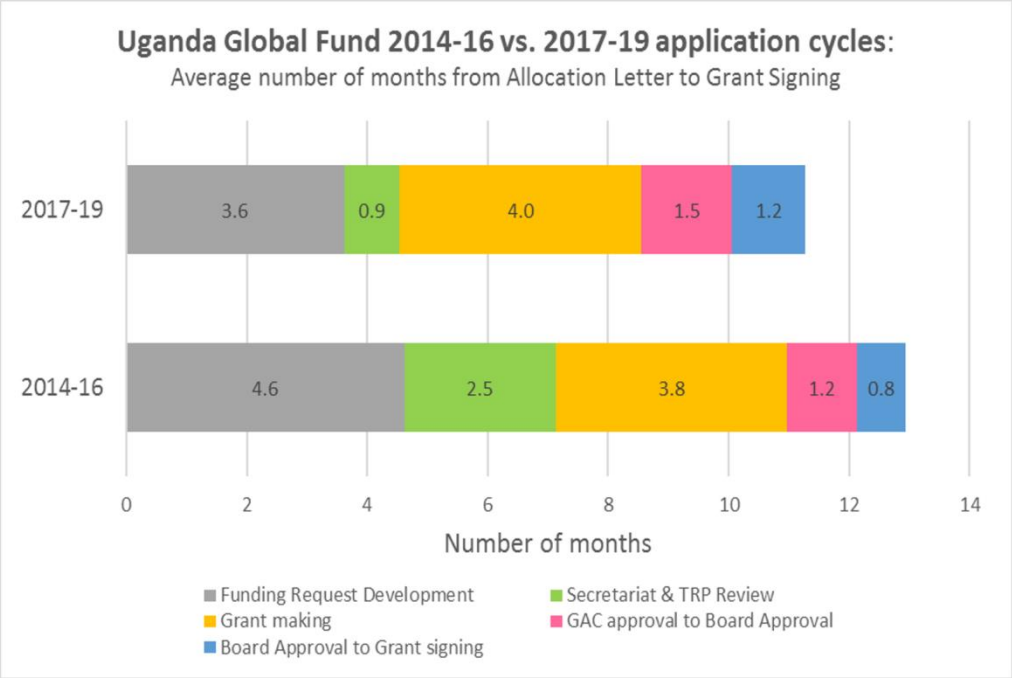
Most stakeholders noted that there were no significant changes in terms of application requirements for the 2014-2016 and the 2017-2019 funding requests, which was in line with expectations given that Uganda submitted applications for full review. Most of the participants had vast knowledge of the Global Fund processes, particularly the funding request development which they have accumulated over a long period of involvement in Global Fund applications. The process was further aided with guidance and clear guidelines for the application by the Global Fund. Consequently, the country engaged mostly local consultants instead of international expatriate consultants as have been engaged in prior Global Fund application cycles. In addition, the funding request benefited from strong involvement of Principal Recipients and program implementers who had previous experience in Global Fund applications.

The funding request was improved by an allocation letter, which stated the resource envelope and program split ahead of time. Compared to the rounds-based funding model, stakeholders noted that knowing this information ahead of time facilitated and guided planning by stakeholders and later prioritization of activities.

As a result of these factors, a high-quality application was written and the outcome was a successful TRP review requiring minimal iteration by country stakeholders. Fewer iterations also meant the application

process also took less time compared to the previous cycles. Figure 4 below compares Uganda's Global Fund 2014-16 vs 2017-2019 application cycles by illustrating the number of months taken from the receipt of the allocation letter to grant signing. The process took approximately 13 months during the 2014-2016 application cycle and 11 months during the 2017-2019 application cycle. Much of the time efficiency was notable during the funding request development stage (reducing from 4.6 to 3.6 months). However, stakeholders also noted that the funding request development period would have even been less (~3 months total) if it were not for the requested change in program split, following the initial funding request submission for Window 1 in mid-March 2017. This caused a 2-week delay in submission due to the reintegration of RSSH activities into the disease-specific funding requests – see more details in Chapter 4.

Figure 4: Comparison of Global Fund 2014-16 and 2017-19 application cycles in Uganda.



However, it is important to note that despite the funding request development process being better guided, managed and coordinated, there is less evidence about improvements to the grant-making process. Key informants noted that the grant-making process at country level is still unclear. The grant-making step is a key process in translating the funding request (once approved) into a grant agreement. Global Fund estimates grant-making should be completed over a period of five to eight months. The purpose of this phase is to identify capacity gaps and risks related to grant implementation and determine risk mitigation measures, review and agree on implementation arrangements and plans, and develop and negotiate key grant documents.(7) The perception from key informants in Uganda is that the grant making process is still hazy due to unclear stakeholder roles.

> *"There is confusion as to who is supposed to lead grant making... Is it meant to be a consultative process? Is it meant to be led by the Country Team or the PRs? This all needs to be clarified..."* (*KII, CCM)*

Finding 2. Uganda's 2017-2019 funding request development process was highly inclusive in terms of stakeholder representation and participation compared to previous cycles.

Robustness: *(Ranking = 1) Strong triangulation across high quality data sources. This was supported across multiple data sources including a mix of factual evidence from documents (funding requests), observation meetings and perception-based evidence from key informants. There was broad agreement*

from key informants close to the process, that stakeholder representation and participation was high this time around.

Country Dialogue and priority setting in Uganda were characterized by participation from various stakeholders as represented on the CCM and beyond. Participation included civil society representing people living with HIV, TB and malaria, local NGOs, international NGOs, Faith Based Organizations, Private Sector, Academia, Key Affected Populations, Government (MoFPED, MOH, Ministry of Local Government, Uganda AIDS Commission), and multilateral and bilateral agencies.

> *"There was improvement in 2014 [in terms of inclusivity], but this time the situation was much better, they invited many of us, first meeting we were around 200 or more, numbers reduced as time went by…I don't think there will be anyone who will complain that they were not involved. Those who didn't participate didn't want to." (KII, civil society)*

As a result, the majority of stakeholders, especially the key populations' representatives, noted that most of their priorities were included in the grant. For example, the HIV/TB application submitted by the Principal Recipient TASO included a number of activities directed toward reducing stigma and discrimination, as well as strengthening of an MSM-led clinic, monthly outreach to MSM, commercial sex workers, and others.

> *"…and if you look at the submitted application, all issues of KPs, at least 90% are included." (KII, Key populations)*

This was an improvement compared to the previous applications, which were described by a key informant as "*a kind of high table approach"* where the MOH officials would sit with technical people and discuss what to write in the application.

In addition, there was also stronger engagement from development partners compared to previous application cycles, especially PEPFAR, CDC, USAID, and DFID. Development partners are represented on the CCM with one individual representing US government, one for bilateral partners, and one for multilateral partners. Additionally, at the country dialogue, there was strong presence and involvement of partners and during the budgeting process, partners presented on their funding and resources for coming years. Key informants noted that this was an improvement from the previous cycles and this increased harmonization of activities, which led to better work planning and less duplication.

However, despite the benefits of a high level of inclusivity of stakeholders, it was not without drawbacks. For example, the high level of representation and participation from over 80 country stakeholders in the funding request development has been perceived by some stakeholders to translate into high transaction costs in terms of time lost for program implementation of the current grants and costs for meetings over the application cycle period.

> *"And also, the consultation process is very long and apart from the physical costs, the 'mental costs' are very high, though I think the money got at the end was good. There is a need to do the costing of the process I think." (Key Informant, MOH)*

With large numbers of stakeholders, consensus of country priorities is difficult given the various stakeholder interests and priorities and this prolongs the process.

Consistency of participation throughout the application cycle remains challenging, as highlighted by the various stakeholders due to the length of the application process (which is more than 10 months). Key stakeholders, especially program personnel, found it challenging to attend the whole application cycle due to competing roles and responsibilities to fulfill outside of the Global Fund application cycle.

Inconsistent participation by program personnel during the application cycle may indirectly affect the grant-making process where budgets and key issues are resolved and negotiated.

Lastly, there were concerns about involvement of district officials in the funding request development process. At the stakeholder dissemination workshop, it was noted that though the Ministry of Local Government was involved, there is need to also involve district officials, e.g. the District Health officers (DHOs) as they are responsible for implementation of the grants at the district level.

CHAPTER 4: Translation of the Global Fund strategy in country

This chapter examines how the Global Fund Strategy 2017-2022 and related policies are playing out in Uganda. Preliminary findings are reported, however in-depth and robust findings will be reported in due course as the grants are operationalized through implementation in 2018 and 2019. This chapter focuses on Resilient and Sustainable Systems for Health (RSSH), gender and human rights, key and vulnerable populations, co-financing and resource mobilization, and examines how these have been considered in the funding request and grant-making process.

4.1 Resilient and Sustainable Systems for Health (RSSH)

In the 2017-2019 grant application cycle, the Global Fund emphasized the need for strong health systems as a strategy aimed at strengthening communities' health through improved health care access and effective and efficient health care service delivery for HIV, TB, and malaria in Uganda. To achieve this, the Global Fund suggested a program split wherein countries could integrate RSSH programming within disease-specific grants, or gave countries the option to submit a revised program split.(6)In the 2016 allocation letter, the Global Fund encouraged "integrated programming across diseases and investments in resilient and sustainable systems for health", but further indicated that "As part of the principle of country ownership, it is up to the CCM to assess the best use of funds across eligible disease components".

Finding 3. Unclear guidelines from Global Fund regarding the RSSH application affected in-country decisions on whether to apply for RSSH as stand-alone funding or integrated into the main disease-specific grants.

Robustness: *(Ranking = 2) The finding is supported by mostly perception-based evidence. The evidence is considered to be of high quality and robust given ample triangulation across a broad selection of stakeholder groups with largely convergent opinions, plus the proximity of the key informants to the funding request development process.*

Based on the Global Fund Board's decision in November 2016, Uganda was allocated US$465,057,044 for HIV, TB, Malaria, and RSSH. The Global Fund gave the country the option to submit a proposed revised program split for review. Unlike the 2014 allocation letter, , there was no separate allocation specified for RSSH in the 2016 allocation letter, as countries were expected to apportion money from disease allocations for RSSH elements to be supported. Messages in the allocation letter conflicted with instructions in Annex A that accompanied the allocation letter: "Cross-cutting RSSH investments can be included in any funding request or submitted as a stand-alone funding request. A joint application including two or more disease components and RSSH investments is strongly encouraged…The funding designated to cross-cutting RSSH interventions does not need to be documented in the program split unless a stand-alone RSSH funding request is planned." The majority of in-country stakeholders considered Global Fund's guidance on submitting a stand-alone RSSH unclear, as illustrated by this respondent:

> *"The biggest problem we had, was that Global Fund didn't guide us exactly on what to do and how to apply for the RSSH. They didn't put a specific amount of money for RSSH but rather kept on saying that RSSH activities should be integrated in the disease grants yet at the same that saying that more attention should be given to RSSH. The whole thing was confusing." (KII, technical partner)*

Despite the ambiguity around the guidelines, Uganda, through the CCM, decided to submit a stand-alone RSSH application totaling to US$21,266,115 on 20 March 2017. In a letter dated 23 March 2017, the Global Fund rejected the proposed program split and requested the country revise the application to enable progression to TRP review. The Global Fund outlined their reasons for rejecting the RSSH stand-alone grant: inefficient allocation of funds, elevated administrative costs, additional human and travel resources associated with bringing on a third Principal Recipient, and unnecessarily high communication costs. Uganda was therefore requested by the Global Fund to reallocate the RSSH funds across the disease-specific grants by 31 March 2017. As a result, there was nearly two weeks' time lost as writing teams reconvened to integrate RSSH activities into the disease-specific grants.

Finding 4. Some in-country stakeholders – especially the program implementers – felt that there was limited stakeholder consultation, involvement and consensus around the decision to submit a stand-alone RSSH and this caused confusion and mixed reactions.

Robustness*: (Ranking = 2) The finding is supported by mostly perception-based evidence from key informants and facts from the proposed RSSH funding request. The evidence is of high quality because triangulation was across several interviews with key stakeholders (representing multiple stakeholder groups) with proximity to the funding request development process.*

Evidence from some key informants shows that there was no consensus among in-country stakeholders around the decision to submit a stand-alone RSSH funding request. Most of the Ministry of Health program personnel felt that their views were not accommodated. Program personnel were uncomfortable with the suggested cuts from their disease-specific budgets (as suggested in the allocation letter) to fund RSSH. (Note: The annex to the allocation letter stated in the previous grants that 6.4% of Global Fund funding in Uganda was allocated to RSSH and suggested 10% of the total allocation in the 2017-2019 cycle go toward RSSH). The proposed RSSH stand-alone funding request indicated that US$20 million was pulled from the malaria funding request and US$ 1,266,115 from the TB funding request, while nothing was pulled from the HIV funding request.

In part, negative attitudes towards RSSH stemmed from challenges faced while implementing the 2014-16 RSSH grant, and issues of absorption therein. Key informants corroborated spending data to show that RSSH programs during that period were characterized by low rates of absorption and sub-optimal coordination among the different disease programs. They further reported that the performance-based system of the Global Fund business model intensified cautious attitudes toward RSSH by affecting the country's prioritization as they aimed to include activities that are "easier to implement" by the country (i.e. have higher absorption). Most program implementers urged that, during implementation, it is easier to reprogram funds within disease specific grants than across different grants. Due to that, and in anticipation of possibly needing to reallocate resources to high-absorption activities in the midst of implementation, many stakeholders concluded that it was preferable to have RSSH activities embedded within disease-specific grants. For these reasons, some informants questioned the country's decision to propose a stand-alone RSSH funding request in the current window.

> *"There were many reasons why we preferred to have RSSH within our disease-specific grants because the past experience showed that it was not easy to implement RSSH and that is why we failed to absorb those funds on time. Also important to note is that conditions of implementing the*

grants allow us to switch money around within the grants unlike between grants." (KII, government)

Informants also noted a general perception that rejection of the stand-alone RSSH funding request was due to risk aversion (by both the country and Global Fund secretariat) to spend on "software" components of the health system such as building capacities at sub-national and health facility levels, supporting human resources to provide oversight in different departments, and enhancing quarterly support supervision and mentorship, among other activities considered "higher risk" due to perceived absorption challenges. Document evidence indicates the Global Fund also seemed concerned about investing in high-risk activities under the RSSH stand-alone grant. In their response letter, the Global Fund stressed the need to have key health commodities of the three diseases fully funded in order to maximize impact, and further recommended that any funds that remain after allocation to health commodities should be kept within the disease-specific grants. This could in part explain why the upcoming grant is highly commoditized (at least 80%[1]).

On the other hand, the CCM and a few in-country stakeholders advocated for a stand-alone RSSH grant with the rationale that the highly commoditized grants would need to have strong health systems in place to maximize impact. Informants perceived health system requirements (like health workers, diagnostic laboratories, and transportation systems, among other things) as cutting across all three diseases, therefore having a separate stand-alone grant would reduce overlap and duplication and would minimize costs.

In view of the requested changes and revisions, the CCM concluded that it was no longer viable to submit a revised standalone RSSH grant. On 4 April 2017, the country submitted the final revised country program split totaling to USD $465,057,044, reintegrating activities in the previous stand-alone RSSH (Table 5).

Table 5. Summary of re-allocation of funds previously allocated to the stand-alone RSSH

Activities Reallocated	**Grant**	**Amount (USD)**
Integrated some RSSH interventions and activities, including procurement/supply chain and human resources in the Malaria grant	UGA-M-MoFPED	393,282
Cross cutting RSSH activities within allocation	UGA-M-MoFPED	382,555
Integrated some RSSH interventions and activities in the HIV funding request, including healthcare service support and training	UGA-H-MoFPED	324,475
Re-allocated some funds back to the TB funding request to cover GeneExpert equipment, accessories and TB-specific community activities for finding TB cases	UGA-T-MoFPED	1,266,115
Integrated some RSSH interventions and activities into the TB funding request for specifically strengthening Community Responses and Systems for HIV and TB national responses	UGA-T-MoFPED	1,257,656
RSSH Activities proposed in Prioritized Above Allocation Request (PAAR) in the malaria grant	UGA-M-MoFPED UGA-C-TASO	12,460,851

[1] The exact percentage is dependent on the inclusion of certain supply management costs as *commodities*

Removed some RSSH interventions and activities from the funding requests and asked GoU to fund them		4,590,863
Removed some RSSH interventions and activities from the funding requests and asked Development Partners to fund them.		449,533
Estimated PR costs		140,785
Total RSSH Reallocation		**21,266,115**

In addition, majority of activities (80.2%) in the stand-alone RSSH funding request could not fit into the main disease-specific funding requests and were either targeted under GoU support ($4,590,863; 21.6%) or placed in the prioritized above allocation request (PAAR) ($12,460,851; 59.6%), which does not necessarily assure funding unless cost savings/efficiencies are identified. There are early examples of RSSH components moving from the PAAR to getting funded, such as printing HMIS tools and forms which was integrated in the malaria grant during the grant making process through US$1.4m identified in savings.

The Global Fund's rejection of the proposed stand-alone RSSH funding request resulted in a heated debate as the CCM wondered why countries were given the option to submit a revised program split other than the indicative program split suggested by the Global Fund allocation letter. Additionally, most respondents perceived Global Fund's immediate rejection of the stand-alone RSSH funding request as "unfair" since they expected Global Fund to first review and then give the CCM an opportunity to justify the activities and budgets in the stand-alone RSSH before making a final decision. Some key informants have suggested RSSH could more easily be prioritized if it were given a specific amount in the allocation letter, as this would help ensure it is maintained on the agenda, and would limit pushback among disease-specific program managers concerned that a RSSH stand-alone funding request was reducing the funds allocated to their disease programs.

Overall, the performance framework upon which the grants are monitored and evaluated highly influences the prioritization process, and is a likely factor – in addition to the fact that the country has large funding shortages for commodities – to shift towards commoditization of Global Fund grants in Uganda, thus ignoring the cross-cutting health systems activities that are not linked to direct health outcomes.

4.2 Key and Vulnerable Populations, Human Rights and Gender

In the NFM, the Global Fund emphasized meaningful engagement of key and vulnerable populations and representatives for human rights and gender, with the aim of improving and promoting response towards epidemics holistically. To that effect, the 2017-2019 Global Fund grant application process focused on a stronger involvement of organizations and individuals representing key and vulnerable populations, human rights, and gender. The funding request and grant-making process evaluation considered whether these priorities had a stronger focus compared to previous funding cycles through exploring the involvement of human rights and gender experts in grant development processes, the extent to which key and vulnerable populations are defined and addressed in funding requests, and whether investments are adequate in proposed grants.

Finding 5. There was strong participation of key and vulnerable populations, and gender and human rights constituencies in the 2017-2019 funding request development compared to the previous funding cycle.

Robustness: *(Ranking = 1) The finding is supported by data from key informants and documented evidence. There was a mix of factual evidence and perception-based evidence that indicated broad convergence of opinion across a wide variety of stakeholder groups and was deemed high-quality given some key informants' proximity to the topic, which limited the potential for bias.*

Evidence from both document review and interviews indicate that there was strong involvement of key and vulnerable populations in the 2017-2019 funding requests compared to the previous grant applications. Representatives of key and vulnerable populations and civil societies were identified, reached, and participated in the negotiation for inclusion of key population priorities in the funding request. However, according to most of the key informants, the participation of key populations was more visible in the HIV funding request than TB and malaria funding requests.

Similarly, during the application development for the catalytic matching funds requests, several constituencies, including key and vulnerable populations, were reached and their views considered. They participated in the setting of priorities, writing the matching funds requests, as well as addressing TRP review comments on the matching funds application.

> *"We [key populations] were engaged by all groups during the data collection, in terms of areas of focus, who to report what, who to implement what and other areas." (KII, Key populations)*

Evidence from key informants also shows that human rights and gender expertise is represented through the different Civil Society Organization constituents on the CCM. However, there were suggestions made towards improving and increasing the involvement of the Ministry of Gender, Uganda Human Rights Commission, political leaders, and Ministry of Education on the CCM.

The depths of "meaningful engagement" in the application process seemed to vary according to key informants as some key population representatives, like long distance truck drivers and uniformed personnel, felt that they were not equally represented within the wider key population platform. There was also limited understanding about the total estimates of key and vulnerable populations in Uganda making it difficult to plan and budget explicitly. However, the proposed key population baseline assessment that the country will be conducting with resources from the Global Fund will be used to inform better programming on human rights.

> *"The Most At Risk Persons (MARP) platform has two people on the CCM board representing the key population. One member is from MSM community and another person represents CSWs [commercial sex workers] but the same issue is coming up from other key populations as they often ask questions like, 'how sure are we that 'us' transgender people are being catered for?, how sure are we that 'us' truckers we are being catered for?'" (KII, Key Populations)*

Most key populations also noted that their participation was also hampered by lack of data and evidence to support their proposed interventions. They noted that there is limited literature on issues to do with key populations in Uganda and since it is mandatory to support all prioritized activities in the Global Fund funding request with evidence, it was difficult to sustain some interventions for key populations within the proposal.

Finding 6. Findings suggest a mixed focus in terms of prioritization of key and vulnerable populations by in-country stakeholders, Global Fund and between disease programs.

Robustness: *(Ranking = 3) The finding is supported by few data sources and is perception based from key informants. It is only supported by a few documents (mainly the NSPs).*

There are perceived differences between the definitions, categorization and level of prominence for key populations according to Global Fund and in-country stakeholders. For example, in-country

stakeholders identify key populations in priority order as fishing communities, commercial sex workers, uniformed persons, MSM, truckers, and injecting drug users, while Global Fund's emphasis on key populations was perceived to strongly focus on MSM. Informants perceived these differences to affect prioritization of health needs among key and vulnerable populations, and given the cultural sensitivity of "key populations" in Uganda, this perception could negatively affect implementation of key population activities.

> *"...during the different stakeholder meetings, you would see that people were concerned about how Global Fund defines key populations and relate it to Uganda's definition, which in the actual sense seems different. Stakeholders are concerned that Global Fund mostly considers 'gay' people" (KII, government)*

Furthermore, there were concerns about the different categorization of key and vulnerable populations across Malaria, HIV and TB programs. For instance, the malaria program considers and defines key populations as vulnerable populations with reduced immunity (children <5 years and pregnant women), people living with HIV, refugees and internally displaced persons (IDPs) and hard-to-reach populations (defined as populations living in areas beyond 5 km distance or more than 45 minutes walking distance from a health facility or are limited by physical barriers like mountains, rivers, etc.). The TB Program defines key populations as those in close contact with TB cases, prisoners, refugees and IDPs, TB hotspots, previously treated TB patients, health workers, diabetic people etc. while the HIV program considers key populations to be fishing communities, commercial sex workers, uniformed persons, and MSMs. Informants wondered how the different key and vulnerable populations under the different grants would be addressed if the grant application was to be based on Global Fund's perceived definition.

> *"You know we have a challenge with applying that Global Fund definition of key populations to suit our categorization of key populations under the different diseases. Our disease programs categorize key populations differently and we address their needs differently. So how will equality and equitable consideration of needs be addressed if we concentrate on Global Fund's definition? That is why we concentrate on our National Strategic Plans." (KII, government)*

Most stakeholders noted that despite the difference in understanding of key and vulnerable populations, there is no discrimination in service delivery given that activities are prioritized according to NSPs, which aim at universally addressing health concerns of all populations. For example, guiding principles for key populations in the Uganda Malaria Reduction Strategic Plan (UMRSP) include universal coverage with proven malaria interventions, equity, non-discrimination, participation, accountability, and the right to the health elements of availability and accessibility.

4.3 Catalytic Funding

In the 2017-2019 funding cycle, the Global Fund Board approved some countries to access additional funds that were to cover activities and programs not accounted for in the country allocations but were considered crucial to achieve the objectives of Global Fund's 2017-2022 Strategy. Specifically, the matching funds were to *incentivize* eligible countries to align programs toward the strategic priorities that are critical to driving impact and achieving the Global Fund Strategy 2017–2022. To that effect, Uganda submitted two requests for matching funds to address human rights-related barriers to health service access by key populations and for programs for HIV services for adolescent girls and young women and US$ 4.4 m and US$ 5m were respectively allocated to those components.

Finding 7. The process of applying for matching funds was unclear and not well streamlined

***Robustness**: (Ranking = 1) The finding is supported mostly by perception-based evidence from key informant interviews. The evidence is considered to be of high quality and robust given triangulation across various stakeholder groups with largely convergent opinions.*

There was general misunderstanding by stakeholders about matching funds, mostly because it was a new strategy and the country stakeholders felt that the Global Fund did not provide enough guidance, which caused a lot of confusion around the content areas. Some stakeholders interpreted the human rights matching funds as specific to sexual orientation barriers to service delivery, rather than human rights barriers more broadly. Key informants indicated that the matching funds application was complex, characterized by deeper thoughts on human rights barriers, and this prolonged the whole process as reaching an agreement on what "a human rights barrier" is, took several meetings. Determining a key human rights barrier versus a general barrier remains an issue of concern. Some stakeholders, however, were pleased with incentivizing of matching funds arguing that it will help address health-related issues in the sub-populations where the disease burden (especially HIV) is most prevalent.

> *"The catalytic funds application was a more complicated application to write because it had to have deeper thought mainly in the area of key populations and human rights. For example, just agreeing on the human rights barriers was a very protracted discussion. It was not a very easy discussion to have because people would take a long time to agree on some issues… we generally had to put in a lot of thinking." (KII, Civil Society)*

Most stakeholders noted that the application and approval process for the matching funds has dragged on causing some inefficiencies (time and cost). Stakeholders are concerned that implementation of matching funds will fall behind schedule, yet the activities therein are supposed to supplement activities in the main grants, whose implementation started in January 2018. Implementation of the two matching funds grants is expected in May 2018 and the PCE will prospectively track and monitor the matching fund grants, including whether there are unintended consequences of the delayed start.

Despite having allocated US$5 million to programs for HIV services for adolescent girls and young women and US$4.4 million to programs to address human rights-related barriers to health service access by key populations, earlier on there was concern that failure by in-country stakeholders to rally consensus around unpacking activities within *"human rights-related barriers to accessing health"* could affect implementation of the matching funds. The evaluation will however be tracking prospectively the implementation of matching funds.

> *"When it comes to implementation, I foresee a challenge because up to now most stakeholders have not yet agreed on what exactly 'human rights barriers' are and what activities we should concentrate on during this implementation." (KII, government)*

4.4 Co-financing and Sustainability

The Global Fund requires countries to demonstrate their commitment to improving population health according to the 2017-2022 Sustainability, Transition and Co financing (STC) policy framework. Co-financing pertains to pooled domestic public resources and domestic private contributions that finance the health sector and National Strategic Plans supported by the Global Fund.(8) The co-financing requirements, according to the Global Fund, are twofold: progressive government expenditure on health to meet national universal health coverage (UHC) goals, and demonstrating increasing co-financing of Global Fund supported programs over each allocation period and the country's demonstration of 'willingness to pay commitments' for the previous allocation.

Finding 8. Per Global fund requirements for Co-financing, the country demonstrated the needed commitment to meet the counterpart funding for the three disease programs.

Robustness: *(Ranking = 1) The finding is supported by multiple data sources, including both data from key informants and documented evidence from funding request documents and TRP reviews. The supporting evidence is more factual than subjective.*

According to the available documentation, GoU made sufficient co-financing commitments to access the full "co-financing incentive" as per the requirements in the STC policy.(9) Uganda's co-financing commitment for the 2017-2019 allocation is US$34,879,278 for a three-year period. Key informants mentioned that the government significantly contributes to health care in the form of infrastructure and operations, human resources for health, and laboratory services. Twenty percent of these health expenditures are directed towards HIV, TB and malaria. Additionally, the country has a minimum annual expenditure of 100 billion Ugandan Shillings (UGX) for case management of malaria, HIV and TB, which, according to some key informants, is above the country's allocation per annum requirements. The GoU has also committed to increase the budget line for 2017/2018 to UGX 110 billion as commitment towards the fight against HIV, TB and malaria. Furthermore, in addition to increasing commitments towards ACTs, ARVs and anti-TB medicines in 2016, the government also increased funding on health system operations by absorbing the 1,800 health workers that were supported in the previous grants (1,200 and 600 health workers previously supported by PEPFAR and the Global Fund respectively).

However, most stakeholders noted that whereas the government shows increased health budgets in absolute figures, the proportion of government spending on health as compared to the national budgets has stagnated around 8% for several years falling short of the Abuja Declaration (15%).

Despite the country's efforts to increase domestic resource mobilization to boost HIV, TB and malaria activities, there was less evidence around tracking of the co-financing commitments, both within the country and by the Global Fund. The commonly mentioned tracking mechanism is through the Integrated Finance Management System (IFMs) where different budgets like the National Annual budgets of the MoFPED, ministerial budget framework documents, and budget support and health projects under the Medium Term Expenditure Framework (MTEF) track expenditures. However, stakeholders felt that the effectiveness of these tracking mechanisms remain unclear.

Finding 9. The Government of Uganda has undertaken several initiatives aimed at increasing domestic resource contributions for HIV, TB, and Malaria to ensure sustainability.

Robustness: *(Ranking = 1) The finding is supported by multiple data sources, including both data from key informants and documented evidence (including funding request documents, TRP reviews, and NSPs). There was a mix of factual evidence and perception-based evidence from key informants with close proximity to the topic.*

To be able to sustain the gains of Global Fund funding as well as reduce the vast dependence on donor support in the health sector, the GoU has undertaken several initiatives to increase the domestic resource contributions to improve sustainability of the impact against malaria, HIV and TB. Although most of these initiatives are not yet operational, their intended efforts aim at increasing strong domestic resource contributions in the fight against diseases including malaria, HIV and TB. These initiatives include:

- A gazetted budget allocation towards procurement of ARVs, ACTs and TB drugs. This budget line accounts for almost half of the National Medical Stores procurement budget and increased from UGX 100 billion in 2016 to UGX 110 billion in 2017; it is expected to reach UGX 130 billion by 2019. Additionally, the training introduction of community health extension workers (CHEWs)

on government payroll will strengthen community sensitization and mobilization, not only for malaria but also HIV and TB. However, the operationalization of CHEWs policy is still under debate by the Ministry of Health and Ministry of Finance.

- With the country's health financing strategy, the purpose is to increase and sustain domestic resource mobilization as well as start up a social health protection system that will reach and benefit up to 30 percent of Ugandans by 2025.(10) Additionally, the financing strategy aims to increase and strengthen purchasing mechanisms for effective, equitable and efficient resource allocation.

- Uganda plans to enact the National Health Insurance Scheme (NHIS) with the aim of reducing the burden of disease and ensuring that almost 25% of the population can access health care services, even for the complicated cases that cannot be managed in country. Malaria, HIV and TB are the leading causes of mortality in Uganda,(11) so the NHIS is expected to immensely contribute to the sustainability of the fight against these three diseases.

- There have been additional investments in health systems. In the development budget financed by GoU, resources increased from UGX 70 billion in fiscal year 2011 to 143 billion UGX in fiscal year 2017, primarily to support health systems. The government has also availed of loans such as the USD $110 million credit for the Uganda Reproductive, Maternal and Child Health Services Improvement Project under the Global Financing Facility.

- Officially launched in June 2017, the One Dollar Initiative is a private sector initiative that mobilizes local resources and financing for HIV/AIDS with the aim of supplementing efforts of GoU and development partners towards the HIV/AIDS response. There has been progress so far with the development of 2018-2020 operational plan and mobilization of resources.

- In March 2017, the AIDS Trust Fund was approved. Though not yet operational, this fund aims at mobilizing extra domestic funds towards the response of HIV in the country.

- Other resource mobilization strategies used by GoU to sustain efforts towards the fight against malaria, HIV and TB include: supporting local manufacturing of commodities like Long lasting insecticide nets (LLINs), malaria rapid diagnostic tests (mRDTs), and a reduction of global prices for malaria case management and vector control that will make malaria commodities more affordable for the government and communities.

Limitations

A major limitation of this first phase of the evaluation is that it has been retrospective in nature since the PCE launched after many of the funding request and grant-making processes had already been completed. As such, data collection has heavily relied on KIIs, which can be prone to recall, and respondent bias. To minimize these potential biases, stakeholders with the greatest involvement in the funding request (close proximity) were invited for interviews. In addition, the team mapped out the whole funding request and grant making process to help stakeholders visualize all key steps and thematic areas and during interviews, stakeholders were encouraged to revisit relevant documents in order to recall past experiences of the grant application processes. To ensure robustness, findings were triangulated across multiple data sources (interviews, observations and document review) in addition to triangulation of interview data across multiple stakeholder groups.

Given the sensitivity of some topic areas, some stakeholders were uncomfortable speaking about issues related to Global Fund; however, the evaluation team assured them of confidentiality and emphasized that the PCE are independent evaluators of Global Fund policies and processes, whose aim is to provide

real time actionable recommendations to improve program implementation of malaria, HIV and TB in Uganda.

CHAPTER 5: Capacity Development

The PCE has benefited from collaboration and coordination, with significant multi-directional learning from the CEP to the GEP and vice versa, as well as across PCE countries. Frequent communication, team planning, and in-person workshops have helped strengthen the overall PCE platform. Partnership has occurred in three main ways during the first six months of the evaluation:

1. Weekly Skype conference calls in which IDRC, IHME and PATH teams exchanged updates on the work in progress, discussed data collection, planned for workshops, meetings and deliverables, examined emerging findings, provided feedback on evaluation tools, celebrated milestones reached, and prepared for next steps. Methodological questions or uncertainty were reviewed and clarified. This is in addition to email communication.
2. Joint development and use of evaluation tools, e.g. KII topic guides built by CEP/GEPs, network survey, analysis matrix, etc.
3. Basecamp, an online work stream platform, is used to upload key documents including CEP observation notes, PCE evaluation instruments, and information on quantitative research, official communications shared by the Global Fund, and PCE reports and slides.
4. CEP-GEP in-person workshops (highlighted in Table 6 below)

Table 6: PCE Workshops

Pre-Evaluation workshop and stakeholder workshop July 2017 Kampala, Uganda	• Harmonized understanding of key focus areas for this evaluation • PCE dissemination Stakeholder Workshop • Finalized a list of the major evaluation priorities of the country-level stakeholders • Post workshop briefing and agreements for final Evaluation Questions • Drafted evaluation framework and plan based on reaching consensus around evaluation areas and methods available • Agreement on key next steps for inception phase in Uganda
Evaluation Phase Launch October 2017 Seattle, Washington, USA	• Reviewed the PCE tools, including PCE analysis matrix • Reinforced PCE-specific process evaluation skills • Practiced data extraction from document review and meeting observations into PCE analysis matrix • Adapted KII topic guides and partnership survey to be Uganda-specific • Discussed impact evaluation goals and guidance on early quantitative analysis • Knowledge transfer for resource tracking tools and practices • Work planning for the early evaluation phase
Data Analysis and Annual Report Workshop January 2018 Kampala, Uganda	• Compiled and review the evidence for each sub-question, including rating the strength of evidence • Identified data gaps and arranged to gather additional evidence • Began preparations for the Partnership network survey • Discussed country context in relation to key evaluation priorities • Continued familiarization with resource tracking; evaluated early findings • Became familiar with small area estimates, how they are produced, and how to interpret and explain analysis • Discussed resource tracking analyses and how they could complement other

	evaluation findings • Triangulated data across process evaluation, resource, tracking, and impact evaluation where possible • Drafted a slide deck of country progress and preliminary findings for February TERG meeting • Prepared for Annual Country Report • Updated work plans
Workshop and stakeholder dissemination meeting April 2018 Kampala, Uganda	• Reviewed grant analysis and discussed grant tracking next steps • Reviewed global level impact chains and thematic evaluation frameworks and related indicators • Harmonized understanding of key focus areas for next evaluation phase • Reviewed funding request and grant-making results and dissemination slide deck • PCE dissemination Stakeholder Workshop • Post workshop briefing • Drafted slide deck outline for May TERG presentation • Agreement on key next steps for next evaluation phase in Uganda

5.1 GEP-CEP knowledge transfer

Because it is prospective and country-focused, the PCE offers opportunities for dynamic, continuous learning and problem solving, including between the CEPs and GEPs. During the inception phase, a PCE capacity development plan was established that identified opportunities for Global Evaluation Partners to learn from Country Evaluation Partners, including contextual and cultural details, and identified opportunities for specific capacity strengthening activities to implement in-country. Given IDRC's expertise in conducting process evaluation for Gavi FCE, capacity to conduct qualitative data collection, triangulation, and analysis was already in-place. However, new tools, such as the PCE analysis matrix (the framework approach), were introduced to support the process evaluation data triangulation and analysis. IHME-PATH learned from the FCE experience, which helped shape the overall evaluation platform. Quantitative aspects of the PCE have provided opportunities for skills transfer to IDRC, including using small area estimation, coding in R, and understanding the process for resource tracking and impact evaluation. These skills were shared and developed during two CEP-GEP workshops, and ongoing quantitative analysis learning will be supported.

5.2 Plans for future learning and skills development

IDRC and IHME-PATH plan to continue working together for further skills development based on country-specific needs. Trainings will aim to ensure that skills required for the Evaluation Phase are aligned with the PCE data collection and analytic needs. IHME will continue to lead many analyses for outcome measurement, collaborating closely with IDRC on code, tools and data analysis for resource tracking and impact evaluation. PATH will continue to support skills development to strengthen the process evaluation approach, including evaluative thinking through root cause analyses and capacity building to conduct the partnership network survey from end to end (from survey development, to data management, to analysis and interpretation) – particularly targeting new members of the IDRC team. Furthermore, there are plans to harmonize across the PCE countries, to the extent to which harmonization is possible and desirable. To this end, a multi-partner meeting is planned for cross-CEP knowledge sharing and GEP-CEP working sessions, scheduled in Seattle in June 2018.

CHAPTER 6: Overall conclusions and recommendations

The Global Fund's new funding model is progressively streamlining and differentiating grant application and approval processes in-line with the country context and this contributed to timely submission of funding requests with the aim of limiting significant delays into the implementation period. The successes of the 2017-2019 funding cycle were likely achieved through a combination of: (1) changes to grant development process; (2) strong and supportive Country Teams, who helped advise and kept funding request and grant-making on track; and (3) overall better country preparedness (in terms of gathering the necessary evidence), as well as experience and capacity of in-country stakeholders for Global Fund processes. In the Global Fund's 2017-2022 strategy, it was mentioned that RSSH, key and vulnerable populations, gender and human rights would be of strong focus. However, there was limited reflection of these focus areas in practice at country level because of the disconnect between the priorities written in the Global Fund strategy documents and policy and country priorities. For instance, the allocation letter was not clear in terms of the country applying for a stand-alone RSSH or reintegrating RSSH activities into the disease specific grants. Similarly, there was insufficient guidance in the allocation letter around the application for catalytic matching funds. Overall, the process of developing the funding request was seen as inclusive and concluded with an application that was perceived to meet almost all Global Fund requirements. Some informants did however report difficulties of developing a funding request across such a diverse set of stakeholders.

Reflections for consideration and actions

The reflections for consideration and action provided in this report have been drawn from recommendations of the advisory board and feedback from the country stakeholders during the April dissemination workshop in Kampala:

- Whereas the role of CCM in coordinating and mobilizing resources for the funding request and grant-making process is well appreciated, there remains a grey area regarding the mandate of key actors (CCM board, PRs and Country Teams) in situations where there is lack of consensus, as reflected in decisions around RSSH. Such situations have implications for the decision-making process and moving forward, the PCE will continue to track processes around decision-making and consensus building as relates to Global Fund 2018-2020 grant implementation.

- For countries like Uganda, which are under additional safeguards due to previous mishandling of Global Fund money, clearer guidance on the RSSH component is necessary to reflect the minimum level of risk that Global Fund is willing to accept. The Global Fund should continue to support RSSH-type activities, however there is need for more exploration on the most effective RSSH model – is it better for the country to have a stand-alone RSSH grant or integrate RSSH activities within the disease specific grants?

- Given the misunderstanding of the matching funds request by stakeholders, there should be deliberate efforts to provide clear guidance to the country in circumstances where Global Fund introduces a new funding component, like the matching funds.

- There are several mentioned initiatives aimed at increasing domestic resources contributions for HIV, TB and malaria to ensure sustainability, most of these initiatives are not operational yet. This could be area of interest for PCE to track the progress of mentioned initiatives.

- In light of the counterpart financing, though GoU demonstrated the necessary commitment, the tracking mechanisms and their effectiveness are not clear to the stakeholders. There should be a clear demonstration on how co-financing commitments will be tracked and followed up.

CHAPTER 7: Plans for 2018

7.1 Partnership Network Survey (February-April 2018)

The PCE team administered the partnership survey tool to stakeholders who were directly involved in the funding request and grant-making processes. The purpose of this survey is to gain understanding about the nature and role of partnerships between the Global Fund, partners, and in-country stakeholders in carrying out the activities in the funding request and grant making processes. This tool specifically asks the respondent to report their professional relationships (collaboration) with others during the funding request and grant--making processes. These 'name generator' questions collect the data necessary for mapping and analyzing the network structure. Initial respondents will be identified based on their known involvement in the processes; each new name they provide will be contacted to participate. The survey collects data to measure relationships between the partnership context and enabling environment, the partnership structure, the performance of partners and partnership practices, and finally the added value of the partnership (effectiveness, efficiency and country ownership), which will be analyzed through network analysis.(12) This data will be used for mapping and analysis of the Global Fund partner network.

7.2 Advisory Board meeting

As part of the preparations for the stakeholder dissemination meeting, IDRC held an advisory board meeting in March 2018 This meeting was aimed at presentation of the PCE preliminary findings and to get feedback from the board. The next Advisory Panel meeting is tentatively planned for June.

7.3 Stakeholder Dissemination Meeting

IDRC convened a dissemination meeting in on April 27, 2018. The meeting was attended by a diverse group of stakeholders involved in the control of malaria, HIV/AIDS and TB in Uganda. A total of 66 stakeholders attended. Representation was as follows:

- Ministry of Health (Program Manager TB program and officers for HIV/AIDS, TB and malaria control programs, Fund Coordination Unit)
- Ministry of Finance (Officials from the Fund Coordination Unit)
- Health Development Partners (WHO, USAID, CDC/PEPFAR, Irish Aid, UN, DFID)
- CCM (CCM secretariat, constituency representatives)
- Civil Society Organizations
- PCE Advisory Board
- Local Funding Agent (PWC)
- Global Fund Technical Evaluation Reference Group (TERG)
- IHME /PATH (Global Evaluation Partner)
- IDRC PCE team

The aim of the dissemination workshop was to provide stakeholders with updates on the PCE process, initial PCE findings, and provide a platform to receive feedback and recommendations moving forward. The meeting was officially opened by the Director General of Health services representing the Minister of Health. Key among the issues highlighted were;- strong stakeholder support and cooperation towards the evaluation team, emphasis of the MOH to take note and act upon the recommendations from the evaluation and the need for the PCE to pass on its skill to country stakeholders so that the country is in position to continue the evaluation for sustainability purposes.

7.4 Process tracking as Uganda moves into implementation of new grants

The evaluation phase has so far included document review, non-participant observation at key meetings, and KIIs, focusing mainly on questions related to the funding request and grant application/making process (refer to the evaluation table for more details). Going forward, the team, through the same evaluation methods, is embarking on the process of assessing the impact of the 2017- 2019 funding cycle as the implementation of new grants starts.

7.5 Resource tracking and impact evaluation

Upon initiation of implementation, resource tracking methods will be applied to compare early activities and progress between the current grants and early stages of former grants. The resource tracking study will bring together multiple sources of data on budgets, disbursements and spending for the three diseases to analyze the distribution, trends and patterns of Global Fund resources around the country, as well as how it compares with resources from other development partners and domestic health financing. Major areas of emphasis will be understanding allocation, reprogramming, absorption and co-financing. For example, allocation analyses will explore the proportion of funds dedicated to different service delivery areas, different geographical areas, and how that distribution is changing over time. Reprogramming analyses will explore the difference between original budgets and actual spending in terms of implementation activities. Each resource tracking analysis will be contextualized by qualitative data collection (described in this report) to not only understand what the trends of resource distribution are, but why they are coming about.

In addition, efforts are already underway to measure health systems outputs and intervention outcomes. Data from HMIS, programs and surveys will be used in combination to track the health system outputs such as treatment and prevention coverage over time and sub nationally. Indicators linked to specific program activities will be monitored more closely, and early progress towards those indicators will be assessed. Finally, we will continue making progress measuring population-based indicators such as intervention coverage and burden of disease, in order to prepare to ultimately assess impact**.** This will link with the resource tracking study to enable an understanding of how health investments translate into outputs, outcomes and ultimately impact.

7.6 Gaining access to additional data sources

The Evaluation team is already in the process of obtaining access to additional data sources necessary for the evaluation process. The request for access to DHIS2 was submitted to the Ministry of Health and was of recent approved. This will be particularly helpful in monitoring and measuring direct health systems outputs related to HIV, TB and malaria. The team is also in the process of obtaining access to the Uganda Population Based HIV Impact Assessment Survey. The Uganda Population-Based HIV Impact Assessment (UPHIA), a household-based national survey, was conducted from August 2016 to March 2017 to assess the progress of Uganda's national HIV response. A request has been sent and awaiting approval.

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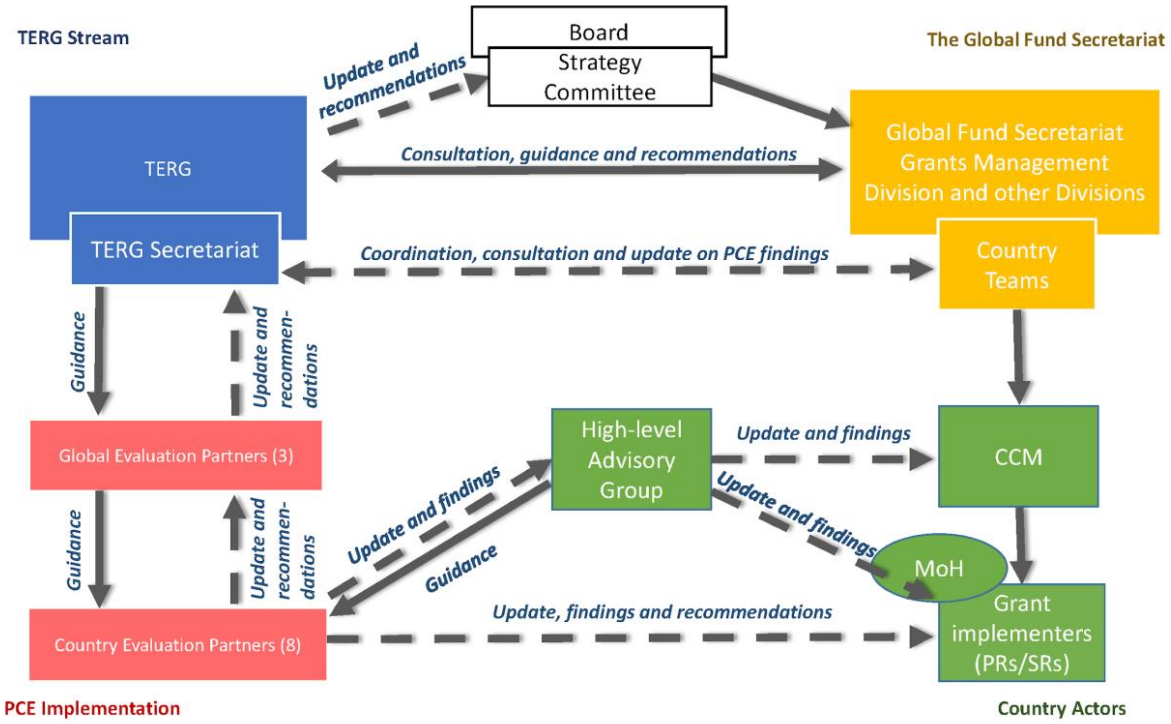
Annexes to the report

Annex I. PCE Governance



Annex II. PCE High-Level Advisory Board Members

No.	NAME	PROFILE
1	PROFESSOR CHARLES KARAMAGI	Professor and Epidemiologist
2	PROFESSOR ELLY KATABIRA	Professor of Medicine in the Department of Medicine, School of Medicine, Makerere University College of Health Sciences, Kampala, Uganda.
3	DR. MIRIAM NANYUNJA	Works with WHO Uganda Country Office as a Disease Prevention and Control Advisor to the Health Sector in Uganda.
4	DR. SABRINA KITAKA	Senior Lecturer of Pediatrics and Child Health at the School of Medicine, Makerere University. Member of the Uganda National Advisory Committee for Vaccines and Immunization
5	DR. SAM OKWARE	Executive Director, Uganda National Health Research Organization.
6	DR. ALEX OPIO	Former Commissioner, National Disease Control - Ministry of Health. Independent Consultant
7	DR. JANE KENGEYA KAYONDO	Senior Science Program Manager at the Africa Research Excellence Fund (AREF) and coordinator in the East & Southern Africa region
8	DR. JESSICA NSUNGWA	Acting Commissioner (Community Health), MOH
9	DR. SERAPHINE ADIBAKU	Public Health Specialist, Malaria Expert and Independent Consultant
10	Assoc. Prof Anne Katahoire	Professor of Behavioral Social Science at the Child Health and Development Centre, Makerere University College of Health Sciences, School of Medicine.

Annex III. Evaluation framework including specific evaluation questions under the broad evaluation areas

Big Themes	Broad Evaluation Questions	Priority
Absorption	What are the drivers of consistently low rates of absorption of Global Fund investments in Uganda? What aspects of the Global Fund business model facilitate or hinder effective and efficient absorption?	High
Priority Setting / Resource Allocation	How does the decision-making process in Uganda determine Global Fund investment priorities, program split, and resource allocation? To what extent does the process for determining investment priorities and resource allocations in Uganda result in grants strategically designed to deliver maximum impact?	High
	What is the role of health system strengthening in achieving impact of Global Fund investments?	Med
	To what extent is allocation of Global Fund resources complementary to other resources (PEPFAR, domestic etc.)?	Med
Grant Application / Making	To what extent are expected implementation bottlenecks anticipated and planned for in grant making phase?	Med
	How effectively are key and hard-to-reach populations considered, defined, and addressed in the grant application?	Low
CCM Roles / Functionality	What are the facilitators and barriers to the CCM functioning effectively within the standards/scope as defined by the Global Fund business model?	High
Accountability	How effective are Global Fund accountability structures and oversight mechanisms (e.g. audits) at enabling program results?	Med
Financial Flows & Fund Coordination	How effectively do Global Fund resources move from global to national to sub-national levels?	Med
	What are the trends and distribution of Global Fund resources in Uganda?	Med
Sustainability / Co-financing	How effective is the STC policy in stimulating co-financing?	Med
	To what extent is the STC policy applied and contributing to preparing Uganda for sustainability and transition?	Low
Implementation	What are the barriers to and facilitators of translating Global Fund resources into health system outputs? What are the barriers and facilitators of translating health system outputs into health outcomes?	High
	To what extent do planned activities and grant flexibility maximize the effectiveness of implementation?	High
Impact	What are the trends and distribution of HIV, TB and malaria-related health outputs and outcomes in Uganda?	Med
	To what extent do Global Fund resources contribute to improvement in health outputs and outcomes for HIV, TB and malaria in Uganda?	Med

Annex IV. Indicative country-level work plans for January – June 2018