



# Uganda Work Plan

## FY 2017

### Project Year 6

**October 2016-September 2017**



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## ENVISION PROJECT OVERVIEW

The U.S. Agency for International Development (USAID)'s ENVISION project (2011-2019) is designed to support the vision of the World Health Organization (WHO) and its member states by targeting the control and elimination of seven neglected tropical diseases (NTDs) including, lymphatic filariasis (LF), onchocerciasis (OV), schistosomiasis (SCH), three soil-transmitted helminths (STH; roundworm, whipworm, hookworm) and trachoma. ENVISION's goal is to strengthen NTD programming at global and country levels and support Ministries of Health (MOH) to achieve their NTD control and elimination goals.

At the global level, ENVISION – in close coordination and collaboration with WHO, USAID and other stakeholders- contributes to several technical areas in support of global NTD control and elimination goals, including:

- Drug and diagnostics procurement, where global donation programs are unavailable,
- Capacity strengthening,
- Management and implementation of ENVISION's Technical Assistance Facility (TAF),
- Disease mapping,
- NTD policy and technical guideline development, and
- NTD monitoring and evaluation (M&E).

At the country level, ENVISION provides support to national NTD programs by providing strategic technical and financial assistance for a comprehensive package of NTD interventions, including:

- Strategic annual and multi-year planning
- Advocacy
- Social mobilization and health education
- Capacity strengthening
- Baseline disease mapping
- Preventive chemotherapy (PC) or mass drug administration (MDA)
- Drug and commodity supply management and procurement
- Program supervision
- M&E, including disease-specific assessments (DSA) and surveillance

In Uganda, ENVISION project activities are implemented by RTI International and The Carter Center.

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## ACRONYMS LIST

ACHS	Assistant Commissioner of Health Services
AE	Adverse Events
ALB	Albendazole
AoC	Ambassadors of Change
APOC	African Programme for Onchocerciasis Control
ASTMH	American Society for Tropical Medicine and Hygiene
BCC	Behavior Change Communication
BMU	Beach Management Unit
BWCP	Bilharzia and Worm Control Program
CAO	Chief Administrative Officer
CCA	Circulating Cathodic Antigen
CCP	John Hopkins School of Public Health's Center for Communication Programs
CDD	Community Drug Distributor (Community Medicine Distributor)
CDTI	Community-Directed Treatment with Ivermectin
CFA	Circulating Filarial Antigen
CHD	Child Health Day
CHEWS	Community Health Extension Workers
CY	Calendar Year
CMD	Community Medicine Distributors
DBL	Danish Bilharziasis Laboratory, Denmark
DFID	Department For International Development, UK
DGHS	Director General of Health Services
DHO	District Health Office(r)
DHT	District Health Team
DOC	District Onchocerciasis Coordinator
DQA	Data Quality Assessment
DRC	Democratic Republic of the Congo
DSA	Disease-Specific Assessments
EU	European Union
FOGs	Fixed Obligated Grants
FP	Focal Person (district-level)
FY	Fiscal Year
GIZ	German Corporation for International Cooperation (Deutsche Gesellschaft für Internationale Zusammenarbeit, established in 2011 through a merger of Deutscher Entwicklungsdienst (DED), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and Internationale Weiterbildung und Entwicklung (InWEnt))
GoU	Government of Uganda
GTMP	Global Trachoma Mapping Project
GTZ	German Technical Cooperation Agency (Gesellschaft für Technische Zusammenarbeit)
HAT	Human African Trypanosomiasis
HPED	Health Promotion Education Division (MoH)
HSD	Health Sub district
IA	Impact Assessment
IDM	Intensive Disease Management
IEC	Information, Education, and Communication

IRS	Indoor residual spraying
ITI	International Trachoma Initiative
IU	Implementation Unit
IVM	Ivermectin (Mectizan)
JRSM	Joint Request for Selected (PC) Medicines (WHO)
KAP	Knowledge, Attitude and Practice (study)
KEMRI	Kenya Medical Research Institute
LC	Local Council
LC5	Local Council 5 (District Level)
LF	Lymphatic Filariasis
LLINS	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
Mf	Microfilariae
MMDP	Morbidity Management and Disability Prevention
MOH	Ministry of Health
MP	Minister of Parliament
MRC	Medical Research Council (UK)
NMS	National Medical Stores
NOCP	National Onchocerciasis Control Program
NS	Nodding Syndrome
NTD	Neglected Tropical Disease
NTDCP	Neglected Tropical Disease Control Program
OV	Onchocerciasis
PC	Preventive Chemotherapy
PCR	Polymerase Chain Reaction
PDC	Parish Development Committee
PELF	Program to Eliminate Lymphatic Filariasis
PEM	Participatory Evaluation Meeting
PHC	Primary Health Care
PTS	Post treatment surveillance
PM	Program manager
PZQ	Praziquantel
RDC	Resident District Commissioner
RPRG	Regional Program Review Group
SAE	Serious Adverse Event
SAFE	Surgery, Antibiotics, Facial cleanliness, Environmental improvements
SAS	Senior Assistant Secretary
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative (Imperial College London, UK)
SPO	Senior Program Officer
STH	Soil-Transmitted Helminthiasis
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TAF	Technical Assistance Facility
TAS	Transmission Assessment Survey
TEO	Tetracycline Eye Ointment
TF	Trachomatous infection - Follicular

TIPAC Tool for Integrated Planning and Costing  
TIS Trachoma Impact Survey  
TOT Training of Trainers  
Trust Queen Elizabeth Diamond Jubilee Trust  
TSS Trachoma Surveillance Survey  
TT Trachomatous Trichiasis  
UVRI Uganda Virus Research Institute  
UIG Ultimate Intervention Goal  
UOEEAC Uganda Onchocerciasis Elimination Expert Advisory Committee  
USAID United States Agency for International Development  
VCD Vector Control Division (MOH)  
VHT Village Health Team  
WFP World Food Programme  
WHO World Health Organization  
ZTH Zithromax

## COUNTRY OVERVIEW

### 1) General Country Background

#### a) Administrative Structure

Uganda is divided into four administrative regions: Central, Western, Eastern, and Northern. These four regions are in turn divided into districts. The districts are further divided into counties, sub counties, parishes, and villages. In 2002, there were 56 districts, which by 2010 had increased to 112 districts, including the Kampala City Council Authority.

By an act of Parliament in September 2015, 23 new districts were created to become operational in a phased manner over the next four fiscal years, to commence in July 2016. The new districts are: Kagadi (previously part of Kibaale district), Kakumiro (from Kibaale), Omoro (from Gulu) and Rubanda (from Kabale), effective July 1, 2016; Namisindwa (from Manafwa), Pakwach (from Nebbi), Butebo (from Pallisa), Rukiga (from Kabale), Kyotera (from Rakai) and Bunyangabu (from Kabarole), effective July 1, 2017; Nabilatuk (from Nakapiripirit), Bugweri (from Iganga), Kasanda (from Mubende), Kwania (from Apac), Kapelebyong (from Amuria), and Kikuube (from Hoima), effective July 1, 2018; and Obongi (from Moyo), Kazo (from Kiruhura), Rwampara (from Mbarara), Kitagwenda (from Kamwenge), Madi-Okollo (from Arua), Karenga (from Kaabong) and Lusot (from Moroto), effective July 1, 2019. This redistricting will bring the total number of districts to 135 in 2019.

Districts are sometimes loosely grouped into sub-regions based on names given during the colonial period: There are 11 current subregions: Buganda, Busoga, Bukedi, Teso, Karamoja, Lango, Acholi, West Nile, Bunyoro, Ankole and Kigezi (see the Uganda Regional Map, below). For example, Karamoja sub-region is composed of seven current districts within the original Karamoja administrative (district) unit. Sub-regions, however, are not active administrative or political units although they more or less demarcate certain ethnic groups and are used to refer to key targeted areas and ethnic groups for disease control activities, for example, targeting of specific Information, Education, and Communication (IEC) materials.

Uganda is administered through a decentralized system in which some powers are devolved from the central government to the district and the lower-level local governments. The Ugandan Ministry of Health (MOH) and the Ugandan Neglected Tropical Disease Control Program (NTDCP) both conduct their activities along the political and civil service administrative structures found in districts, as outlined below.

#### *District level*

Each district has an elected political head, known as the Local Council 5 (LC5) Chairperson, who presides over a council of ministers or secretaries (at LC5 level). Council ministers or secretaries are responsible for specific portfolios: for example, the Secretary for Health is the district equivalent of the national-level Minister of Health. Other top leaders at the district level include the Chief Administrative Officer (CAO), a civil servant who is the accounting officer of the district and has overall oversight of the civil service in the district. The Resident District Commissioner (RDC) represents the Office of the President in the district and is responsible for supervision of implementation of all government programs and projects in the district as well as security. The district's local government headquarters are located in town or municipal councils (urban centers). Town and municipal councils have their own structures



similar to those of the district local administrations. In FY17, ENVISION will support mass drug administration (MDA) and related activities in 55 districts.

#### *County and sub county levels*

Districts are divided into counties (a non-functional administrative level), which are further divided into sub counties. Counties may be equivalent to a health sub-district (HSD) or may contain two or more HSDs depending on their size and/or population. Sub counties are currently the most active lower units in the local government system. The sub county is headed by a Senior Assistant Secretary (SAS), formerly titled sub county Chief, a civil servant reporting directly to the district-level CAO. Also at the sub county level are Local Council 3 (LC3) Chairpersons and Councilors, who are elected representatives. The LC3 chairs and the SAS are partners in program planning and implementation at sub county level. In FY17, ENVISION will support MDA and related activities in 459 sub counties, the same as in FY16.

#### *Parish and community levels*

Each sub county is further divided into parishes, each headed by a parish chief—a civil servant—and a Local Council 2 (LC2) chairperson—an elected leader. Each parish has a parish development committee (PDC). The lowest administrative unit in Uganda is the community level, known as Local Council 1 (LC1) or village. Some LC1s that are large or densely populated are subdivided into cells (urban areas), kinship zones, or loose social groups, for example “Rwot Kweri” farming groups commonly seen in Northern Uganda. This LC1 council is headed by a chairperson and assisted by councilors, with a requirement for female representatives on the council. In FY17, ENVISION will support MDA and related activities in 2,172 parishes and 13,735 communities. In districts where MDA is being conducted for Schistosomiasis (SCH) only, ENVISION will support school-based MDA exclusively.

#### b) NTD Program Partners

The MOH’s NTDCP is an integrated program led by the NTD Secretariat. The NTDCP manages the program against the Innovative and Intensified Disease Management/Case Management (IDM/CM) NTDs<sup>1</sup> as well as against the five preventive chemotherapy (PC) NTDs: Onchocerciasis (OV), Lymphatic Filariasis (LF), Schistosomiasis (SCH), Soil-Transmitted Helminthiasis (STH), and Trachoma. The MOH sets the country’s NTD-related policies, includes NTDs in its annual policy statements to the national assembly, and provides an enabling environment for NTD-related program implementation and research. The NTDCP is led by the NTD Secretariat, chaired by a National Coordinator, who is assisted by program managers (PMs), senior program staff, scientists, technologists/ technicians, and other support staff. The MOH’s Top Management Committee, chaired by the Director General of Health Services (DGHS), serves as the equivalent of a steering committee for the entire MOH; and the NTD Technical Committee (see the Strategic Planning section, below). The MOH Top Management, through the DGHS and the Minister of Health, the State Minister for Health – General duties, and the State Minister for Health – Primary Health Care, also conducts program-specific high-level advocacy on behalf of the NTDCP; for example, during visits with representatives of Parliament and meetings with partners whenever delegations visit (e.g., RTI leadership, Pfizer, DFID). Clearing, handling and transportation of all NTD drugs and supplies from the port of entry to their final destinations (districts and lower level health

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<sup>1</sup> Including Human African Trypanosomiasis (HAT), Leishmaniasis, Jiggers, Buruli ulcer, Cysticercosis, Tungiasis, Rabies, Leprosy, Plague, and Guinea Worm (which has been eliminated from Uganda). National programs for HAT, Leishmaniasis, and Cysticercosis are based at VCD; the program for Plague is based at Uganda Virus Research Institute (UVRI) in Entebbe; and Buruli Ulcer Disease and Jigger Control are based at the MOH headquarters.

units) are handled by the National Medical Stores through an arrangement with MOH and the national treasury.

The MOH's disease-specific programs are managed by MOH staff, consisting of trained Program Managers, Scientists, Technicians and support staff. The MOH pays their salaries, wages and other emoluments; provides office, storage, and laboratory space, equipment such as microscopes, centrifuges, and sampling equipment, and supplies including reagents; and pays for stationery, and utilities (water, electricity, telephone, and internet), and ground rates (taxes on plots of land where Government buildings are located, imposed by City and Municipal authorities). At other levels of the health system, the MOH and district local governments recruit and provide salaries for the administrative and technical staff who implement NTD-related activities. The major donors supporting the NTDCP for PC-NTD control and elimination are the U.S. Agency for International Development (USAID), the World Health Organization (WHO), the U.K. Department for International Development (DFID), and the Queen Elizabeth Diamond Jubilee Trust (The Trust). The NTDCP's implementing partners include RTI International, The Carter Center, Sightsavers (UK), Schistosomiasis Control Initiative (SCI, Imperial College London, UK), and CBM International (Germany). The MOH's Trachoma Program, which is part of the integrated NTDCP, has additional partners working on water, sanitation, and hygiene (WASH) activities, referred to as WASH partners (see details in Table 1).

**CBM** is one of the Trust's two implementing partners for trachomatous trichiasis (TT) surgeries.

**Sightsavers** has long been a partner for trachoma and eye disease control. In 2006, it supported the first trachoma baseline surveys in eastern Uganda and has for many years supported eye care services through specialized clinics throughout the country. Sightsavers is the Trust's other implementing partner for TT surgeries, supporting these in 17 districts with a possibility of expansion to others.

Sightsavers also supports OV control/elimination in eastern Uganda, including MDA in Masindi, Buliisa, Hoima, and Kibaale, and post-treatment surveillance (PTS) activities in Hoima and Kibaale districts. ENVISION supports two of these same districts, Masindi and Buliisa, for SCH and/or trachoma MDA. Sightsavers has also supported vector control in Pader, Kitgum and Lamwo districts.

In FY17, Sightsavers will continue to support the NTDCP's LF Program in conducting rapid assessments of the burden of chronic manifestations of LF, as well as in conducting hydrocelectomies and lymphedema management, in Amuru, Pader, Kitgum and Lamwo Districts (Acholi sub region, Northern Region).

**The Carter Center** supports OV elimination activities in 37 districts (including the districts supported by Sightsavers) with both private funding and funding from USAID through ENVISION. These activities include MDA, targeted vector control or vector elimination where there is ongoing transmission, PTS where transmission has been interrupted, and knowledge, attitude and practice (KAP) studies for districts where the three years of PTS have been completed. The Carter Center also supports OV-related cross-border activities between Uganda and the Democratic Republic of Congo (DRC) and South Sudan, potentially including activities in each of those two other countries. It should be noted that activities that The Carter Center is proposing to carry out in FY17 in this ENVISION work plan are also financially supported, in part, by The Carter Center's other donors.

The Carter Center also supports the national molecular laboratory through a collaboration with the University of South Florida (Prof Tom Unnasch), and the Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) which provides technical oversight of the national OV elimination program and guidance to the MOH.

**SCI/DFID:** DFID has supported SCH and STH control in Uganda since 2003 through SCI (Imperial College London, UK), focusing on MDA-related activities, disease re-assessments, and operational research. Prior

to FY16, SCI supported MDA and assessments in districts with low SCH endemicity (considered as prevalence between 1% and 10%). In FY16, SCI and RTI swapped and/or transferred certain districts, with the agreement of the MOH, enabling SCI to support districts that are endemic for SCH and STH only, and enabling RTI to support districts that are endemic for SCH and STH together with other NTDs (LF, OV, trachoma). ENVISION will continue to support these “new” districts whatever their level of SCH endemicity.

For the operational research component, SCI collaborates with institutions supported by the European Union (EU), Wellcome Trust, Medical Research Council (MRC UK), The Royal Society (UK) and Kenya Medical Research Institute (KEMRI) .

**The Trust** provides funding support for the NTDCP’s implementation of the Surgery (S), Facial cleanliness (F), and Environmental improvements (E) components of the SAFE (Surgery–Antibiotics–Facial cleanliness–Environmental improvements) strategy for elimination of blinding trachoma, through The Carter Center which administers the funds and manages planning and coordination, and Sightsavers and CBM which serve as implementing partners. The focus is the S component, with some complementary support for the F and E components.

Through calendar year (CY) 2016, activities have consisted of field surveys for TT especially in districts where there seems to be a disparity between the TT backlog reported in earlier surveys and the “observed” prevalence of TT; and large-scale TT surgery camps in 17 districts of Eastern Uganda including all districts of Busoga and Karamoja sub regions, some of which have now reached the Ultimate Intervention Goals (UIGs) for trachomatous inflammation – follicular (TF) and TT required for elimination of trachoma. In 2017, the Trust will extend these activities to the rest of the trachoma-endemic districts in Northern, Western and West Nile regions.

The Trust is also supporting small-scale facial cleanliness and environmental improvement initiatives through its WASH partners, Water Mission Uganda, Water Aid Uganda, and Busoga Trust, over the period 2016-2018. The John Hopkins School of Public Health’s Center for Communication Programs (CCP) signed an agreement with The Carter Center/The Trust to provide strategic communication technical support to these WASH partners. CCP is currently finalizing updated integrated IEC/behavior change communication (BCC) materials, on the basis of the existing IEC materials and communication strategy shared with them by RTI.

### **Trachoma WASH partners**

1. **WaterAid** is currently involved in small scale sanitation programs in Busoga and Karamoja sub regions. Their support targets selected sub counties and parishes, not the whole district.
2. **Water Mission** is conducting a three-year program (2016-2018) in all 10 districts of Busoga sub region in eastern Uganda. They plan to cover 88 sub counties and 587 parishes in these 10 districts. They are focusing on community sanitation by training district and sub county leaders, Parish and Community F and E Ambassadors of Change (AoC). The training targets community leaders at various levels, including teachers, opinion and religious leaders and politicians at Parish Level. They are trained on the causes, transmission, control, and prevention of trachoma. Water Mission also supports water harvesting for domestic use and the establishment of community water points (taps). They are currently working in some sub counties in eastern Uganda including the districts of Buyende and Namayingo.
3. **Busoga Trust** supports water supply and sanitation programs in Busoga sub region. It is managed by the Church of Uganda.

4. **John Hopkins University-CCP:** The CCP's main focus is on research on communication barriers and designing appropriate IEC and BCC materials for the elimination of trachoma.
5. **UNICEF:** UNICEF is one of the key WASH partners in the country; funding WASH-related programs in schools and working closely with the MOH's Health Promotion and Education Division (HPED) and Environmental Health.

**WHO/Uganda:** Globally, WHO sets the guidelines for control and elimination of NTDs and coordinates the donation of albendazole (ALB) for LF and STH, praziquantel (PZQ) for SCH, and ivermectin (IVM) for LF and OV. In Uganda, WHO's Country Office participates in NTD Technical meetings, NTD Secretariat meetings and planning meetings. From 2005-2015, WHO funded a study, conducted by the MOH's Vector Control Division (VCD), to assess the impact of deworming on STH in a total of ten districts (two per region) drawn from five regions (Karamoja, Eastern, Central, Western, and West Nile), selected based on potential favorable conditions for transmission of STH (SCH was not targeted, but since the diagnostic method is the same, it was also reported as well). WHO also supports the Program in areas of diagnostics (specifications, sources), joint applications for donated NTD drugs, and through the Regional Program Review Group (RPRG) where it advises Uganda on implementation units to undertake TAS or stop MDA for LF.

**Malaria Consortium Uganda** is piloting Podoconiosis case detection and management in Kibaale, Kyenjojo and Kamwenge Districts, with activities including training of health workers, supportive supervision, and community awareness-raising through mass media and production of IEC and training materials, expected to continue into 2017. The Consortium has shown interest in supporting morbidity management and disability prevention (MMDP) for LF.

**Footworks** carried out training of health workers in case management for Podoconiosis in October 2015, for participants from Kamwenge, Kabarole, Kibaale, Ibanda (western Uganda), Kween, and Manafwa (eastern Uganda) districts. It is hoped that they will extend similar support to other highly affected districts such as Nakapiripirit and Napak in eastern Uganda, which are co-endemic for Podoconiosis and LF.

**Table 1: NTD partners working in Uganda, donor support and summarized activities**

Partner	Location	Activities	Is USAID providing direct financial support to this partner?	List other donors supporting these partners/activities
RTI ENVISION	Central level 55 districts (MDA)	<ul style="list-style-type: none"> <li>•Ongoing technical assistance [TA] to the NTDCP, including support for implementation of WHO tools (Integrated NTD Database, Tool for Integrated Planning and Costing [TIPAC], Tropical Data survey system)</li> <li>•Training on NTDs and MDA for central, district, and sub-district-level personnel</li> <li>•MDA for LF, OV, SCH, STH, and trachoma</li> <li>•Ongoing TA for M&amp;E of NTD program activities</li> <li>•Disease-specific assessments for LF (pre-TAS, TAS1, and TAS2), trachoma (impact</li> </ul>	Yes	None

Partner	Location	Activities	Is USAID providing direct financial support to this partner?	List other donors supporting these partners/activities
		and surveillance surveys), SCH-STH (re-assessments) <ul style="list-style-type: none"> <li>•Procurement of drugs and diagnostics not available from donation programs, as needed (may include Filariasis Test Strips and Kato-Katz kits, and Praziquantel and Tetracycline eye ointment)</li> </ul>		
CBM	Northern and Eastern Uganda	Implementing partner for TT surgery and trachoma-related field surveys	No	The Trust
SCI	Central Region (districts along the shores of Lake Victoria and Victoria Nile and island districts within the Lake) and Western Uganda	Technical assistance, capacity-building, operational research, MDA and reassessments of prevalence, intensity and morbidity in high and low-SCH endemicity districts	No	DFID
Sightsavers	a) Busoga sub region in Eastern Uganda (7 districts) Karamoja sub region in Eastern Region (5 districts) ----- b) Bunyoro-Western (4 districts)  c) Northern Region in 4 districts  d) Northern Uganda in 4 districts	a) Technical and financial assistance to NTDCP and district local governments for strategic planning, capacity building, equipment for TT surgeries and eye care; logistics, motorcycles, mobile sound systems for IEC campaigns in Karamoja sub-region where radio services are not well developed  b) OV control and elimination activities in 4 districts (MDA and <i>Simulium</i> vector control)  c) <i>Simulium</i> vector control, involving dosing of rivers with Abate (an organophosphate)  d) MMDP activities – rapid assessment of magnitude; lymphoedema management and hydrocelectomies in 4 districts	No	The Trust; Standard Chartered Bank (Uganda); Standard Chartered Bank; DFID
The Carter Center	37 OV-endemic districts  Karamoja (7 districts) Busoga (8 districts) Northern and western regions (15 districts)	Capacity building, planning, support to MOH and districts for OV MDAs; Vector control/elimination; Entomological surveillance; OV impact assessments; Post PTS and KAP studies Lead agency for technical assistance (TA) and funds management for TT surgeries and WASH activities for The Trust  TT surgeries in trachoma-endemic districts of northern and western Uganda, beginning in April 2017	Yes	The Trust

Partner	Location	Activities	Is USAID providing direct financial support to this partner?	List other donors supporting these partners/activities
WHO-UG	In all NTD endemic districts with active PC-NTD programs	At country level, provides technical support, coordination of capacity building/trainings, and assessment of interventions on STH infections	No	WHO Uganda, AFRO, and Geneva
Trachoma WASH partners (Water Mission, Water Aid, Busoga Trust, AVSI/Italian Cooperation, World Vision and John Hopkins University)	Busoga and Karamoja regions	Financial and technical support for trachoma-related WASH activities and BCC	No	The Trust
Lions Club Uganda	Central level	Advocacy at national and district levels  Act as a conduit for funds in support of trachoma implementation activities through The Carter Center (TT surgeries and F and E activities)	No	Lions Club International
Environmental Health Division, MOH	All regions	Guidelines on sanitation; Hand-washing programs in schools; latrine coverage surveys in districts; M&E	No	WHO; DANIDA; DFID, GIZ, Italian Cooperation; others
Ministry of Education's School Health Department	All regions	Deworming, sanitation, and WASH activities in schools  Training of teachers in charge of pupils' health and sanitation  Policy formulation, coordination, advocacy, training and M&E	No	UNICEF

## 2) National NTD Program Overview

In all NTD-endemic districts supported by USAID and other partners, the NTDCP's NTD Secretariat and targeted districts coordinate the following activities prior to, during, and after MDA:

- Advocacy to district leaders
- Training of district trainers, sub county supervisors, parish supervisors, teachers, and community drug distributors (CDDs), also referred to as Community Medicine Distributors (CMDs and CDDs are volunteers selected by their communities)
- Sensitization, health education, and mobilization of communities; MDA
- Monitoring of adverse events (AEs) including Serious Adverse Events (SAEs)
- Data collection, compilation, and reporting

These activities last from one to two months, depending on the number of drug packages to be distributed in the district. Other activities include disease-specific assessments (DSAs) including impact and surveillance surveys, reassessments, pre-transmission assessment (TAS) surveys and TAS surveys, as and when required. The NTDCP carry out extensive national and district-level capacity building, including the training of specialized survey teams, district focal persons, district health officers (DHOs), and central supervisors and advocates. Trainings and/or refresher trainings remain necessary due to staff transfers, mobility within and outside districts, and to continually reinforce the pertinent messages. All the above activities are integrated across all PC-NTDs.

USAID's support to the NTDCP commenced in 2007, focusing on the integration of four vertical PC-NTD programs, the completion of mapping of all PC-NTDs, and the scaling up of MDA to all eligible districts. The national NTD program commenced integration of its PC-NTD programs in 2007, with this USAID support.

### a) Lymphatic Filariasis

In Uganda, LF is transmitted by the common malaria mosquitoes (*Anopheles gambiae* and *Anopheles funestus*). The Culex mosquito is also important in urban areas. Baseline epidemiological studies and rapid mapping of LF started in 1998, using chronic clinical manifestations, circulating filarial antigen (CFA) prevalence, and night blood smears to detect nocturnally periodic microfilariae (Mf). The first baseline surveys revealed that LF was highly endemic in parts of Northern and Eastern Uganda, with prevalence higher than 30% in some areas. The most common clinical manifestation was hydrocele, followed by elephantiasis. Rapid mapping of LF using CFA in school children and adults was conducted throughout the country from 2000 to 2002. These surveys showed that LF was widely distributed, but mostly concentrated in areas of Northern and Eastern Uganda, which lie north of the central lakes (Kyoga and Kwana). A small focus was found in Bundibugyo and Ntoroko Districts in Western Uganda along the border with DRC, where the disease is associated with *A. bwambiae* (of the *An. gambiae* species complex) which breeds in the hot sulfur springs.

The MOH's Program to Eliminate Lymphatic Filariasis (PELF) is part of the VCD. The national plan for LF elimination aims to eliminate LF by 2020 through a multi-pronged approach, consisting of the : (1) annual MDA with IVM and ALB in all 57 originally-endemic districts; (2) MMDP to reduce the burden of LF chronic manifestations in affected populations; and (3) other interventions that impact on LF, such as long-lasting insecticide-treated nets (LLINs) and indoor residual spraying (IRS).

Uganda first conducted MDA for LF in 2002 in Lira and Katakwi districts (now split into 7 districts), treating more than a million people, with minimal AEs. The PELF extended MDA to five, then 12 districts, with support from WHO and the Liverpool LF Support Centre. This was one-off support, as most partners

were uncomfortable with the political situation in the country. The civil war and insurgency that escalated in eastern and northern Uganda in 2003 interrupted treatment in that year and in 2006.

With the support of USAID, LF mapping was completed in the whole country in early 2010 and distribution maps were produced. MDA was fully scaled up, with 100% geographical coverage, by the end of 2010.

Since the commencement of USAID support, LF-endemic districts have conducted five or six rounds of MDA, although some of the rounds might have not achieved sufficient, 65% epidemiological coverage. Transmission assessment surveys (TAS) conducted through FY15 indicated that LF transmission has been interrupted in 35 districts (with approximately 8.4 million people freed from risk of infection). An additional eight districts conducted, and passed, TAS in FY16; per WHO/Uganda's guidance, the MOH has submitted a request to the RPRG for these districts to stop MDA (it may be noted that this is contrary to advice provided by ENVISION staff, that RPRG approval is not needed for stopping following a successful TAS). Five more districts will conduct TAS in FY17. This means that just nine districts (including one new district, Omoro) with a total population of about 2.5 million people are being targeted for MDA in FY17. There are clear indications that interruption of LF transmission may be achieved throughout the country by or before 2020.

The districts that are still in need of treatment include some of the more difficult populations to reach, and there is a need for an improvement in MDA drug coverage rates. The most heavily affected districts are in the Northern region where, historically, the chronic manifestations of LF (hydroceles and elephantiasis) are most common. The PELF remains confident that these districts will achieve stop-MDA status by 2020 and some of the pre-TAS surveys point in this direction.

MMDP is the second component of the LF elimination strategy. Support for this component will commence in CY 2016, from Sightsavers in the northern districts of Gulu, Lamwo, Pader, and Kitgum. The support is towards the rapid assessment of the burden in these districts, with lymphedema management and hydrocelectomies to be conducted in some of the health facilities. Planning for this support has been completed by PELF and Sightsavers and a vehicle will also be provided to the PELF PM to facilitate his movements in the country, with field activities expected to commence before the end of CY2016. The Malaria Consortium has expressed interest in supporting MMDP but this is yet to be formalized.

Vector control interventions such as IRS and use of LLINs under the MOH's Malaria Control Program indirectly contribute to LF elimination in Uganda. The MOH is conducting IRS in malaria hyper-endemic districts of Northern and Eastern Uganda, where LF is also co-endemic. The MOH has distributed LLINs in all of the country's districts. If these initiatives are sustained, they will help to wipe out residual transmission.

## b) Trachoma

The NTDCP trachoma program's baseline mapping showed 44 districts to be endemic (defined as  $\geq 5\%$  TF). Baseline epidemiological mapping of trachoma using WHO methodology started in 2006 with the financial support of Sightsavers. The surveys covered two districts from Karamoja sub-region and four from Busoga sub-region. The surveys showed that trachoma was highly endemic in all the districts surveyed, with TF rates in children ranging from 30% to 65%. Mapping of the rest of the country commenced with the establishment of the NTDCP in 2007, starting with priority regions in northern and eastern Uganda. By 2011, 51 districts originally suspected endemic for trachoma had been mapped, showing TF prevalence ranging from 5% to 67% in 44 districts, and TF of  $< 5\%$  in the other seven districts. A desk review conducted in 2014, with ENVISION technical and financial support, of eight districts



neighboring known trachoma-endemic districts, analyzed eye clinic and Health Management and Information System (HMIS) records for reported eye infections and morbidity including TF, TT and evidence of corneal scarring. The review showed just one district (Pallisa) with evidence of significant active trachoma; the district then registered TF of 5%-9.9% when subsequently mapped following Global Trachoma Mapping Project methodology.

The WHO SAFE strategy for trachoma elimination guides the NTDCP trachoma activities. The first MDA with Zithromax (ZTH) and tetracycline eye ointment (TEO) commenced in eastern Uganda in 2007, with scale-up to 100% geographic coverage by 2013. The NTDCP has conducted MDA in 36 endemic districts (38, with redistricting), based on their baseline TF prevalence and impact survey results: at least one round with sufficient coverage in districts with prevalence of 5-9.9%, three rounds in districts with prevalence of 10-29.9% and at least five rounds in districts with TF of  $\geq 30\%$ . In FY17, the NTDCP will conduct MDA in two districts, both in Karamoja sub region, with ENVISION support. Additional districts could be targeted, depending on the results of surveys planned in late FY16 (see below).

As of June 2016, the NTDCP has conducted trachoma impact surveys (TIS) showing that MDA can be stopped in 22 districts. TIS are scheduled for late FY16 (August 2016) in Masindi, Kiryandongo, Kitgum, Lamwo, Amolatar, and Oyam Districts. Re-surveys are also scheduled for late FY16 (July 2016) in Butaleja, Pallisa, Yumbe, Apac and Kole Districts, all of which registered 5-9.9% TF at baseline between 2009 and 2012 and have not initiated MDA. As conditions may since have changed, these surveys are required to guide the decision whether to initiate MDA and how many rounds would be needed. In FY17, the NTDCP will conduct TIS in eight districts.

Based on the results of trachoma mapping surveys, the MOH has conducted TT surgeries with support from NGOs including CBM, Sightsavers, and the Lions Club, with Sightsavers performing most of the surgeries through surgical camps at health units and in the field. These surveys indicated that trachoma was highly endemic (TF of  $\geq 30\%$  and TT of  $\geq 10\%$ ) in the seven districts of Busoga sub-region, Eastern Region, which are occupied by the Basoga tribal group. Sightsavers and CBM support TT surgeries and other eye care services such as glaucoma in this sub region. As noted above, in 2014 the Trust started to support TT surgeries and some activities related to the "F" and "E" components through Water Aid, Water Mission and Busoga Trust.

### c) Onchocerciasis

OV, caused by the filarial worm *Onchocerca volvulus*, was originally endemic in 37 of 112 districts. An estimated two million people are infected, and nearly three million people are currently at risk of infection. These numbers are currently being reviewed by the NTD Secretariat following successful interventions in many foci where transmission has been interrupted and MDA stopped, and may consequently be reduced. As of June 2016, 18 districts have been able to stop MDA for OV – a major accomplishment. MDA is continuing in only 23 districts.

Following years of interventions, the remaining foci that are most endemic are those located in the districts of northern Uganda, bordering South Sudan, where the disease is associated with blindness and (recently) Nodding Syndrome (NS). These northern districts are recovering from the effects of civil war; many disease-control activities were significantly delayed because it was not possible to conduct mapping and MDA activities during that period. In the aftermath of the war, participation in MDA remains low due to trauma and suspicion of government-supported activities. Epilepsy, a common feature of NS, has been reported from many OV foci, including those northern districts as well as Buliisa, Masindi, Hoima and Kibaale in western Uganda; earlier, it was observed in Budongo and Kashoyi Kitomi

Foci. In the mid-1950s, in Victoria Nile focus, the rare clinical condition Nakalanga Syndrome (endemic dwarfism) was also associated with OV.

The strategy for OV control and elimination in Uganda is twice-yearly MDA, paired with vector elimination/control where feasible. The latter is determined through vector prospecting to show the degree to which a focus is isolated, something which depends on the flight range of the vector. Uganda's National Onchocerciasis Certification guidelines have set targets of 95% for program coverage and 80% for epidemiological coverage (more ambitious than WHO's target of  $\geq 80\%$  therapeutic coverage of the eligible population), with the intent of speeding up progress towards elimination. The MOH's VCD has an advanced modern molecular laboratory, funded by The Carter Center.<sup>2</sup> Field assessments, including entomological and serologic data collection, are supported by ENVISION through The Carter Center.

OV mapping and vector surveys were conducted from the mid-1940s to the mid-1970s when the economic and political situation became unstable. From then until the mid-1990s, practically the only OV-related activity was monitoring of the Victoria Nile Focus where the vector had been eliminated and dosing of rivers flowing from Mt Ruwenzori on the border with DRC. Mapping resumed in the mid-1990s, with support from WHO, German Technical Cooperation Agency (GTZ)/German Corporation for International Cooperation (GIZ), WHO/African Programme for Onchocerciasis Control (APOC), and River Blindness Foundation (USA), finding that nodule prevalence ranged from 10% to about 30% and parasite prevalence (microfilariae) was up to 100% in OV-endemic areas.

Large scale OV control started in the 1950s in the Victoria Nile focus, consisting of intermittent treatment of the River Nile with low doses of dichlorodiphenyltrichloroethane (DDT), a chlorinated hydrocarbon insecticide. This larviciding resulted in elimination of the *S. damnosum s.l.* vector in that focus in 1974. Skin snip and entomological surveys conducted periodically by the VCD since then, have confirmed the elimination of this vector, and of OV, from this focus.

From 1992 to 2007, the MOH conducted MDA with IVM for OV annually. In 2007, the MOH's National Onchocerciasis Control Program (NOCP) launched a two-pronged control and elimination strategy, as recommended by WHO and APOC. The strategy entailed: (i) MDA once or twice per year in all endemic foci, using IVM alone or in combination with ALB in areas co-endemic for LF, and (ii) vector control/elimination campaigns in all isolated foci and in some semi-isolated foci where control/elimination was deemed feasible by the NOCP. Areas targeted for OV control conducted treatment annually whereas areas targeted for OV elimination conducted treatments twice per year. Both the annual and semiannual treatment strategies incorporate aspects of the community-directed treatment with IVM (CDTI) approach, in which communities play a key role in making decisions about how to run the program, who should distribute IVM, and the method of distribution (central or house-to-house)

In 2007, the MOH launched an elimination policy with twice-yearly treatment in five foci where OV is targeted for elimination with IVM. The Mid-north districts adopted this approach as well, in 2010 after peace was restored in the area.

USAID's support for OV control and elimination began in 2007, via support for the MOH's integrated PC-NTD platform. In areas co-endemic for LF and OV, with twice-yearly MDA, the first round targets LF/OV, and the second round targets OV alone, both with ENVISION support.

The NOCP currently implements MDA in 23 endemic districts. This MDA is conducted twice per year in 21 districts (led by the NOCP) and once per year in two districts that are co-endemic for LF and that have

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<sup>2</sup> The MOH provides personnel including scientists and technicians, and The Carter Center provides reagents, technical guidance and operational funds.

not been targeted for OV elimination by the NOCP (led by the PELF, with support from RTI ENVISION). In the 21 districts that conduct two rounds of MDA, the first round is for OV only and the second round is for OV integrated with other targeted PC-NTDs, as appropriate (typically LF or STH). ENVISION supports all of these districts for at least one round, and Sightsavers jointly supports three of these districts (Masindi, Buliisa, and Hoima).

USAID also supports: (a) trainings at different levels, (b) mobilization and sensitization (health education), (c) MDA registration or register updates, (d) epidemiologic assessments, (e) coverage validation and reporting, (g) IEC materials (that will align with the overall IEC strategy), and (h) cross-border surveillance. Apart from MDA treatment and data validation that will take place twice in a year, and entomological assessments that will be done monthly depending on the focus status, the rest of the activities will be conducted once per year.

Since 2007, MDA for the treatment of OV has been halted in 18 districts (10 foci) and MDAs are continuing in 23 districts found in Bwindi, Nyagak-Bondo, Lhubiriha and Madi-Mid-North. MDA will continue in the foci of Nyagak-Bondo, Bwindi and west Nile, where transmission is suspected interrupted, until the status of OV in the DRC border districts is established.

The NOCP supplements MDA with vector monitoring and/or control in six of the nine foci where MDA is ongoing, with support from The Carter Center and other partners (non-USAID funds). Sightsavers is supporting vector control in the Northern focus, where disease endemicity and transmission rates have been high. The NOCP conducts river-dosing activities in some foci, using Abate insecticide as a larvicide (provided by The Carter Center, with non-USAID funds). Analyses of fly and blood samples from residents in endemic areas are conducted at the VCD's advanced molecular biology laboratory. Post-treatment surveillance surveys, to determine recrudescence potential and infection with OV parasites, are conducted through parasitological indicators (skin snips microscopy for microfilariae and Ov-16 ELISA serology for parasites in blood) and entomological indicators/xenodiagnosis (polymerase chain reaction (PCR) analysis of black flies for infective larvae).

PTS surveys have been conducted in all the foci where MDA has stopped, showing no cases or signs of recrudescence to date. Crab trapping is part of the surveillance to monitor foci where vectors have been eliminated. The fresh water crabs (*Potamonautes spp*) live in phoretic association with the larvae and pupae of *S. neavei* complex. Crabs are trapped with locally made traps and the crab catches are examined for the larvae and pupae of *S. neavei sl* which attach themselves to the body and limbs of the crabs. The larvae, pupae and pupal cases (exuviae) of *Simulium* flies are picked from the crabs and examined under a dissecting (stereo-microscope) and identified to species level using morphological criteria, and preserved. The numbers caught are recorded to determine any changes in species composition and abundance. In some foci, crabs have disappeared following dosing of rivers and or deforestation along streams that used to breed the crabs and support *Simulium* fly breeding. Larval infestation of crabs is an indirect way of measuring the level of vector infestations in a focus. Human landing catches are also in use to collect biting adult *Simulium neavei sl* and other fly species.

In FY17, ENVISION will continue to support monthly fly captures in places where treatment is still ongoing, and crab captures to see if they are carrying immature stages of the *Simulium neavei* black flies. The MOH plans to continue these activities during the PTS period after transmission is interrupted. In selected foci, The Carter Center will continue to support river dosing with Abate.

The Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) was formed in 2008, to review the country field and laboratory progress reports using the national OV elimination guidelines and to advise the national government whether MDA should be stopped. The UOEEAC is composed of Ugandan and international OV experts, with Prof. Tom Unnasch from the University of South Florida

currently serving as chair. The UOEEAC's annual meeting is financially supported by The Carter Center and ENVISION. UOEEAC responsibilities are to (i) review programmatic activity reports from each elimination-targeted focus in Uganda annually; (ii) advise the MOH on focus-specific M&E activities and recommend halting of treatment when appropriate, in accordance with international and national guidelines; and (iii) make any other recommendations to the MOH on activities needed to reach the national 2020 OV elimination goal. Please see Appendix 9 for the August 2016 version of the UOEEAC's OV "flag."

#### d) Schistosomiasis and STH

The objective of the NTDCP's Bilharzia and Worm Control Program (BWCP) is to eliminate SCH and STH morbidity by 2020, and to reduce prevalence to a manageable level by 2020. Low-endemicity SCH districts are targeted for elimination and already some districts are showing very low prevalence following several years of MDA.

##### Schistosomiasis

SCH, due to *Schistosoma mansoni* for intestinal SCH and *S. haematobium* for urogenital SCH, is endemic in 87 districts. *S. mansoni* is the more common of the two, occurring in all 87 districts; *S. haematobium* is now confined to a few districts in northern Uganda, where it is co-endemic with *S. mansoni*. In Uganda, SCH is associated with large water bodies, permanent and semi-permanent rivers, streams, water reservoirs constructed for watering animals, and irrigation schemes.

The MOH's strategy for SCH is to focus on the control of morbidity, through treatment of at-risk groups according to WHO risk categories and adjusted to reflect the high levels of SCH transmission in the country. In high-risk ( $\geq 50\%$  prevalence) areas, the NTDCP follows WHO guidance in treating school-age children (SAC) and high-risk adults annually. Historically, the NTDCP has treated SAC annually in moderate-risk ( $\geq 10\%$ - $< 50\%$  prevalence) areas, and once every two years in low-risk ( $\geq 1\%$ - $< 10\%$  prevalence) areas, as compared to WHO recommendations for once every two years and twice during primary schooling age, respectively. It should be noted that the NTDCP often conducts MDA for SCH at sub-district level, based on ecological zone, meaning that within a given district more than one treatment strategy may be applied. Efforts are in progress to identify these sub-district-level differences in the Integrated NTD Database. The NTDCP conducts SCH prevalence evaluation surveys once districts complete their fifth or sixth round of SCH MDA, and in general it does aim to adjust the treatment strategy for the district depending on the findings, however this is complicated by the fact that strategies are often determined at sub-district, by ecological zone.

The MOH initiated SCH baseline surveys in 1988 along the shores of Lake Victoria, later extending these to other parts of the country with support from the African Development Bank and the Danish Bilharziasis Laboratory (DBL). These surveys revealed that *S. mansoni* is endemic in 87 districts, and *S. haematobium* is found in only five districts of the Lango sub-region (Apac, Kole, Oyam, Lira, Dokolo), where it is co-endemic with *S. mansoni*. However, *S. haematobium* has virtually disappeared from these districts following years of MDA. The areas affected most by any type of SCH are around the shores of Lakes Victoria, Lake Kwana, Lake Kyoga, Albert Nile, and Lake Albert on the Uganda–DRC border. In some areas, SCH prevalence was found to be almost 100%, with high intensity of infection.

Approximately 5.4 million people are estimated to be infected, and 10.9 million people are at risk, of SCH. Of the endemic districts targeted for SCH MDA, 35 are considered high risk with intense transmission and high re-infection rates, 13 are moderate risk, and 39 are of low risk, with low

transmission and re-infection rates. Human behavior, cultural practices, poor sanitation, cross border movements in search of fish and snails, suitable temperatures, and highly susceptible snail hosts and perennial transmission, maintain the high SCH endemicity in many parts of the country.

For certain districts in the Albertine Rift valley (Nebbi, Buliisa, Hoima, Ntoroko) and in the east (Namayingo and Mayuge), reinfection rates are high and there are concerns that the SCH situation is not improving; consequently the Technical committee, national and regional meetings, and the recent joint NTDCP-SCI SCH review / feedback workshop have called for intensified efforts including possibly twice-yearly MDAs or operational research. Recent studies by VCD and MRC have shown that in a cohort of school children who were treated and cleared of *S. mansoni* eggs, almost 80% were re-infected and shedding *S. mansoni* eggs when re-examined three weeks after treatment. Also, up to 50% of children under five, who are not treated with PZQ (for lack of pediatric formulations), were found to be infected. In FY17 ENVISION will facilitate community dialogue on SCH prevention practices, including improvement of PZQ uptake in SAC and high-risk adults. Major landing sites will be used to initiate discussion with community members and involve Beach Management Units (BMUs – management units of landing sites/marinas, elected by residents to implement regulation of fishing, health, and security) and local leaders. These community dialogues will intensify social mobilization and health education, with all activities closely supervised by the districts, NTD Secretariat and RTI. ENVISION will also support visits by district political leaders to the densely populated landing sites, to conduct mobilization for MDA.

#### Soil Transmitted Helminthiasis

The MOH's strategy for STH is to deworm children ages 1-15 years twice per year, during Child Health Days (CHDs), everywhere in the country. MDA has been scheduled to align with the Child Health Days, thus integrating the two programs. In districts that are co-endemic for LF, the ALB required for STH MDA is provided via the PELF's LF MDA. In cases where LF funds and or drugs are delayed, districts generally postpone their CHDs while waiting for the LF MDA resources.

STH is endemic in all 122 districts, based on reported cases through the HMIS and baseline surveys. In Uganda there are four nematode species of public health importance. These are *Ascaris lumbricoides* (roundworms), *Trichuris trichiura* (whipworms), and *Ancylostoma duodenale* and *Necator americanus* (hookworms). Hookworm is homogeneously distributed in the country, exceeding 60% mean baseline prevalence in SAC. *A. lumbricoides* and *T. trichiura* are concentrated in south-western Uganda, where the prevalence can be as high as 100%, with heavy intensities (but now *T. trichiura* seems to be spreading to central Uganda due to migration, as evidenced from recent SCH re-assessment surveys). The NTDCP's MDA for LF, funded by ENVISION, has contributed to control of STH. The MOH also conducts school-based deworming using ALB or MBD semiannually, in April and October, during Child Health Days (which includes schools), coordinated by the Child Health Division and jointly funded by the MOH's primary health care funds and funds from UNICEF. (In districts co-endemic for LF and STH, the MDA is integrated, so children take a combination of IVM+ALB (or ALB alone for under-fives) during the first round of treatment and ALB alone in the 2nd round.) Schools also participate in sanitation programs, have sanitation clubs, and run competitions during sanitation weeks.

#### Integrated SCH-STH

Data on the prevalence and distribution of SCH and STH in Uganda are collected via stool and urine surveys which have been conducted over decades by VCD. Stool samples were once processed using centrifugation method but now is rarely used because it is time consuming. The method of choice is Kato-Katz technique of stool examination, which provides information on both *S. mansoni* and the range of types of STH. Urine samples are sometimes tested with Haemastix® testing for blood in urine or

centrifuged. The samples are examined and the eggs / ova are counted to determine the intensity of infection. In recent years the Circulating Cathodic Antigen (CCA) point-of-care test has also been used, in low-risk areas where SCH is targeted for elimination, due to its higher sensitivity, particularly for light infections.

SCH and STH MDA are integrated, per WHO best practices, where non-LF districts use ALB from other sources or Mebendazole donated by Children Without Worms. The first integrated MDA was launched in 2003, funded by SCI. MDA with praziquantel (PZQ) and ALB, conducted in communities and schools, annually in high and moderate risk communities and every two years in low-risk communities, is the main strategy for SCH and STH control, combined with sanitation promotion and behavior change. The objectives of the program are to reduce incidence of heavy infections; lower the intensity of transmission; and prevent development of gross morbidity and damage to the spleen, liver, and bladder due to heavy worm loads and long term chronic infections. In low-risk districts, MDA targets SAC only. Where high infection rates are reported in adults, adults are treated as well. Presently, ENVISION supports STH MDA only through MDA for LF (which includes ALB, one of the drugs used for STH).

The MOH aims to conduct surveys for SCH (and STH) after three years of MDA (called “re-assessment surveys”) to assess the impact of MDA on SCH prevalence and intensity. In theory the findings could be used to steer the program’s strategy – if a district changes risk category, then the frequency of treatment could be adjusted accordingly in line with WHO guidance. The surveys are based on LQA sampling method and using the Kato-Katz technique.

After five or six years of MDA, morbidity is included in the MOH’s SCH-STH surveys. Morbidity indicators, including spleen length, splenic vein diameter, liver size and liver image pattern, portal vein walls and diameter, and evidence of pipe-stem fibrosis, are detected by ultrasonography. These morbidity indicators, together with the prevalence rate and intensities (eggs per gram) detected, are used to measure the impact of MDAs on the burden of the disease in a given area. Generally, prevalence and intensity have been reduced in the majority of districts, and morbidity indicators have improved in all surveyed districts.

### 3) Snapshot of NTD status in Uganda

**Table 2: Snapshot of the expected status of the NTD program in Uganda as of September 30, 2016<sup>3</sup>**

		Columns C+D+E=B for each disease*			Columns F+G+H=C for each disease				
		MAPPING GAP DETERMINATION			MDA GAP DETERMINATION		MDA ACHIEVEMENT	DSA NEEDS	
A	B	C	D	E	F		G	H	I
Disease	Total No. of Districts in Uganda	No. of districts classified as endemic	No. of districts classified as non-endemic	No. of districts in need of initial mapping	No. of districts receiving MDA as of 09/30/16		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/16	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/16	No. of districts requiring DSA as of 09/30/16
					USAID-funded	Others			

<sup>3</sup> This represents the 2017 geography of 122 districts.

Lymphatic Filariasis	122	57	65	0	16	0	0	41	Pre-TAS: 0 TAS1: 5 TAS2: 16 TAS3: 0
Onchocerciasis		37	85	0	23 <sup>4</sup>	0	0	14	0
Schistosomiasis		87	48	0	44	43	0	0	0
Soil-transmitted helminths		122	0	0	16	106	0	0	0
Trachoma		44	78	0	9	0	5 <sup>5</sup>	30	TIS: 8

## PLANNED ACTIVITIES

### 1) NTD Program Capacity Strengthening

#### a) Strategic Capacity Strengthening Approach

#### **Objective 1. Strengthen capacity for annual work planning and activity planning:**

- a) Participation of NTDCP personnel (four program managers and four senior program staff) in a two-week evening course on Project Planning and Management offered by the Uganda Management Institute (either at the UMI campus or by special arrangement at the VCD office). Topics covered will include problem analysis, participatory approach, project planning, management, monitoring and evaluation, procurement, business and investment plans.

The course is expected to increase the participants' knowledge and skills in problem analysis, M&E, participatory approaches towards project planning and management, and procurement.

- b) It is planned that ENVISION staff will assist the NTDCP in identifying opportunities to use the TIPAC tool in a more focused manner, namely by narrowing the scope for specific activities (e.g., how to continue support for SCH and STH MDA as MDA for LF is progressively stopped).

#### **Objective 2. Strengthen capacity to manage PC-NTD data and to use data for programmatic decision-making:**

- a) Participation of the MOH's NTD Data Manager in a three-week-long training on M&E on Information Systems and Database management at the Uganda Management Institute. This course will help to equip the staff member to take on many of the national PC-NTD M&E tasks that up until now have been undertaken by RTI staff.
- b) Workshop convened to use national PC-NTD data for programmatic decision-making. The NTDCP has compiled a great deal of NTD data in the Integrated NTD Database. ENVISION and SCI will jointly fund a meeting to focus on using the country's own data, to enable more informed

<sup>4</sup> In three of these districts, Sightsavers supports one round of MDA.

<sup>5</sup> These are the five districts that registered between 5 and 9.9% TF at baseline and have not initiated MDA, and are conducting resurveys in FY16 (results not yet known).

programmatic decisions. About 30 participants are expected to attend the workshop; SCI will cover the cost of ten of these.

- c) Training 20 NTDCP Managers and senior staff on the Integrated NTD database: The MOH's NTD database is undergoing final updates and will soon be ready for uploading onto a server, from where staff will be granted access. Staff were introduced to the database during its development but it is necessary to train them in its use. This will ensure that staff can access and extract data from the database for use by MOH, districts and partners.
- d) Harmonization of data in districts that have achieved stop-MDA criteria for LF and/or trachoma. ENVISION will technically support the NTDCP's national data manager, the M&E Assistants, and other officers to selected districts that have stopped MDA, to ensure that all MDA records are available locally. The need for this was noted in DQAs which found that most districts do not have copies of reports or that data contained within the reports are not the same as that at the central level; and is required as part of preparation of an elimination dossier for either of the two diseases.

Central teams will travel to the districts with copies of progress and MDA reports covering several years. These will be compared with what is available at the district health offices and sub county. The costs cover travel for the teams going to these districts, photocopying expenses and district staff allowances.

### **Objective 3. Improve MDA treatment coverage:**

- a) Micro planning for MDA and associated activities in 16 districts (six in Albertine Region, one on the shore of Lake Victoria, two in Karamoja Subregion, and seven in Acholi Subregion) that have experienced difficulty reaching the required treatment coverage. These areas have faced specific additional challenges, such as including poor infrastructure, low literacy, sanitation/latrine coverage of  $\leq 10\%$ , and semi-aridity with frequent famine in Karamoja Subregion; post-conflict syndrome, in Acholi Subregion; and the fear of side-effects and adverse events in Albertine Region.

The central-level NTDCP and RTI will work with the respective district teams to develop district specific plans (micro planning) for MDA detailing all related activities, their dates, the persons responsible and their roles, the resources required (including drugs, registers, reporting forms, fuel, and staff allowances), supervision, monitoring, and reporting. The micro planning meetings will be held in specific districts attended by district political, civic and technical leaders where they will review their districts' situation and agree on what needs to be included in their plans. Decisions on the available resources in the district, who should participate in NTD MDA implementation, their roles, and timelines will be taken. They will commit to ensuring the plans are implemented and supported.

- b) Incorporation of Knowledge, Attitude and Practices (KAP) surveys into the planned MDA coverage validation surveys in 10 districts (RTI) and three districts (The Carter Center), to gain a more nuanced understanding of why people choose to take (or not to take) treatment. In addition, The Carter Center will be supporting KAP surveys with non-USAID funds which will provide additional information on these choices.
- c) Institute the use of supervisory monitoring forms as part of planned supportive supervision during MDA, to ensure that observations and feedback are structured and reported systematically.



**Objective 4: Planning for PC-NTD control after MDA for LF and/or OV is stopped:**

- d) Meeting to discuss plans for PC-NTD control after MDA for LF and/or OV is stopped. As much of the drug supply for STH (ALB) is provided as part of the donation of IVM+ALB for LF MDA, and as much of the funding for MDA implementation of both SCH and STH (the “control diseases”) presently comes from USAID through funding of MDA for LF and/or OV (the “elimination diseases”), it is necessary to plan for how both of the control PC-NTDs (SCH and STH) will be targeted once LF MDA is no longer required. To develop a strategy for this transition, ENVISION will support the NTDCP in organizing a workshop with relevant stakeholders, including the MOH’s School Health Program and the Ministry of Education and Sports, to consider and decide on options for program implementation and for advocacy as needed.
  - e) As noted above under Objective 1, ENVISION will work closely with the MOH to identify the optimum use of TIPAC to plan for long term PC-NTD control after LF and OV MDA has stopped. This activity will help to identify funding gaps and in advocating for supplementary support from other sources.
- b) Monitoring Capacity Strengthening

The activities mentioned above will be reported on, as a requirement of the funding for the activity, through monitoring of the following indicators:

**Objective 1. Strengthen capacity for annual work planning and activity planning:**

- a) Timely planning and reporting
- b) Improved quality of reports and plans
- c) Improved use of data for planning

**Objective 2. Strengthen capacity to manage PC-NTD data and to use data for programmatic decision-making:**

- a) NTD data accessed by all relevant personnel
- b) Data fully analyzed and reports generated and shared
- c) NTD database completed, verified and regularly updated
- d) Decisions made based on data analyzed
- e) Data in districts harmonized with Integrated NTD Database

**Objective 3. Improve MDA treatment coverage:**

- a) Detailed district implementation plans based on locally-generated data
- b) Active participation of all the district leaders before, during and after MDA
- c) Clearly spelt-out roles of the various arms of local government
- d) Timely implementation of NTD activities
- e) Timely delivery of drugs and MDA-related logistics
- f) Timely release of funds
- g) Improved inter-sectoral collaboration

**Objective 4: Planning for PC-NTD control after MDA for LF and/or OV is stopped:**

- a) Post Treatment Surveillance activities, to include STH and/or SCH, ongoing in districts that have stopped MDA for LF and/or OV
- b) Annual treatment reports shared by the National School Health Program with the NTDCP, to document ongoing treatments after community-based LF MDA ends

## 2) Project Assistance

### a) Strategic Planning

**NTD Technical Committee meetings:** The MOH provides technical guidance and support to the NTDCP through an NTD Technical Committee that was established in 2014. The committee membership includes the Commissioner of Health Services, CH as Chair; NTDCP National Coordinator; Assistant Commissioner of Health Services (ACHS) from VCD; ACHS from HPED; ACHS from Environmental Health Division; ACHS from Veterinary Public Health; ACHS from Resource Center; ACHS from Pharmacy; two DHOs (rotational); PM, Intensive Disease Management (IDM) (rotational); PM PCT (rotational); representatives from WHO and implementing partners, including the ENVISION/RTI data officer. In 2016, four members from the Trachoma Taskforce were nominated and incorporated into the NTD Technical Committee to avoid the creation of a parallel Trachoma Task Force. They include two ophthalmologists and two members from the Trust-supported F&E partners. The committee is responsible for guiding and overseeing NTD program implementation; reviewing district-level program reports; monitoring and evaluating program performance of district focal persons (FPs); serving as intermediary between the NTD Secretariat and the MOH's Senior Management Committee; advocating/mobilizing resources for NTD control and/or elimination; identifying capacity-building needs; and reviewing NTD Secretariat annual work plans, as needed. The Committee has begun to refer to data from the Integrated NTD Database in its discussions, and it is expected that this will continue in FY17.

This committee should meet quarterly but the number of meetings may be reduced depending on member availability. ENVISION will continue to support the meetings and the committee's field visits to monitor and evaluate the NTD program.

**National planning and stakeholders' annual review meeting:** The three-day National Planning and Stakeholders annual review meeting reviews past performance and develops national plans and budgets for the coming year – the FY17 meeting will develop a plan for the FY18 period. MOH participants typically include the districts, represented by DHO and FP from each of the regions; NTD Program Managers and senior program staff; and National Medical Stores (NMS). They are joined by key partners including the Carter Center, SCI, and RTI.

The 2016 meeting focused on “Ensuring quality intervention and maintaining success during a period of transition.” Recommendations from this meeting included the following:

- NTD Programs need to adapt or adopt best practices from one another to advance progress toward elimination goal: ENVISION will support this through micro-planning and reviews
- ENVISION/RTI and other partners should support STH surveys: ENVISION will support STH surveys for programmatic decision-making (as part of SCH surveys)
- Karamoja region and SCH hyper-endemic districts should be accorded special consideration in the program budgets: ENVISION will provide intensive support for MDA in Karamoja Region
- KAP studies should be carried out in trachoma and SCH hyper-endemic districts to guide program planning process and implementation practices: ENVISION will support KAP surveys as part of post-MDA coverage validation surveys
- Central Teams should take developed activity plans when travelling to districts for advocacy and supervision. This will help to properly guide the flow of activities: ENVISION will support the central-level teams' visits to the districts for advocacy and supervision

- The M&E team should conduct post-MDA beneficiary interviews to determine satisfaction in order to improve intervention quality: ENVISION will support this as part of the KAP component of post-MDA coverage validation surveys, and of community dialogue
- A documentary on NTDs needs to be developed for in-country use in social mobilization: ENVISION will support the production of two documentaries, one focused on SCH for Albertine Region and one focused on trachoma for Karamoja Region. The program is currently using posters and radio messages. However, documentaries are powerful tools for advocacy and behavior change, and have greater impact overall. Additionally, the documentaries show local examples of transmission modes, sign and symptoms of the disease and progress over time.
- The NTD Secretariat should streamline the timeliness of drug application process, clearance and distribution to endemic communities: ENVISION is already involved in assisting the NTDCP with these different phases
- SAE forms should be delivered with other program logistics: ENVISION supports the inclusion of SAE forms in deliveries of supplies for MDA
- The NTD Secretariat should liaise with the Malaria Consortium and Malaria Control Program/MOH to ensure that program messages are delivered through community dialogues/school health clubs in an integrated manner in Bunyoro and other regions: ENVISION will be supporting community dialogues in identified districts, especially in the Albertine Region. Messages on malaria, NTDs, hygiene and sanitation can be communicated through these channels.
- Health Education Department/MOH should review NTD IEC materials and BCC strategies that the program is currently using so as to make them relevant to the current situation: ENVISION will support a workshop to review the NTDCP's IEC materials and social mobilization strategy

**National data review meeting:** This meeting, conducted for the first time in FY16, reviews and harmonizes historical and current data from the five PC-NTD programs (and from the IDM program, as available)<sup>6</sup> compiled in Uganda's Integrated NTD Database. The review allows for identification of any inconsistencies or gaps in the data, and for agreement on ways to retrieve the missing data from the necessary sources. In FY17, this meeting will bring together the MOH's data manager(s) and program managers and partners, and will focus on the review of compiled data from FY15 and FY16.

**Regional planning and review workshops:** Each year, the NTDCP holds a two-day regional planning meeting in each region to review and plan for the upcoming MDA campaigns and related activities. In FY17, ENVISION will support these meetings in three regions – Eastern, Western, and Northern. The meetings are convened by the NTDCP Secretariat and involve the districts (DHOs and NTD focal persons) and implementing partners including RTI, SCI, and The Carter Center. In the meetings, the group will review coverage data and survey results, discuss specific challenges and related solutions, and develop district-level plans and budgets for FY18. These work plans will inform ENVISION's fixed obligation grants (FOGs) to these districts in FY18.

**Orientation of NTDCP staff in implementation, use of TIPAC:** ENVISION will support a TIPAC orientation for MOH Program Managers. The purpose of the orientation is to highlight specific activities the TIPAC may be used for in Uganda and outline a plan for ensuring the TIPAC focal point is able to meet with necessary stakeholders to get the necessary information. Some examples of how the TIPAC may be used

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<sup>6</sup> Data are available for HAT and Plague, and in more limited fashion for Leishmaniasis.

include preparing for a meeting to discuss transition from LF/OV MDA platforms to SCH/STH only and to assist in the annual planning meeting.

**Review and update of the National NTD Master Plan:** The MOH's current National Strategic NTD Master Plan covers the period 2014-19. The document was reviewed and updated in December 2014, with WHO support, to cover the period 2015-2020, but the process was not completed. ENVISION will support the NTDCP in conducting a three-day meeting to review, update and complete the Master Plan.

**Cross-border meeting for Trachoma (Karamoja region) and SCH (Albertine region and Namayingo District):** Cross-border transmission of Trachoma has been a concern in Karamoja Region (which borders Kenya), and cross-border transmission of SCH has been a concern in Albertine region (which borders DRC) and in Namayingo District (which borders Kenya). ENVISION will support the NTDCP Secretariat in conducting a national-level meeting in Kampala bringing together the NTD leadership of Uganda, DRC, and Kenya, including central and district-level MOH representatives, WHO country offices and WHO/AFRO, and partners. Topics will include the development of a framework for coordinated implementation of MDA; strategies for ensuring effective implementation of MDA, and the joint review of MDA results. The output from this meeting will be the development of a joint operational plan for the control and elimination of NTDs, involvement of cross-border traditional/cultural leadership and strategic utilization of human resource capacity available in the region.

**Meeting to discuss plans for PC-NTD control after MDA for LF and/or OV is stopped:** As noted, Uganda's NTDCP integrated four of its PC-NTD programs (LF, OV, SCH, and STH) starting in 2007, and presently MDA for these diseases is generally conducted in an integrated fashion where they are co-endemic. MDA for LF and/or OV is progressively being stopped as districts complete the requisite number of rounds of treatment with sufficient drug coverage (confirmed through TAS and/or stop-MDA surveys). As much of the drug supply for STH (ALB) is provided as part of the donation of IVM+ALB for LF MDA, and as much of the funding for MDA implementation of both SCH and STH (the "control diseases") presently comes from USAID through funding of MDA for LF and/or OV (the "elimination diseases"), it is necessary to plan for how both of the other PC-NTDs (SCH and STH) will continue to be controlled once LF MDA is no longer required. To develop a strategy for this transition, ENVISION will support the NTDCP in organizing a workshop with relevant stakeholders, including the MOH's School Health Program and the Ministry of Education and Sports, to consider and decide on options for program implementation and for advocacy as needed.

Existing resources that will be considered in the planning process include the quantities of ALB and/or MBD sporadically donated by the World Food Programme (WFP) and World Vision, and the twice-yearly deworming of SAC (5-14 years) through the Child Health Days.

**UOEEAC annual technical meeting:** ENVISION will support the UOEEAC in holding its three-day annual meeting with an estimated 70 participants. Participants will review the progress of the NOCP, through the results of treatment coverage and epidemiological and entomological surveys, and to make recommendations as needed. Concrete recommendations of the technical committee may include whether to stop or continue IVM treatment in specific foci or districts. In line with WHO's 2016 OV elimination guidance, the committee will recommend post-treatment surveillance in areas that stop MDA. As a best practice, the reasons for stopping treatment will be explained in the communities, along with guidance on avoiding recrudescence. Participants will be provided with copies of the report from the previous meeting. The meeting will be recorded and photographed, and the committee will make statements to the news media.

**OV epidemiological & entomological coordination meetings:** ENVISION will support two meetings of the MOH and the Carter Center's technical advisor with seven district vector control officers before and

after the UOEEAC meeting, to review and plan surveillance activities. These meetings are an opportunity to share experiences, discuss program performance and progress, and decide on strategies for program improvement, helping to maintain a clear focus on disease elimination objectives.

**Bi-annual review meetings with OV/VCO NTD district focal persons:** ENVISION will support The Carter Center's facilitation of two bi-annual review meetings to share field experience, assess program progress made, discuss challenges, and plan the way forward. Participants will include 40 NTD focal persons and their assistants from 20 districts (Kisoro, Kabale, Kanungu, Kasese, Zombo, Nebbi, Arua, Adjumani, Moyo, Buliisa, Hoima, Masindi, Oyam, Nwoya, Lira, Amuru, Kitgum, Gulu, Pader and Lamwo) where treatment with IVM is ongoing, six foci heads from districts from West Nile focus (Yumbe, Maracha-Terego, and Koboko districts), and District Onchocerciasis Coordinators (DOCs) and their assistants from the above mentioned districts and foci,<sup>7</sup> central level MOH officials including the OV program manager and National NTD Coordinator, and partners.

**Micro planning for MDA and associated activities in 16 districts, involving the central-level MOH:** Improving the efficiency (in terms of duration) and the quality (in terms of treatment coverage) of MDA campaigns is a priority for the NTDCP. Challenges have included poor planning, high turnover of district NTD focal persons, lack of involvement of relevant stakeholders, and low program ownership. To help improve MDA efficiency and coverage, ENVISION will support micro-planning for MDA in ENVISION-supported districts that have experienced particular challenges with MDA efficiency and/or coverage. The micro planning meetings will be attended by district political, civic and technical leaders who will review their district's situation and agree on what needs to be included in the district plans for the coming year. The participants will review available resources in the district, identify who should participate in NTD MDA implementation and their roles, and agree on the timeline. They will commit themselves to ensuring the plan is implemented and supported. The following districts have been identified as requiring more intensive involvement of the central level: six districts in Albertine Region (Arua, Nebbi, Buliisa, Hoima, Ntoroko, Adjumani); one district on the shore of Lake Victoria (Namayingo); two districts of Karamoja Subregion (Moroto, Nakapiripirit), and seven districts of Acholi Subregion (Amuru, Gulu, Omoro, Lamwo, Kitgum, Pader and Agago). Some of these areas have faced additional specific challenges, such as poor infrastructure, low literacy, sanitation/latrine coverage of ≤10%, and semi-aridity with frequent famine in Karamoja Subregion; post-conflict syndrome in Acholi Subregion; and the fear of side-effects and adverse events in Albertine Region.

In these districts, the central-level NTDCP and RTI will assist the district-level teams in developing a realistic plan for MDA detailing all related activities, their dates, the persons responsible and their roles, the resources required (including drugs, registers, reporting forms, fuel, and staff allowances), supervision, monitoring, and reporting. Prior to these meetings, the NTD program managers and RTI will provide refresher training to the central-level supervisors who will be supporting these districts.

**Micro planning for MDA and associated activities in 38 districts, without the central-level MOH:** In 38 other districts which are generally performing satisfactorily, ENVISION will support the district NTD team to conduct a micro-planning meeting, similar to the ones mentioned above. The districts include: Kamwenge, Rubirizi, Kasese, Kabale, Kisoro, Kanungu, Apac, Kiryandongo, Masindi, Koboko, Yumbe, Zombo, Alebtong, Amolatar, Moyo, Dokolo, Maracha, Oyam, Lira, Mayuge, Bugiri, Buyende, Jinja, Kaberamaido, Serere, Iganga, Kamuli, Luuka, Budaka, Butaleja, Kaliro, Katakwi, Kumi, Namutumba, Ngora, Pallisa, Soroti, and Tororo.

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<sup>7</sup> In most cases, these are the same people as the district-level NTD focal persons.

## b) NTD Secretariat

The NTD Secretariat consists of the office of the national NTD Coordinator and the PELF, BWCP, NOCP, and Trachoma program managers, along with the offices of drug logistics and data management and the MOH's Health Promotion and Education Department. NTD partners are part of the Secretariat, in the sense of being part of the Steering Committee.

The NTD Secretariat is chaired by the NTDCP National Coordinator who is also the ACHS, Vector Borne Diseases Control. The Secretariat is responsible for overseeing and coordinating NTD activities. It has a membership of more than 12 officers from the following offices: MOH NTD (PC and IDM) program managers; senior staff from PC NTD, Human African Trypanosomiasis (HAT), Leishmaniasis, Rabies, and Jiggers Programs; HPED; and representatives from RTI, SCI, Sightsavers, The Carter Center, and WHO. There may be need in the near future to include representation from partners working with the Trust in F&E. Some of the members of the NTD Secretariat form membership of the NTD Technical Committee.

The NTD Secretariat meets monthly and is responsible for the following:

- Overseeing the implementation of the NTD program on behalf of the MOH
- Building capacity at central and district levels
- Advocating for the NTDCP
- Planning and budgeting to support program implementation
- Supervising M&E
- Allocating resources
- Supporting districts in developing detailed action plans
- Developing and reviewing plans for operational research
- Participating in annual regional review planning meetings
- Submitting drug applications
- Coordinating with NMS to receive and clear drug shipments through customs
- Delivering medicines to districts
- Participating in regular meetings with partners
- Performing daily management and coordination of NTD activities
- Developing guidelines, manuals, and IEC materials.

### **NTD Secretariat office operating costs**

ENVISION will provide financial support to maintain office equipment and vehicles (including the replacement of vehicle tires) for the office of the national NTD Coordinator and the PELF, BWCP, NOCP, and Trachoma program managers.

### **Program-specific supportive supervision**

ENVISION will continue providing field travel-related expenses, such as per diems, vehicle rental where necessary, and fuel, to teams for specific supportive supervision. This has been key in helping improve performance across specific programs. Through these visits, the program manager and senior staff have been able to identify and address concerns related specifically to the programs.

## c) Advocacy for Building a Sustainable National NTD Program

The NTDCP has used advocacy as a tool to promote its activities and to try to mobilize resources in a sustainable manner. The NTDCP and partners have implemented advocacy through meetings with different stakeholders at the following levels:

- National: Advocacy at this level targets the legislature which makes decisions about national laws and expenditure, as well as MOH senior staff and partners who may have the capacity to seek or allocate funds.
- Regional: targeting district local government, to garner support towards the program. A district is led by an elected local council 5 (LC5) chairman and their executive. There is also an elected LC5 council, with representatives from the sub-counties and technical staff in the district. The council debates budgets, decisions and bylaws. On the technical side, the district is led by a chief administrative officer, appointed by central government. The district also has heads of various departments such as education, health, environment and planning, which are responsible for relevant matters in the whole of the district.
- District: targeting district leaders. Advocacy is meant to elicit support, whether financial, material, or through human capital and facilities. As districts implement activities on behalf of many national programs, which are often in competition for their attention, it is important to remind them of the particular importance of NTDs. Many district leaders have embraced the NTDCP's mission and made available necessary conditions for implementation. Most leaders are familiar with the NTDs in their districts and the damage and ill health they cause to communities.

**Use of the TIPAC for advocacy:** The national government supports the NTDCP through provision of office space, utilities, technical, administrative and support staff, their monthly salaries and allowances, purchase of vehicles that are used to implement activities at various levels, financial support towards some activities such as supportive supervision; collectively, these contributions are substantial. However, the partner funds which presently support control and monitoring activities may no longer be available as the program successfully eliminates those diseases which are targeted for elimination (LF, OV, and Trachoma), leaving those remaining diseases which are targeted for control (SCH and STH) without sufficient support, particularly in those districts where partner support was based on co-endemicity of both types of NTD. To help secure leadership commitment and the funds to fill these anticipated gaps, RTI will assist the NTDCP in updating the TIPAC tool. The reports generated from this tool will provide a clearer picture both of MOH and partner contributions and of any gaps, and will facilitate the NTDCP's advocacy vis-à-vis both the MOH and Government, and to current and prospective partners.

**High-level meeting with district leaders in three regions:** ENVISION will support the central-level NTDCP (consisting of the MOH Director General, PC-NTD Program Managers, and partners) in conducting meetings with district leaders (CAOs, RDCs, LC5s, DHOs, and FPs) from five districts of each of the three regions (Northern, Eastern and Western) that ENVISION will be supporting for MDA. The district representatives will come together in a central place in their respective region, together with civil and political leaders. The goal of these meetings is to communicate to the districts that great progress has been made in controlling PC-NTDs, and to secure their commitment to continued support for PC-NTD-related activities, particularly toward reaching elimination of LF, OV, and trachoma by the 2020 target date. The participants will review each district's MDA and survey results, discussing challenges and possible solutions.

**District-level advocacy with local government and health officials:** ENVISION will support the central-level NTDCP in conducting half-day district-level advocacy meetings in districts supported for MDA by ENVISION, shortly before the MDA campaign. (The other half-day will be devoted to district-level TOT training). In prior years, these meetings have been effective in fostering district-level support for PC-NTD control activities, including the use by RDCs of their free airtime to mobilize the public for the MDA campaigns, and involvement of district leaders in supportive supervision. It is expected that political, technical and administrative district staff, including the DHO, Assistant DHO, NTD Focal person, CAO,



Chief Finance Officer, LC5 Chairperson, Vice LC5 Chairperson, Secretary for Health, District Education Officer, District Inspector of Schools, District Auditor, religious leaders, and RDC, will attend these meetings in their districts.

**Advocacy Breakfast meeting with the Uganda Parliament’s Health and Social Services Committees:**

ENVISION will support the central-level NTDCP in conducting a breakfast meeting with members of parliament (MPs) who are part of parliament’s Health and Social Services Committee, which handles the budgets for the MOH among other responsibilities. The NTDCP will advocate for budgetary support and request the MPs’ assistance in mobilizing the public to participate in the MDA campaigns. The NTDCP team will provide copies of advocacy booklets (developed with support from ENVISION in a prior year, specifically for this category of leader) and other IEC materials. It should be noted that a prior such event in 2014 prompted Parliament to approve funds for jiggers control.

**News publications on NTDs:** As the NTD program continues to make progress towards elimination of targeted diseases, it is important that these successes be disseminated through both the print and electronic media, which reach a large proportion of the population. The news media serve as a form of feedback to leaders and community members on the NTD program which has been running in their districts. English language publications are daily, vernacular ones are weekly. Stories in the news are especially important in those areas which are stopping MDA and shifting to PTS. To put in more effort for MDA, ENVISION will pay for translation of the stories, into the common languages of the target areas, at low cost, throughout the year.

In FY16 ENVISION has supported press releases on program achievements; it will continue to do so in FY17.

**Ministerial statement on NTDs:** A ministerial statement should be given marking the achievement of stop-MDA status by the LF and Trachoma programs in some districts. The Minister of Health would give a statement on NTDs, through the Uganda Media Centre, highlighting the burden of NTDs in the country, what is being done, milestones attained, and encouraging the public to adopt protective behaviors including participation in MDA. Journalists from key media houses would be invited. The Ministerial statement would be prepared by the NTDCP Secretariat, and reviewed and cleared by HPED and the MOH’s Public Relations Officer. The statement is likely to focus on PC-NTDs, but IDM-NTDs could be mentioned as well if there are important announcements.

**OV sensitization workshops in four districts:** ENVISION will support facilitation by the Carter Center of targeted sub-county level advocacy workshops in Pader, Kitgum, Gulu, and Lamwo Districts with district leaders and sub-county leaders, with the goal of increasing the local leaders’ and health workers’ ownership of the NOCP. These districts are targeted because of their continued poor MDA coverage and inadequate community involvement. The workshops will communicate the status of OV MDA coverage and community involvement in the area. It is expected that, following these workshops, health program personnel will increase their supervision of OV-related activities, contributing to stronger community involvement and higher OV MDA treatment coverage.

d) Social Mobilization to Enable NTD Program Activities

ENVISION will support the NTDCP’s social mobilization efforts in FY17, both at national level and in those regions and districts where ENVISION will support MDA. This will begin with a review of the NTDCP’s existing strategies and IEC materials. In general, supported strategies will include a mix of the general (a mass media campaign, production and delivery of IEC materials) and the more targeted (documentaries for, and community dialogue in, specific regions requiring more intensive effort). As part of the social mobilization strategy, the NTDCP will target the following groups:

- Sensitization of sub county leadership: The NTD program does this with the intention of getting buy-in of the sub county leaders into the program, enabling those leaders to mobilize the communities for MDA and also provide supervision for NTD-related activities.
- Mobilization of communities in urban areas using vehicles mounted with PA systems. The NTDCP has noted significant improvement in MDA coverage in urban areas since it began using PA systems to mobilize urban communities for MDA.
- Community meetings which aim to sensitize community members about NTDs. This has mostly been done in OV endemic areas. These meetings have been well attended and treatment coverage has progressively improved.
- Mobilization of communities by Sub county and Parish supervisors using megaphones: Megaphones attract large numbers of people, especially in village settings, enabling messages to reach wide population groups. This has enhanced mobilization efforts and helped encourage targeted communities to seek treatment.

**Workshop to review IEC materials and social mobilization strategies:** ENVISION will support the MOH's HPED to review the NTDCP's social mobilization strategy and IEC materials (including print materials and radio talk shows, jingles, and announcements), and to update these as needed based on the evolving context and the NTDCP's overall strategy. The NTDCP will bring the MOH, selected district representatives (Senior Health Educators), and implementing partners together, and ENVISION will hire an IEC and BCC expert to facilitate the process. This workshop is needed as the materials and strategy were last updated in 2013, and since then there has been a shift in programmatic strategy from control to elimination for certain diseases; certain districts are stopping treatment for some diseases and shifting to post-treatment surveillance; and some of the communities targeted by the NTDCP have changed. The participants will take into account the findings of the FY16 post-MDA coverage surveys in their recommendations on which types of IEC materials, and which messages and formats, to prioritize.

Participants will also develop a plan for evaluating the social mobilization activities to be carried out in FY17. ENVISION will support the pre-testing of the revised materials in the districts, in advance of the FY17 MDA campaign.

The workshop will also help supported districts to determine which social mobilization methods are most appropriate to their specific context. In the past, ENVISION supported radio jingles and radio talk shows in each district, but as each district tends to prefer one method or the other, in FY17 ENVISION will provide funds for just one of these.

**Production and delivery of IEC materials:** Once the NTDCP's IEC materials are reviewed and updated, ENVISION will support the NTDCP in producing and distributing the updated materials to ENVISION-supported areas, in approximately the following quantities:

- Treatment charts: 30,000
- Field guides: 3,000
- Trainers' manuals: 2,000
- Desk-top flipcharts: 2,500.

ENVISION will support the NTDCP in ensuring that the materials reach the intended people at sub-district level; central-level trainers and supervisors will carry IEC materials to the districts and lower levels (e.g., HSDs, subcounties, and parishes) when they visit.

**Develop documentaries on SCH morbidity for Albertine sub region and on the Trachoma burden for Karamoja sub region:** The projection of films, including documentaries, is an especially effective tool for mobilizing rural communities, as evidenced by the experiences of Uganda's NOCP, Expanded Programme on Immunization, and AIDS Control Program which all used documentaries to improve community participation and health-seeking behaviors. ENVISION will technically and financially support the NTDCP in producing documentaries on SCH and trachoma that will be used alongside the current social mobilization strategies in Albertine and Karamoja sub regions, respectively. The intent is to foster greater participation in MDA and also to improve sanitation and personal hygiene.

RTI will contract with a specialized local media firm to script, film, and produce the documentaries. The MOH's HPED will guide the production process.

Sub county supervisors will screen the documentary in a central location within the parish, using projection and/or video equipment from the district health office, and will answer questions from community members.

**Radio campaign for PC-NTDs:** ENVISION will support the NTDCP in organizing a mass media campaign via radio, producing and airing broadcasts of talk shows, jingles, and announcements, to mobilize the public for the MDA campaign while educating listeners on NTDs (especially PC-NTDs) more generally. This is an efficient medium as radio coverage is high in most parts of the country and radio broadcasts are generally trusted by listeners. The districts will produce the messages, with review by HPED and RTI to ensure that the messages are clear, informative, and relevant for the target communities.

A standard English-language message is developed by a district health team (DHT) (health educator) with support of a FP, and sent to all the districts, which translate and modify it to fit their situations and then record the message with a local radio station. The quality of productions tends to be good as there is a lot of competition.

In Karamoja Sub-Region's rural areas, where radio coverage is poor, ENVISION will support mobile audio systems (vehicles equipped with loudspeakers) rather than radio broadcasts.

**Community dialogue to improve MDA coverage in selected areas of three sub-regions:** ENVISION will support community dialogue, an interactive process bringing together the sub-county and parish supervisors, the BMU leaders, the community leaders, and the local communities to jointly identify and analyze challenges related to MDA organization and treatment coverage and propose solutions, in Albertine region, Karamoja sub region, and Acholi sub region which have all had difficulty completing MDA within the targeted period and in reaching the required treatment coverage. These difficulties have been due in part to limited community ownership of NTDCP activities, a critical factor given the importance of community-directed treatment to the NTDCP's MDA strategy. The community dialogue approach has been used successfully by the National Malaria Control Program with support from Malaria Consortium, and it seems an appropriate method for addressing both the fears and opposition to MDA noted among communities and leaders, and the negative publicity and unfounded rumors about the MDA drugs (e.g., that the drugs are for family planning or for reducing the population). The activity will be focused in the highest risk communities or adjacent to landing sites along rivers and lakes where MDA coverage has been poor.

**OV-related health education and sensitization by community supervisors:** ENVISION will support the community supervisors' delivery of health education at community meetings and gatherings, to communicate key messages with IEC materials to ensure community members understand why it is necessary to register themselves and their family members, use dose poles during treatment, and to understand the dangers of not taking IVM and exclusion criteria for treatment, among others. This will enhance IVM uptake, community participation, and ownership. The community supervisors will also

encourage their communities to select more women to work as drug distributors and supervisors at the parish and community levels.

IEC materials will be developed in accordance with the country IEC strategy and efficacy will be evaluated through select community meetings. Questions will be asked that check the level of understanding of onchocerciasis disease in reference to the IEC material used.

**OV, LF, and trachoma post-treatment surveillance sensitization meetings:** ENVISION will support post-treatment surveillance sensitization meetings involving by local leaders, health workers, community supervisors, and drug distributors in districts that have been able to stop MDA for OV, LF, and/or trachoma. The intent of the meetings is to inform the community leaders why treatment has been stopped, to get district buy-in for post-MDA surveillance activities such as continued sensitization of communities, identification and reporting of suspecting cases, testing and if need be treating, and/or initiation of active surveillance by the DHO office. As of July 2016, this includes Nyamugasani focus in Kasese district for OV (the August 2016 UOEEAC meeting will determine whether other foci can stop MDA), and approximately ten districts for LF and/or trachoma. The health workers will use specifically-adapted IEC materials in these meetings.

#### e) Training

##### **ENVISION support through RTI**

**Training of central trainers/supervisors in 55 districts:** ENVISION will support a two-day refresher/retraining of central trainers at VCD/MOH, with facilitation by the NTD programs, ENVISION and other partner organizations as necessary. The training will focus on data management and challenges encountered in districts during MDA.

Central supervisors are responsible for providing technical guidance to districts on program implementation. Their main responsibilities are to train district-based trainers (District TOTs); conduct advocacy in districts, carry out support supervision, and also participate in operational research and impact assessment surveys where appropriate. Before they are dispatched to districts, trainers and supervisors will be equipped with the most up-to-date knowledge on NTDs and the tools used in the program.

**Training of new M&E assistants:** RTI and the NTDCP will train ENVISION's two new M&E Assistants on NTD M&E and program-related issues. The principal cost will be the field visit of the two new M&E Assistants along with any staff who will accompany them. The field visit will offer an opportunity to learn and share practical experiences and problem solving in the field as a team, based on live examples. M&E Assistants are deployed to different regions and districts where they get exposed to different ethnic tribal groups, cultures and attitudes. Often experience gained in one part of the country does not apply to other areas, so it is necessary to share experiences gained in different parts of the country.

**Training of local government officials in FOG management in 55 districts:** ENVISION Uganda and HQ Finance staff will conduct grants management (re)training for officials from 55 districts, focusing on FOGs, management systems questionnaires and anti-terrorism certification, grant budgets, milestones, reports required, common hazards, and other relevant topics. These trainings remain necessary as there remains a gap in comprehension about what FOG agreements entail, and as many government staff have been transferred from endemic districts to non-endemic districts.

**Train/reorient the MOH NTD Data Manager on General M&E Skills:** ENVISION will support the NTDCP's data manager to take a three-week-long training on M&E on Information Systems and Database management at the Uganda Management Institute in May 2017. As the program moves from a focus of

control to elimination there has been a strong need to build the M&E capacity in supporting the programs to carry out disease specific assessments, data validation and harmonization, etc. ENVISION has been providing a supportive role for this but there is need for MOH to take on a more active role in this area. The NTD secretariat has identified the data manager to take on the M&E roles but there would be need for some training if he is to be effective.

**Training of trachoma graders and recorders:** ENVISION will support a five-day training of 4 Graders and 10 Recorders in preparation for planned TIS and trachoma surveillance surveys (TSS), and also to account for attrition of trained recorders. Just before starting the planned surveys, the certified graders and recorders will undertake a one-day refresher training.

**Training of district NTD focal persons – 55 districts:** ENVISION will support (re)training of 55 FPs. This training is conducted once every year and targets FPs in districts that will be conducting MDA in that fiscal year. The training is conducted at the national level for 2 days and the trainers include members of the NTD Secretariat and M&E Assistants who provide support with the data tools. The training focuses on data tools and management, logistics including supply chain management, financial management and the role of ENVISION in NTD elimination/control.

A range of topics is covered including information on each of the disease programs, the importance of observing implementation timelines, the need for supportive supervision, the use of data collection tools for data quality management, AEs and SAEs management and reporting, and prompt reporting. During the training, the program also makes time to discuss with the FPs the challenges that the program is experiencing and ways in which they could be addressed. This training is needed annually because the FPs are short-term consultants, and consequently there is some turnover each year.

**Training of district trainers (TOTs) in 55 districts:** ENVISION will support the training of 1,100 district-level trainers (10 DHT + 10 HSD) during one-and-a-half day sessions in the headquarters of each of the 55 districts.

Training of district TOTs is facilitated by the personnel from the NTD Secretariat. Conducted immediately after advocacy for district leaders and stakeholders, it targets health workers from the DHO office and nearby health facilities and those from HSDs. The following officers are always invited to attend: Medical Officers, Medical and Clinical Ophthalmic Officers, Health Inspectors and Health Assistants, Health Educators, Nursing Officers and 6 VCOs (who are, in most cases, district NTD focal persons). The TOTs are charged with conducting and supervising training at the lower levels and providing overall supervision to the program in the district. This training is needed each year as the district TOTs are frequently transferred within or even outside the districts.

**Training of sub county supervisors and health workers based at HSDs and lower health units:** ENVISION will support the training of 1,000 sub county supervisors and 1,748 health workers in the USAID-supported districts.

The program at the sub county level is coordinated by either Health Assistants or Community Development Officers who serve as sub county supervisors. They are assisted by other health workers or civil servants, such as Community Development Assistants, based at sub county levels or lower levels. Sub county supervisors are the main trainers and supervisors of all NTD activities at sub county levels and below. Training at this level includes health workers in charge of all the health units in the HSD. These supervisors and health workers educate community members; sensitize the political and administrative staff at the sub county level on NTDs; receive and store NTD drugs; facilitate drug deliveries to lower level health units, schools, and communities; and attend to all cases of AEs, including SAEs.

**Training of parish supervisors:** ENVISION will support training of a total of 4,374 Parish Supervisors (two from every parish) in 20 districts by M&E Assistants and Focal persons. Training of these supervisors is critical as they are responsible for training the CMDs for MDA; this was a recommendation of the NTDCP's 2017 national planning meeting. The training will allow the NTDCP to assess weaknesses and institute corrective measures. Parish supervisors serve as the main link between sub county supervisors (HCIII level), CMDs, and leaders in communities and villages (LC1 level). In most instances, they are the Village Health Team (VHT) coordinators at the parish level, serving many health programs, a role that was created by MOH to ease support supervision. These supervisors are responsible for the supervision of CMDs / VHTs. They are also expected to assist CMDs in community mobilization and sensitization, registration, MDAs, AE monitoring, compiling treatment data and filling out treatment summary forms, and also accounting for any drug balances. Parish supervisors are often responsible for other programs, such as the Expanded Program of Immunization, Child Health Day deworming campaigns, and IRS and the distribution of LLINs for malaria control.

**Training of CMDs/VHTs and teachers:** ENVISION will support the training of a total of 54,960 CMDs/VHTs and 31,812 teachers. In 18 SCH-endemic districts, which will carry out MDA in schools only, only teachers will be trained.

Three CMDs picked from among VHT team members, are selected from every village for annual training, which is held at the parish level for all endemic villages. They are, at times, supported by the LC1 chairpersons who in some instances mobilize communities for registration and MDA. LC1s are expected to provide moral support to CMDs/VHTs, provide material incentives where the communities are appreciative, and give them preferential treatment to access some of the services provided by Government, such as bicycles, farm inputs, seeds, and piglets which are part of poverty alleviation campaigns. They are trained and sensitized on NTDs in their communities. Trainings include information on obvious clinical signs; strategies for the elimination or control of each disease; medicines used (their benefits and side effects); distribution instructions; the process of registration of communities and schools; proper usage of dosing poles; how to handle, refer, and report AEs; and how to use the integrated registers and other tools to record village population data, treatment summaries, and medicine balances. In districts with predominantly illiterate or semi-literate populations (for example Karamoja sub-region), the CMDs/VHTs are drawn from the few literate individuals in the villages, but even with this approach, it is often difficult to capture data accurately in these areas. The individuals responsible for handling data may at times resort to using literate volunteers, usually friends or relatives, who are identified by the CMDs themselves. This practice increases the demand for incentives by CMDs.

Additionally, four teachers are trained per school, with two or three schools covered in one day by a single trainer. It is necessary to provide annual training at this level to avoid confusion with the protocols and practices of other public health programs that often operate concurrently.

**Training in Program planning, management and evaluation (including financial management):**

ENVISION will support a total of 12 MOH NTD program managers, senior program staff, and senior RTI staff in attending this two-week evening course at the Uganda Management Institute.

**Training NTDCP Managers and senior staff on the Integrated NTD database (RTI):** The MOH's NTD database is undergoing final updates and will soon be ready for uploading onto a server, from where staff will be granted access. Staff were introduced to the database during its development but it is necessary to train them in its use. This will ensure that staff can access and extract data from the database for use by MoH, districts and partners.

**InsideNGO training for MOH and ENVISION staff:** NTD program managers and/or other senior staff and RTI/Uganda personnel will participate in InsideNGO training.

Topics to be covered include USAID rules and regulations, USAID Grants and Cooperative Agreements, Procurement Planning and Execution, Financial Management for USG Funding, PMD Pro 1: The essentials of Project management.

### **ENVISION support through the Carter Center**

ENVISION will support training in 20 districts (Moyo, Adjumani, Amuru, Nwoya, Gulu, Lira, Oyam, Pader, Lamwo, Kitgum, Nebbi, Zombo, Arua, Kasese, Kabale, Kanungu, Kisoro, Hoima, Masindi, and Bulisa) where either OV treatment is ongoing or where interruption of OV is suspected. The training of health workers, parish supervisors, community supervisors, and CDD training in Hoima, Masindi, and Bulisa will not be supported by the project as this will be covered by Sightsavers. Mentorship and on job support strategy will be implemented by The Carter Center and MOH. The intent is that after two years of support, the districts' capacity will be strengthened and the MOH's and The Carter Center's role vis-à-vis the districts will be reduced.

In many districts, OV is only present in some areas of the district and sometimes health workers (e.g., sub-county focal persons and front line health facility staff who supervise OV activities in the communities) who have been trained on the strategy of the program are transferred to areas that are non-endemic areas and vice versa. This calls for well-targeted annual trainings of health workers on key topics that may include the updating of registers, collection of medicine from the health units, medicine distribution, and how to accurately fill treatment forms for submission to the nearest health unit. The Carter Center will train a total of 215 health workers, 1,201 parish supervisors, 8,200 community supervisors, 3,735 local leaders and 31,305 community drug distributors mainly from Lhubirihha and mid north focus where transmission is ongoing; ENVISION will cover a portion of these total trainees as noted below and in the budget. More than two-thirds of all training (approximately 70 percent) will be completed before the first round of treatment in CY2017. Round 1 should end June 2016 and Round 2 should start in September 2016, but if the activity happens to overlap fiscal years, ENVISION will only support that which happens in FY17.

To enhance mentorship skills among the target groups, MOH and The Carter Center plan to have a special group of MOH and other partners from the National level make field visits and interact with the health workers, sub-county focal persons, parish and community supervisors, drug distributors and community members to ascertain the level of knowledge acquisition and utilization. This will be through random spot checks at various levels (sub-county, parish and community) during or after the training as well as through informal interviews with health workers and document review (i.e., report review). After analyzing the information gathered and determining the knowledge gap, support will be offered. However, in situations where the training has significantly underperformed in terms of knowledge generation, refresher trainings will be organized.

**OV-specific training of parish and community supervisors:** ENVISION will support training of 578 of the 1,155 parish supervisors requiring training in 10 districts. Each training will take place over a three-day period and include district and sub-country staff participation.

Parish supervisors oversee community level activities and are often responsible for other programs in addition to OV. In this role, they train and oversee the work of community supervisors.

ENVISION will support training of half (4,100) of the 8,200 community supervisors who require training.

ENVISION will support a three-day training for about half (1,868) of the 3,735 LCs who require training, in 20 districts.

Community supervisors train and then supervise CDDs; a core responsibility is to ensure census updates. They also ensure health education is provided, the household census is completed using registers, and MDA is provided; reports are drafted and submitted detailing these activities.

**OV-specific re/training of health workers:** ENVISION will support the training of 207 health workers, including 64 new health workers and 143 district-level health workers.

**OV-specific re/training of CDDs:** ENVISION will support community-level training of 16,611 new CDDs, and refresher training for 13,590 CDDs at community level, both in 17 districts. To note, those in Hoima, Masindi, and Bulisa will be trained by Sightsavers.

#### f) MDA Coverage and Challenges

**73% of the 127 districts conducting MDAs across all diseases in FY15 achieved the minimum required coverage. The focus in FY17 is on maintaining good coverage in these and improving performance in the other 27%.**

Integrated MDA target projections: Differences in population figures between UBOS and district reports continues to undermine the interpretation of reported coverage; e.g. from the Adjumani district reports the 2015 target population (popn) is 153,733, the popn 5+ years is 125,306, and the popn 1+ is 147,428. However, the UBOS 2014 census projections estimates the 2015 target population at 239,867, the popn 5+ years 191,894, and the popn 1+ years as 228,354. The differences between these population figures affects coverage, with use of the UBOS figures producing consistently lower coverage rates. Yet the program may not be able to rely on the district figures; e.g. Adjumani district target population in 2014 was 156,513, which was greater than the figure reported for 2015. For certain focal diseases like SCH, final targets may change at the last minute and may not target the entire district. At times local decisions on what areas to treat are based on the quantities of drugs available, the priorities of local authorities, and / or influenced by migration populations. Target population projects in the USAID M&E Workbooks are provided by the national SCH and OV programs, which are derived from district reports. To try and address the challenges of uncertain treatment targets, the NTDCP will closely supervise and monitor changes in registers to ensure that the whole population in the district is captured only when appropriate. Additionally, data compilation and reporting will be closely monitored and supported.

Integrated MDA treatment data collection tools: A number of parallel data collection tools have emerged which are creating confusion at certain reporting levels. The NTDCP is leading a new proposal to simplify the data collection tools; efforts will be made to encourage all partners to agree to use new tools and reduce duplicative reports. This will help address late or lack of coverage and stock reporting when combined with improved supervision. Additionally, funds for data collection are held until a preliminary report of implementation is submitted. As noted, central supervisors and M&E Assistants will spend more time in the districts to ensure that this is done.

MDA scheduling: Often there is a small window of opportunity to implement an MDA campaign. Any delays to the planned MDA schedule could force CDDs and teachers to distribute during inopportune times (i.e. school closure, planting and harvesting seasons, etc) or to miss the MDA entirely. Competing health priorities, such as the need to co-ordinate multiple health activities at once, further increases pressure on health workers and district leaders. A schedule of implementation for MDA is typically worked out when the FOG agreements are signed and the expectation is for district teams to closely follow the schedule. The secretariat has continued to closely monitor the districts to ensure that funds are released and activities implemented within a specific time schedule. Further, the program will ensure that logistics and drugs are delivered in sufficient quantities ahead of the MDA schedule.



Community-based MDA: There is need for continued dialogue with the CMDs to define expectations.

LF MDA: In July 2016 38 districts were targeted for LF MDA. Of these, 35 have so far submitted their reports. Ten districts did not reach 80% program coverage, of which seven are found in the Eastern region and three in the Northern region.

These districts were: Bugiri: 72.55%; Buyende: 71.23%; Kaliro: 73.09%; Kumi: 72.58%; Luuka: 66.39%; Mayuge: 76.71%; Serere: 73.92%; Adjumani: 72.01%; Gulu: 66.62%; and Yumbe: 66.37%.

OV MDA: The OV program conducts annual (2 districts) and bi-annual MDA (20 districts). In FY15, 22 districts were targeted for MDA in Round 1; only 2 had program coverage below 80% with the lowest coverage being 67%. Both of these are post-conflict districts. Though there was a slight improvement registered in the second round, 2 of the 20 districts still failed to achieve sufficient coverage. The lowest coverage attained was 79.05%. Gulu district in both rounds did not achieve the required level, Amuru in Round 1 and Kitgum in Round 2 failed to attain the target. Again all these districts are post conflict districts found in the North. Though MDA has been going on in these districts for a while now, the CDTI strategy being used by the OV program in the other districts was not well established. The program uses an enhanced CDTI/"rwot kweri" (smaller unit) strategy for this region.

In FY17, a total population of 2,561,797 will be targeted for treatment with IVM in the 20 districts where transmission is suspected to be ongoing. To effectively achieve this, The Carter Center will continue to strengthen its collaborations with other partners working in the 20 targeted districts, especially those that are administering treatments for LF (ALB) and OV (IVM). During the MDA campaigns, The Carter Center will ensure districts supply the required amount of drugs to communities and retrieve the correct information when treatment is completed.

SCH MDA: Of the 43 districts targeted for SCH MDA in FY15, reports have been received for 42. About half of those that reported had program coverage of 80% and above; 15 of which had over 100% MDA coverage. Defining the endemic area for most of the SCH districts has been a challenge; this is particularly evident in 15 of the 43 districts where the program coverage was over 100%. Reasons given for low coverage in the other districts included differences between the at-risk population provided by the program and the district, the demographic and physical characteristics of communities (e.g. some of the communities are boat landing sites so most of the inhabitants are fishermen and therefore quite mobile), failure by VHTs to tally treatment reports, and fear of PZQ side effects. Several of these districts had very low coverage including Buikwe: 65.30%, Buvuma: 70.96%, Gomba: 69.09%, Kalangala: 57.13%, Masaka: 21.61%, Mityana: 52.10%, Mukono: 66.21%, Wakiso: 41.69%, Bugiri: 47.39%, Buyende: 72.76%, Kaberamaido: 27.79%, Mayuge: 65.01%, Serere: 76.87%, Adjumani: 11.66%, Agago: 61.62%, Apac: 43.80%, Kabarole: 68.27%, Kasese: 27.05%, and Ntoroko: 35.65%.

STH MDA: In districts co-endemic for LF and STH, MDA targets whole populations from the age of 1 year and above with ENVISION support. However, in all the other districts children in the age category 1-15 years in all the districts in the country are treated semiannually through the MOH Child, now Family Health Months. Data from these treatments are however difficult to obtain. So the data captured is from treatments in districts that ENVISION supports LF MDA and a few other ENVISION supported districts.

Trachoma MDA: In FY15, MDA for trachoma was delayed in certain districts due to Zithromax production delays. Making the best of the situation, MDA was conducted in 7 of the 11 districts that were targeted, using unused drugs from FY14 that were retrieved from other districts (although these were not sufficient to fill the requirements). Only 2 of the 7 districts attained 80% program coverage. The remaining four districts were treated between March and April 2016 and their treatments will be reported in FY16.

### Strategies to Improve MDA Coverage:

The national program has been trying to get ahead of the major factors that affect coverage rates by being proactive in the planning stages of MDA and intensifying supervision during the campaigns. In districts that have achieved good epidemiological and/or program coverage, the program attributes success to the following factors, which will be emphasized in FY17:

- Recognizing good district leadership and clarifying roles and responsibilities at the district level. This has been previously achieved by giving special recognition to district officials at national planning meetings and having supervisors carefully read through technical manuals (including national training field guides) with district focal points. Having functioning organizational frameworks and strong leadership are not always apparent in newly formed districts. In these situations the national program and ENVISION staff will play a more direct role in the implementation including enhanced supportive supervision by the central-level NTDCP and ENVISION led direct implementation. For example, in Arua District, where coverage improved substantially, a central supervisor and / or an M&E Assistant was stationed in the district for the whole implementation period. ENVISION led direct implementation of MDA in Gomba, Kamwenge, Kayunga, Kibaale, Mityana, Mpigi, Rubirizi, Ntoroko, Masindi, Wakiso, Kalangala, Kiryandongo, Abim, Kamuli, Maracha Districts, also succeeded in completing the MDA within the specified period and in improving treatment coverage.
- Adapting MDA strategies to the characteristics of the communities. In FY15 the NTDCP piloted a new strategy for Urban MDA in selected districts which led to improved program coverage. Rather than carry out the routine house-to-house MDA using the VHTs, MDA was carried out by health workers with support of the VHT. In addition to homes, they targeted market places, hospitals, factories, service centers e.g. petrol stations, garages, shops, clubs, offices and parks. The idea was conceived after noting that MDA treatment coverage in the urban areas of districts have been very poor over the years. Other benefits of the strategy included a reduced period of treatment, ability to reach and treat people/ perennial absentees (business people, patients' attendants, civil servants and other workers), and active participation of leaders who have been left out in previous MDAs. These results has prompted the decision to scale up the same strategy in all the districts with urban areas in FY17.
- Close follow-up and monitoring between the central-level NTDCP and relevant program officers. This includes check-in calls to ensure that delays do not occur in the release of funds by the district COA for approved activities. This also includes supervision of community and school registration updates in close consultation with the NTD Data Manager, and participation of the District Biostatistician; districts will be requested to validate the data before submitting either through CSTs, drug coverage surveys, submission of supervisory monitoring forms, or independent monitors. A central supervisor or M&E Assistant, or both, will be in the district during all of these exercises. Introduction of a standardized supervisory checklist detailing expected outcomes and a supervisory monitoring form are expected to ensure that experiences are shared and a consensus reached that may not be sufficiently addressed by an individual.
- Ensuring all health workers are re-trained through the ENVISION project. Frequent transfers of trained health workers and being replaced by those not knowledgeable about disease specific criteria has created knowledge gaps on both school-based and CDTI implementation strategies. Annual trainings assist in filling the knowledge gap and assures health workers have the most up-to-date information to do their job effectively. Reporting content and timelines are covered in ENVISION-supported re-training and training and provision of advocacy meetings help to

strengthen local ownership. Government policy of VHT does not necessarily facilitate community selection of community volunteers and therefore not all CMDs are necessarily embraced by the community; trust between the community and health workers is needed to attain sufficient coverage in MDA. Such issues are addressed in re-training and training along with building the workers' overall health knowledge and skills.

- Strengthening MDA awareness. Multiple health related activities carried out in one month (April/October) creates confusion among community members. Radio broadcasts that share key information on upcoming MDA (including specific dates for outreach) is necessary and is why continued coordination with the NTD programs is paramount.
- Testing social mobilization and IEC strategy. The NTD Secretariat plans to carry out KAP studies in several areas. Since they are mostly qualitative in nature, these studies help provide more insight to a problem/challenge and will help the program strengthen approaches or identify new ones that specifically address reasons for low coverage.

**Table 3: USAID-supported coverage results for FY15 and targets for FY17**

NTD	# Rounds of annual distribution	FY15 Treatment target # DISTRICTS	# Districts not meeting epi coverage target in FY15	# Districts not meeting program coverage target in FY15	FY15 Treatment targets # PERSONS	FY15 # persons treated	FY15 % of treatment target met PERSONS	FY17 treatment targets # DISTRICTS	FY17 treatment targets # PERSONS
LF	1	38	11		9,326,508	7,548,453	80.94	9	2,489,778
OV	2	22		9	2,300,403	2,083,798	90.58	23	2,350,630
		20		4	1,890,454	1,727,399	91.37	21	1,930,126
SCH	1	43		21	3,882,128	3,797,434	97.82	51	4,883,750
STH	2	18		10	5,886,685	4,039,497	67.86	6	1,827,281
		20		16	5,694,271	5,460,148	95.9	3	1,138,667
TRA	1	11		9	2,458,826	900,774	36.63	2	299,920

**MDA Activities planned in FY17 are as follows:**

**MDA supplies:** Supplies required for MDA include register books, IVM dose poles, PZQ dose poles, Zithromax tablets dose poles, Zithromax POS dose poles, T-Shirts (for teachers), and treatment charts. ENVISION will provide pens for CDDs. Other MDA required supplies, such as water cups to assist in the taking of medicine, will be provided locally by the community.

The CMDs, in coordination with LC1 executive committee and community leaders, will provide a small table where the drugs are placed. The community will also provide chairs and stools for use by the CMDs. They also provide water and cups for swallowing the medicines (tablets only). The same arrangement takes place in schools where the key players are the trained teachers assisted by school and class prefects. Other Head Teacher and other teachers also participate. School management board members (parents) are also often present to oversee the exercise and ensure that discipline and order are maintained.

**LF-OV-SCH-STH and Trachoma MDA:** In FY17, ENVISION will support MDA in 55 districts; 9 will treat for LF, 23 (including one of the newly-created districts in northern Uganda) for OV, 2 for Trachoma, 9 for STH integrated with MDA for LF, and 51 for SCH.

In FY17 ENVISION will support the following tailored approaches in selected areas:

1. Enhanced MDA in urban areas: Rolled out for the first time in FY16, this approach resulted in improved MDA coverage, reduced period of treatment, treatment of perennial absentees (businesspeople, patients' attendants, civil servants and other workers), and active participation of leaders who had previously not been involved. The NTDCP will scale up this strategy to other districts with urban centers endemic for NTDs.
2. MDA in Karamoja sub-region: Due to the uniqueness of the region, the NTDCP will implement a comprehensive MDA strategy targeting all stakeholders and leaders, using radio talk shows, jingles and messages, film vans, public address system to posters and banners, to ensure that all persons eligible for treatment are reached.
3. MDA in the Albertine areas and Namayingo district: SCH remains a problem in the Albertine region and Namayingo district with disease prevalence remaining high despite several rounds of MDA. To increase medicine uptake there is a need to massively sensitize the communities about the disease and the drug used. Communities in these regions are mobile (fishing communities) and therefore difficult to find. Additionally, some of these districts are border districts hence there is cross-border movement.
4. Community dialogue in problematic areas: The program plans to carry out community dialogue in some districts that have been problematic. Discussions with community members will include challenges to the NTD program in their communities and how they should be addressed. Ordinary community members and leaders will attend the meetings.
5. District-level feedback meetings during and after MDA: The purpose of these meetings is to review coverage and determine how to maintain or improve it as required. MDA data will be reviewed sub county by sub county; any districts that have not achieved the required coverage will conduct mop up MDA at its own cost. This will be explained to the district in detail during the Advocacy and TOT meeting, and further emphasized during the micro planning meetings. A district supervisor will be assigned to each sub county to provide technical supervision and guidance during MDA.

**OV MDA:** ENVISION will support a tailored approach to enhance drug uptake in the problematic districts of Madi Mid North. This will include support for radio talk jingles and radio announcements in addition to regular social mobilization (see Social Mobilization section).

#### g) Drug and Commodity Supply Management and Procurement

Through NMS, the MOH handles the clearing, handling, storage, and transportation of all drugs imported into the country, including NTD drugs donated or purchased. NMS, on behalf of the Government of Uganda, meets the associated taxes and fees charged on all drugs imported into the country which are meant for public health programs. NMS is an independent corporate statutory body, mandated to procure and distribute all drugs and other supplies / sundries for use in Government Health programs, irrespective of the source of funding or the commodities. Its governing body is chaired by the MOH. NMS receives from the national treasury all funds approved for procurement and distribution of drugs. It works closely with the National Drug Authority, another statutory body supervised by MOH, to ensure that only high-quality drugs and supplies from approved manufacturing facilities are imported for use by the NTDCP.

The following is a description of in-country drug supply chain management processes, and ENVISION's role in providing support to the MOH in each:

- NTD drug quantification: Drug quantification is performed by each of the NTD Program Managers with the help of ENVISION's Logistics support to the NTDCP. This is done after establishing the current in-country stock balance available. The disease program managers quantify the total treatments expected the following year, based on WHO guidelines an application of the drugs is submitted accordingly. The Carter Center supports the MOH's OV Program Manager with the estimates for IVM required for OV.
- Preparation of the Joint Request for Selected Medicines (JRSM) form: The NTDCP's disease program managers, data manager, and the ENVISION Logistics Officer will meet to prepare the WHO JRSM along with the WHO Joint Reporting Form (JRF) and Epidemiological Reporting Form (EPIRF). The NTDCP, with ENVISION support, will co-ordinate the submission of this package, taking into account WHO's proposed move to bi-annual deadlines (15<sup>th</sup> February and 15<sup>th</sup> August).
- Reverse logistics cascade: return of bottles (open or unopened) of NTD drugs: Reverse logistics starts when the campaign has been completed within the communities. Each CMD/VHT is expected to bring back to his/her parish supervisor the treatment report showing how many drugs were used and the balances collected at that point by the supervisor. The remaining drugs are transported by the parish supervisors to the sub county supervisors and to the district stores. Where a district is not expected to treat, all the balances are transferred to the next treating district as new stock. ENVISION actively supports districts to carry out reverse logistics to ensure that drug balances are brought back to HCIVs and district stores, for storage or redistribution to needy areas or safe disposal. Please note that in emergency situations, ENVISION transports drugs from NMS directly to districts. However, this is initiated by the National Coordinator and occurs only a few times in a year.
- Waste management activities: The Government has a policy for disposal of expired drugs/ medical waste. For drugs that expire, they are collected through the reverse logistics of distribution by National Medical stores. The government has very strong policies regarding drug disposal and therefore this is only done at sites that are allowed by Government. In case there are substantial amounts of drugs remaining in a district, ENVISION will use vehicles returning from the field to pick and return them to the temporary drug store at VCD. From here the drugs can be redistributed if still viable (long life) or delivered to NMS for disposal if expired.
- Drugs/commodities requiring cool storage: All NTD drugs shipped into the country come as donations to the Government of Uganda through the Ministry of Health. The MOH has an MOU with National Medical Stores (an arm of the Government) to receive such drugs and store them in the conditions required. Drugs that require cold storage are taken care of since the NMS has a cold supply chain warehouse to take care of such shipments. All lower Health centers are provided with refrigerators for cold storage. However lower Health Centers often run short of gas for the cold chain. This does not affect any of the NTD drugs, which do not require cold storage.
- ENVISION's planned technical assistance for monitoring and management of AEs and SAEs: WHO and RTI have provided SAEs handbooks and reporting forms. ENVISION facilitates the production of copies that are distributed to Programs and districts for their use during MDA. More support is provided to Staff of the Ministry of Health to go to the field and monitor SAEs during MDAs. During refresher training of NTD FPs and central supervisors/trainers, a special session was devoted to AEs and SAE monitoring and management. This year, a special team will be facilitated in every district to monitor and investigate SAEs.

## h) Supervision

### **Support to the national NTD program for supervision at each level:**

The NTD Secretariat and ENVISION together with relevant implementing partners, are responsible for supporting districts during implementation of activities. The major activities to be supervised are training at district and to a lesser extent lower levels due to the very few supervisors available for this activity. In practice, supportive supervision has not often been conducted below district level, largely due to lack of available personnel. In FY17, the Secretariat is going to place a major focus on supportive supervision in districts. All activities at various levels will be supervised by districts backed up by ENVISION. A central supervisor and an M&E Assistant (ENVISION consultant) and some of the senior program staff (including ENVISION staff) will be stationed in the districts, starting right from the training of TOTs, microplanning, to training of sub county supervisors, through the training of Parish supervisors, teachers, CMDs and teachers.

How ENVISION will ensure that WHO guidance and MOH regulations are adhered to and that monitoring mechanisms are in place to secure a sound execution of the MDA:

- PMs and senior staff of NTDCP are conversant with WHO and MOH regulations, which are always covered during training workshops and NTD Secretariat meetings. These regulations are contained in the training manuals and field guides developed by NTD Secretariat with ENVISION support. All TOTs, Central Supervisors, NTD district FPs, sub county Supervisors have these manuals. Besides WHO and MoH regulations, these manuals contain best practices for activities leading to and during MDA, for example how to manage and report SAEs. All these issues will be reinforced during training. With adequate and effective trainings, and close supervision of all implementation activities, it should be possible for all districts to conduct quality MDAs. The key areas here are proper planning, quality training and supervision, accurate data on eligible population, good social mobilization and timely provision of adequate drugs, registers and all the other requirements. The ENVISION RPA, Senior Technical Advisor, SPO and M&E Manager, will be closely involved in the training of central supervisors, NTD Focal Persons and in supportive supervision visits to districts, together with NTD Secretariat. During these interactions, WHO and MoH regulations and monitoring mechanisms will be communicated to participants. The position of Senior Technical Advisor, which was recently created, will strengthen the capacity of ENVISION to disseminate and enforce WHO technical guidance, MoH regulations and also ensure that monitoring mechanisms are in place and adhered to.

Actions that will help to identify and address any potential issues/bottlenecks that arise during the course of the MDAs:

- The ENVISION team will closely supervise and monitor all MDA activities at central level and in the districts, working closely with NTD Secretariat and districts. ENVISION senior management (RPA, Senior Technical Advisor, SPO, M&E Manager, M&E Assistants, Logistician and Finance section) will be constantly calling districts to assess the situation on the ground and visiting targeted districts. M&E Assistants will be in the districts full time. The Logistics Officer will ensure that NTP FPs provide updates on the drug situation on a regular basis. During implementation, ENVISION staff and M&E assistants who are in the field will hold daily review meetings with field supervisors to identify obstacles and challenges. District and lower level leaders will be involved in mobilization.
- ENVISION and NTDCP staff will visit supervisors, opinion leaders, religious leaders and cultural leaders and invite them to be involved in sensitization campaigns and community dialogue. In

these interactions, potentially detrimental issues should be able to come out and be dealt with by district implementers, leaders and ENVISION staff in the district in a timely manner.

- ENVISION-supported supervision will involve the use of supervisory checklists.
- MOH and ENVISION Logistics Officers will closely monitor drug stock-outs through the NTD FP, sub county and parish supervisors, and through use of ENVISION's drug stock call guide.

Actions for assuring that data collection and registration is executed according to pre-established procedures and protocols:

- The NTDCP central supervisors and the M&E Assistants will be deployed during data collection, as previously. Together with the district supervisors, they will ensure that proper registration is conducted, MDA is conducted and completed as planned, and thereafter data compilation commences in schools and communities where applicable. In the past, central and ENVISION supervisors were sent to districts for a period of one week at most but this time round, they will spend 3-4 weeks during MDA implementation, allowing them to be in closer contact with distributors and to offer better supportive supervision.
- ENVISION will fund the Parish and Sub county supervisors to help CMDs and teachers compile the treatment data.
- At the district level, the Biostatistician will provide the program with an accurate list of administrative units and also supporting implementers to collect quality data for analysis by the district. MDA treatments will be reported by village / community, which will make it easier to identify units that have not reported MDA data or have poor coverage.

#### i) Monitoring and Evaluation

Data from ENVISION-supported coverage surveys in July 2015 and January 2016 will help validate the coverage reported by the districts and develop recommendations for improvements during the next MDA. In FY17 the surveys will be conducted in 15 districts that will be selected by the program managers depending on performance (treatment coverage), and drug combinations. The results shall be used to improve program performance, and, where justified, new strategies will be adopted. Survey results will also act as a basis for discussions during advocacy meetings.

A data quality assessment (DQA) is not planned for FY17 as there is need to first implement the recommendations from the previous DQAs.

#### **FY17 Activities**

**Workshop to use national PC-NTD data for programmatic decision-making:** The NTDCP has compiled a great deal of NTD data in the Integrated NTD Database. It is important to plan how to effectively analyze these data, and use the findings for programmatic decision-making. ENVISION and SCI will jointly fund a meeting to focus on using the country's own data, to enable more informed programmatic decisions.

#### Disease-specific assessments

**LF TAS 1 in five districts:** ENVISION will support this activity in Amuru, Pader, Nwoya, Agago and Tororo. Of these districts, 4 are from the North and 1 from the East.

**LF TAS 2 in 16 districts:** ENVISION will support this activity in 16 districts of which 5 are from the Northern region, 9 from East (including all 7 districts in Karamoja region), and 2 from the west. The surveys will aim to detect the prevalence of CFA using Filariasis test strips (FTS). The age group targeted

is 5–7 year olds in primary schools or those not at school, or both, depending on the school enrollment rates in a district. The CFA prevalence is a good indicator to show whether LF transmission has been interrupted.

**Trachoma impact survey in eight districts:** ENVISION will support TIS in Adjumani, Abim, Amudat, Kaabong, Kotido, Nebbi (which will split into two districts, Nebbi and Pakwach) and Napak Districts to determine whether MDA may be stopped. All of these districts except Adjumani have conducted TIS once before, which showed that MDA needed to continue; they have since conducted the required number of additional rounds of MDA and are ready to conduct another TIS.

**Trachoma surveillance survey in 12 districts:** ENVISION will support TSS in Gulu, Omoru (split off from Gulu District), Amuru, Nwoya, Jinja, Iganga, Kamuli, Buyende, Dokolo, Lira, Otuke, and Alebtong Districts, at least 24 months from the time when MDA was stopped. This survey will determine whether to continue with surveillance or initiate MDA.

**SCH (and STH) re-assessments in nine districts:** ENVISION will support this in 2 districts in Eastern region, 4 in the Northern region and 3 in the Western region. Re-assessment of moderate- to high-risk districts treated for SCH is necessary to determine the impact of the treatments and to determine whether the frequency of the MDA should be adjusted. STH is surveyed at the same time as SCH, using the same Kato-Katz diagnostic. Also included are districts which were not properly mapped (the Northern region districts).

**MDA coverage validation surveys in ten districts:** ENVISION will support this using the same protocol as in prior years that was developed in collaboration with the Task Force for Global Health. RTI will provide technical assistance to implement these coverage surveys, which will include a KAP component to evaluate the impact of various IEC materials and social mobilization strategies. The NTD Secretariat intends to disseminate the findings of the surveys to districts and relevant stakeholders through reports.

**Harmonization of data in districts that have achieved stop-MDA criteria for LF and/or trachoma:** ENVISION will support the NTDCP's national data manager, the M&E Assistants, and other officers in selected districts that have stopped MDA, to ensure that all MDA records are available locally. The need for this was noted in DQAs which found that most districts do not have copies of reports or that reports are not the same as those at central level; and is required as part of preparation of an elimination dossier for either of the two diseases.

#### **Specific M&E challenges anticipated in FY17:**

- Poor filing system at the lower levels which contributes to a loss in the available data.
  - Solution: Set up a filing system in the implementing districts by providing file folders at all levels and emphasizing safe custody of the files.
- Use of inaccurate denominators in the computation of treatment coverage which results into false (often lower) reported coverage
  - Solution: Intensify supervision during registration, and validate this dataset before MDA implementation so as to improve the reliability of the denominator.
- The delay of MDA activities in some districts causes a memory gap for implementers, for example CMDs as a result of the time lag between the training and implementation of activities.
  - Solution: Closely supervising district FPs, Subcounty Supervisors and Parish supervisors so as to put pressure on CMDs.



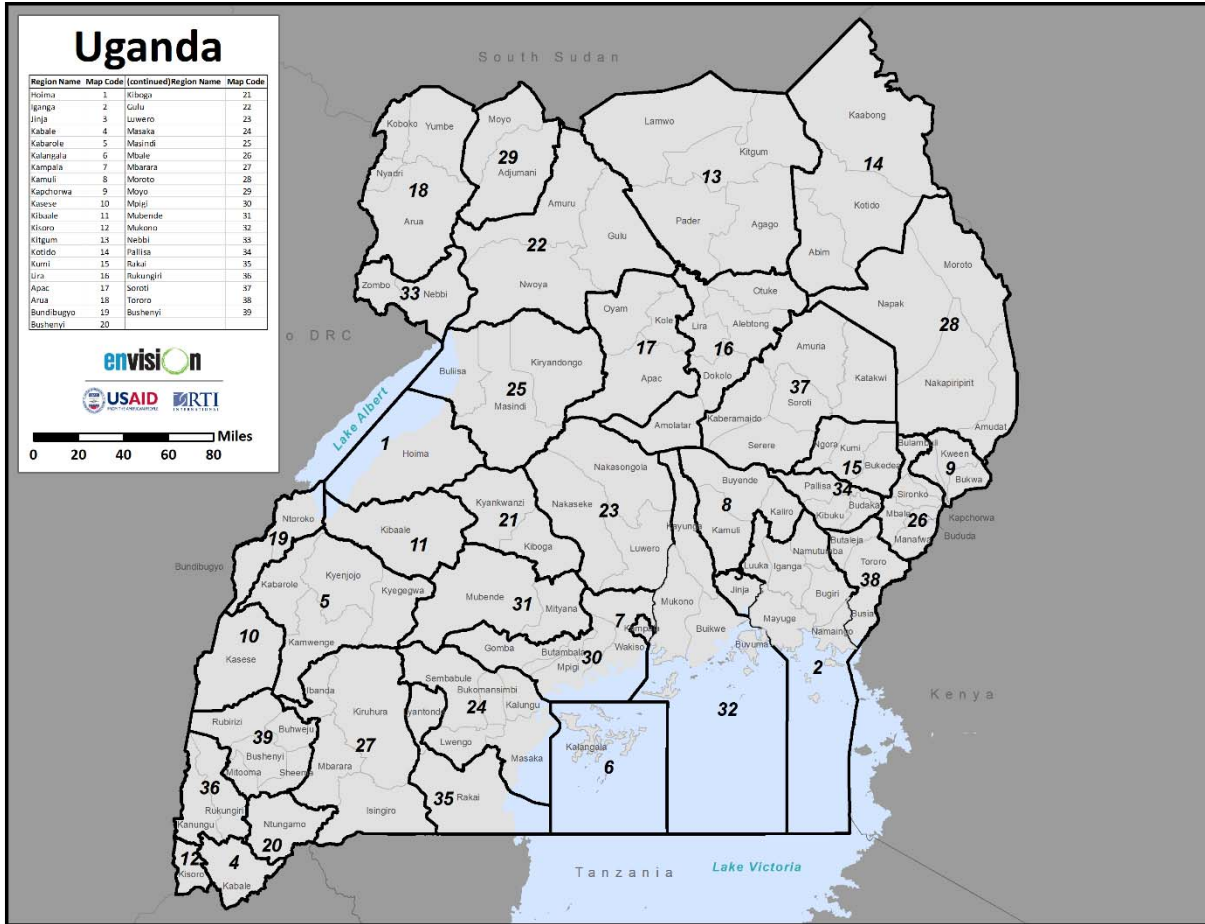
- General lack of sustainability plans for Post treatment surveillance for the case of districts that have achieved the criteria for stopping MDA.
  - Solution: Sustainability plans for post-treatment surveillance should be developed and adopted.
- Some districts do not follow the flow of activities as stipulated in their work plans hence compromising the quality of the subsequent activities.
  - Solution: Close supervision, improved training, written clear activities and timelines.
- Getting Disease Specific assessment results out (feedback) is still a challenge.
  - Solution: PMs will be facilitated and encouraged to do that soon after surveys.
- There is sometimes a knowledge gap at the lower implementing levels (specifically CMDs).
  - Solution: Pilot better training of Parish supervisors in some districts. Ensuring closer supervision will help strengthen the quality of the training cascade at the crucial lower levels.
- Delays in releasing funds to districts.
  - Solution: The NTDCP and ENVISION should station senior supervisors who can follow up with district officials.
- To achieve the desired treatment coverage requires qualified, well trained and experienced staff.
  - Solution: Committed experienced staff to be identified and used; some to be borrowed from districts where MDAs have stopped.
- The training of parish supervisors should be conducted by a central trainer.
  - This activity is proposed for FY17, above.
- Undefined SCH-endemic population/areas in districts
  - Solution: SCH-endemic districts should be guided on the WHO criteria and specifications for determining MDA-eligible population

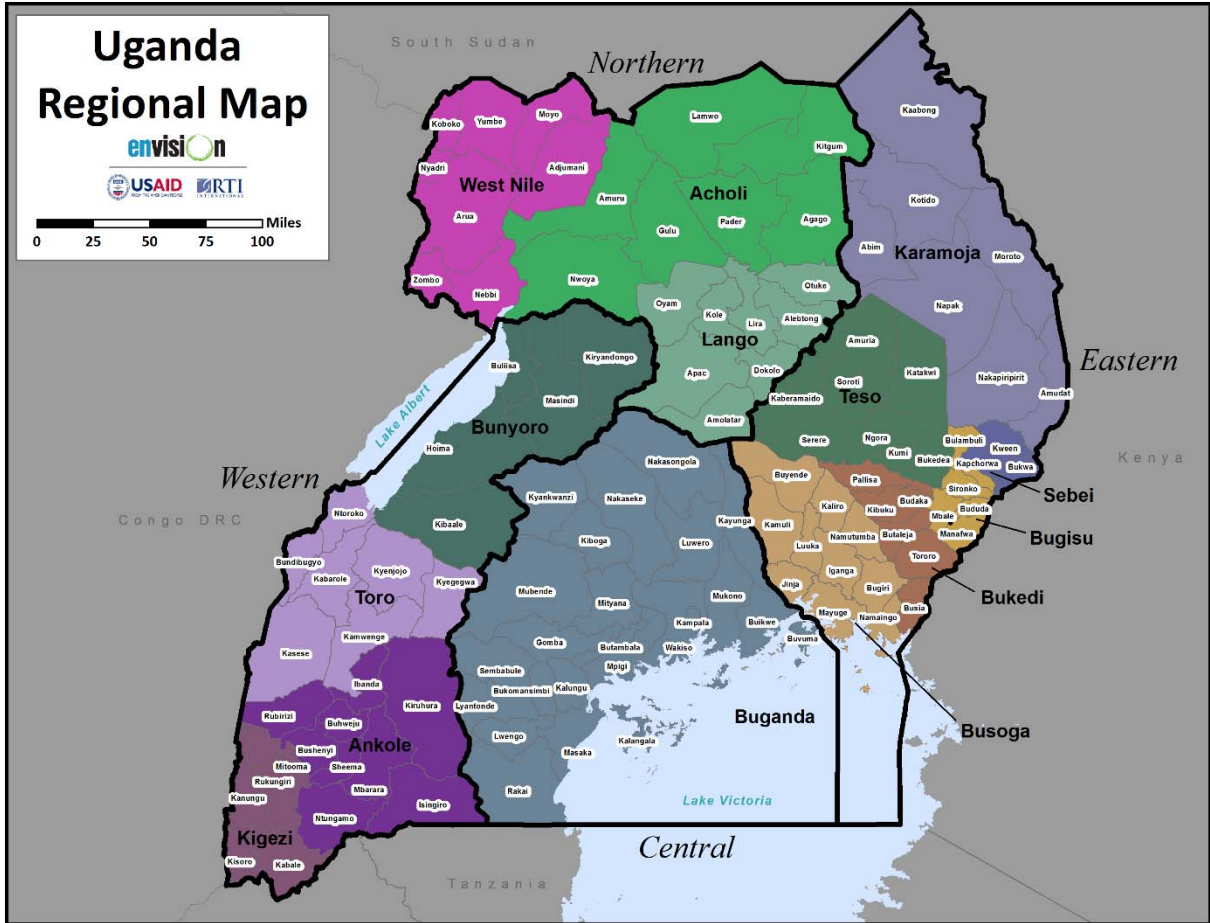
**Table 4: Planned disease-specific assessments for FY17 by disease**

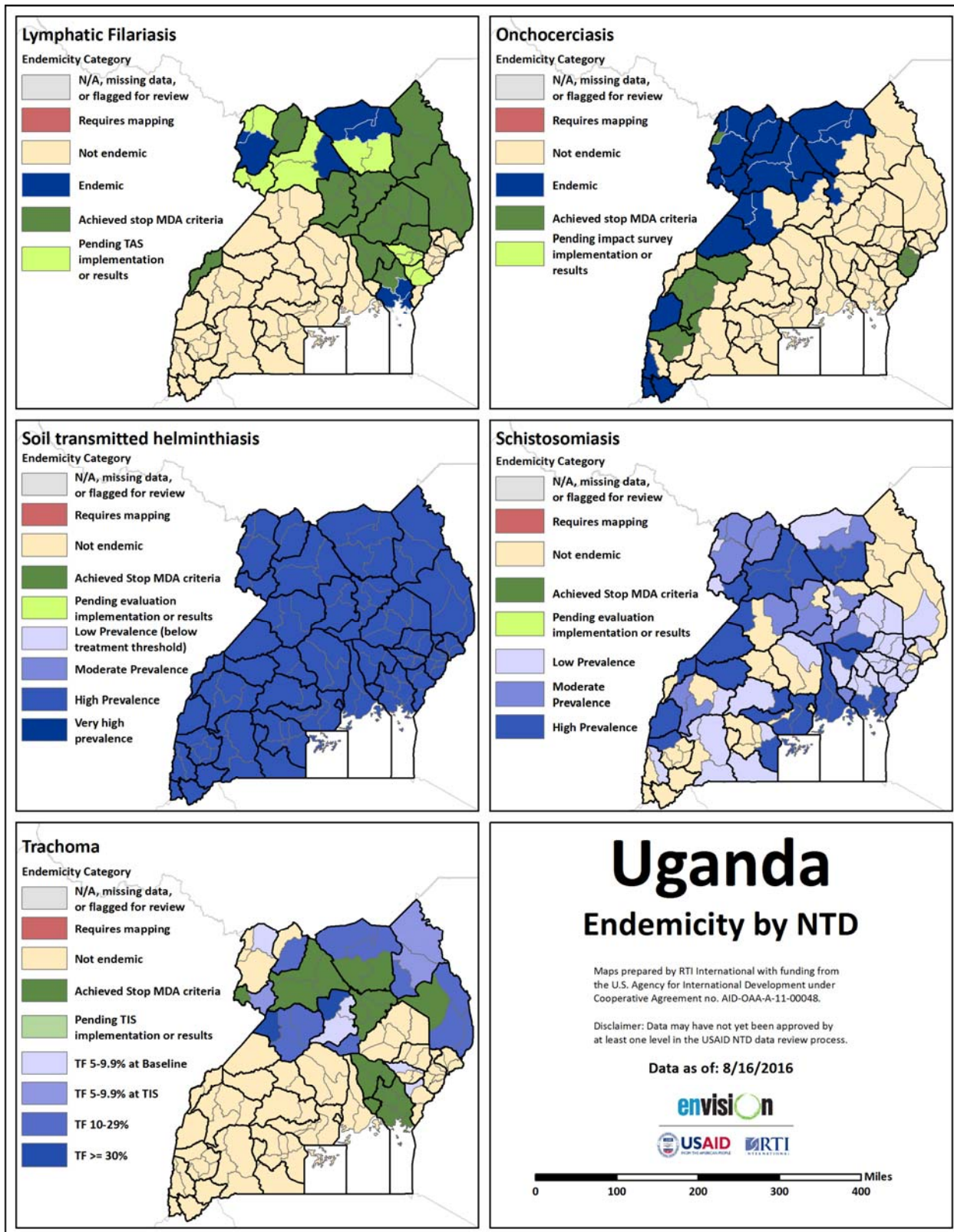
Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method
Lymphatic filariasis [RTI]	57	5	TAS 1: Stop MDA	FTS for antigenaemia; Mf in night blood
		16	TAS 2: Post MDA surveillance	
Trachoma [RTI]	44	8	TIS	Clinical grading (Tropical Data surveys)
		12	TSS	
Schistosomiasis [RTI]	81	9	Re-assessment	Kato Katz
Onchocerciasis [The Carter Center]	23	20	Entomological surveys as part of monitoring of MDA	Fly collection and crab trapping; analysis via Pool-screening for <i>Onchocerca</i> DNA using O-150 PCR
		17	Serological surveys to determine if MDA can be stopped	Blood spots; Ov-16 ELISA



### 3) Maps

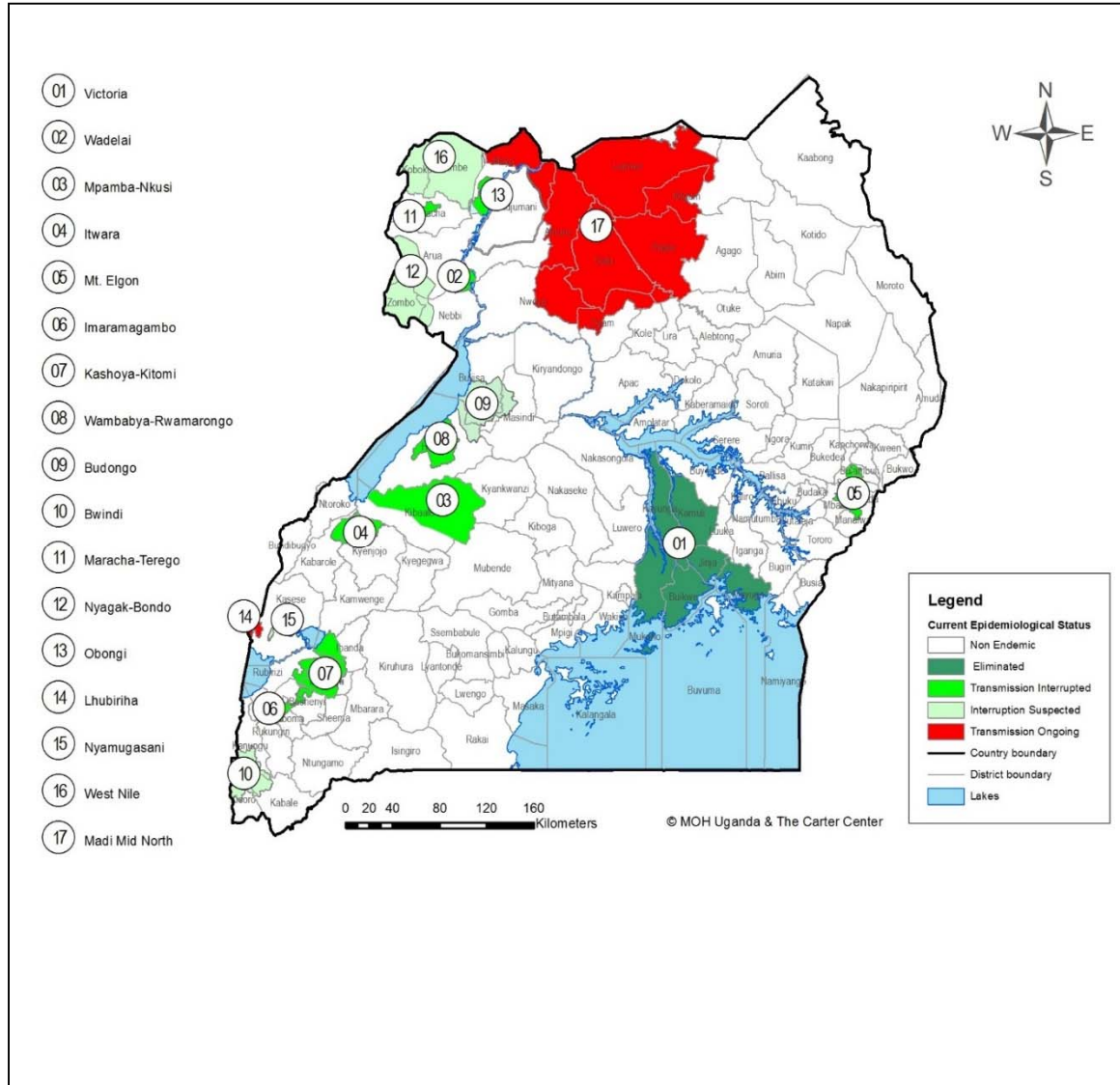


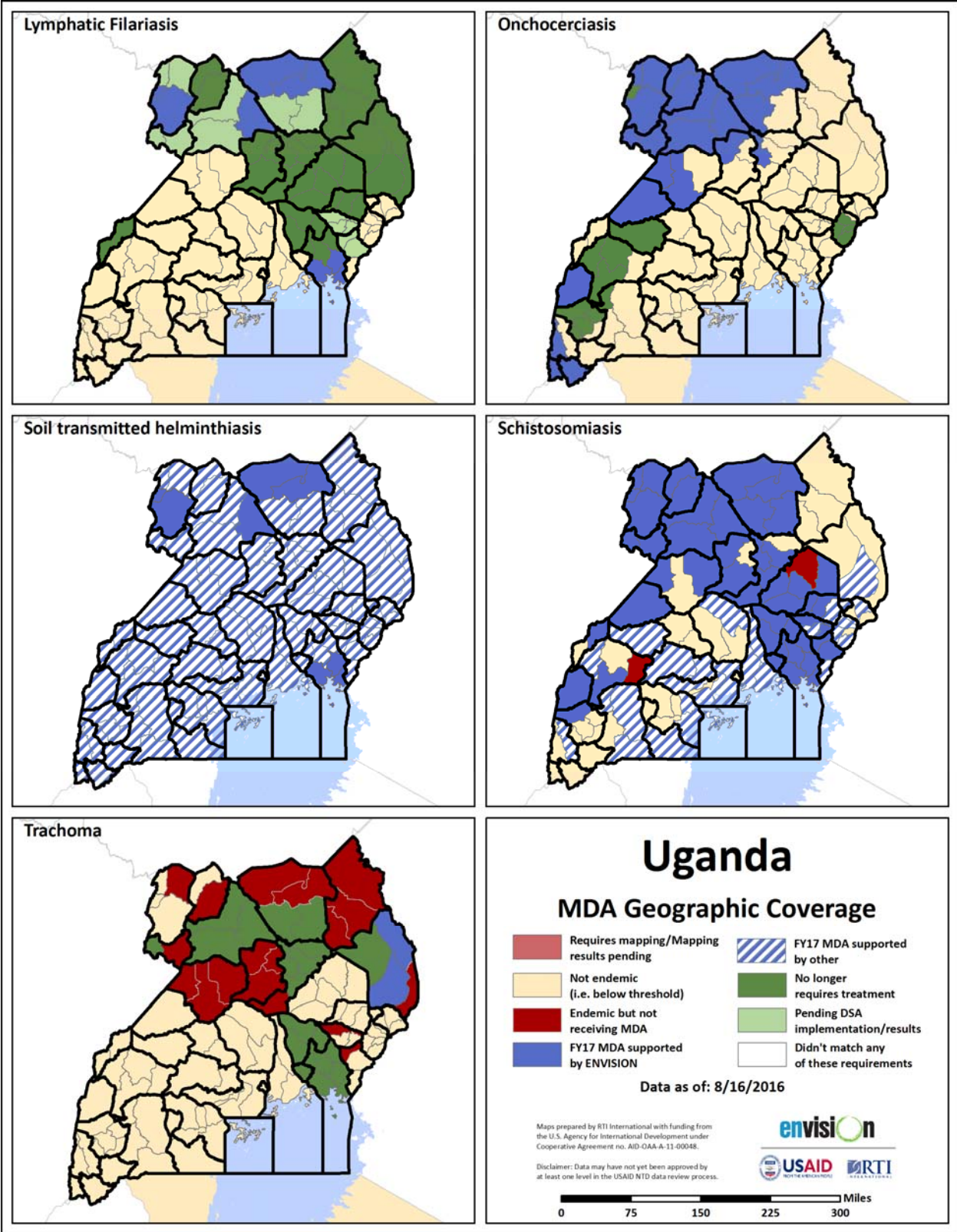


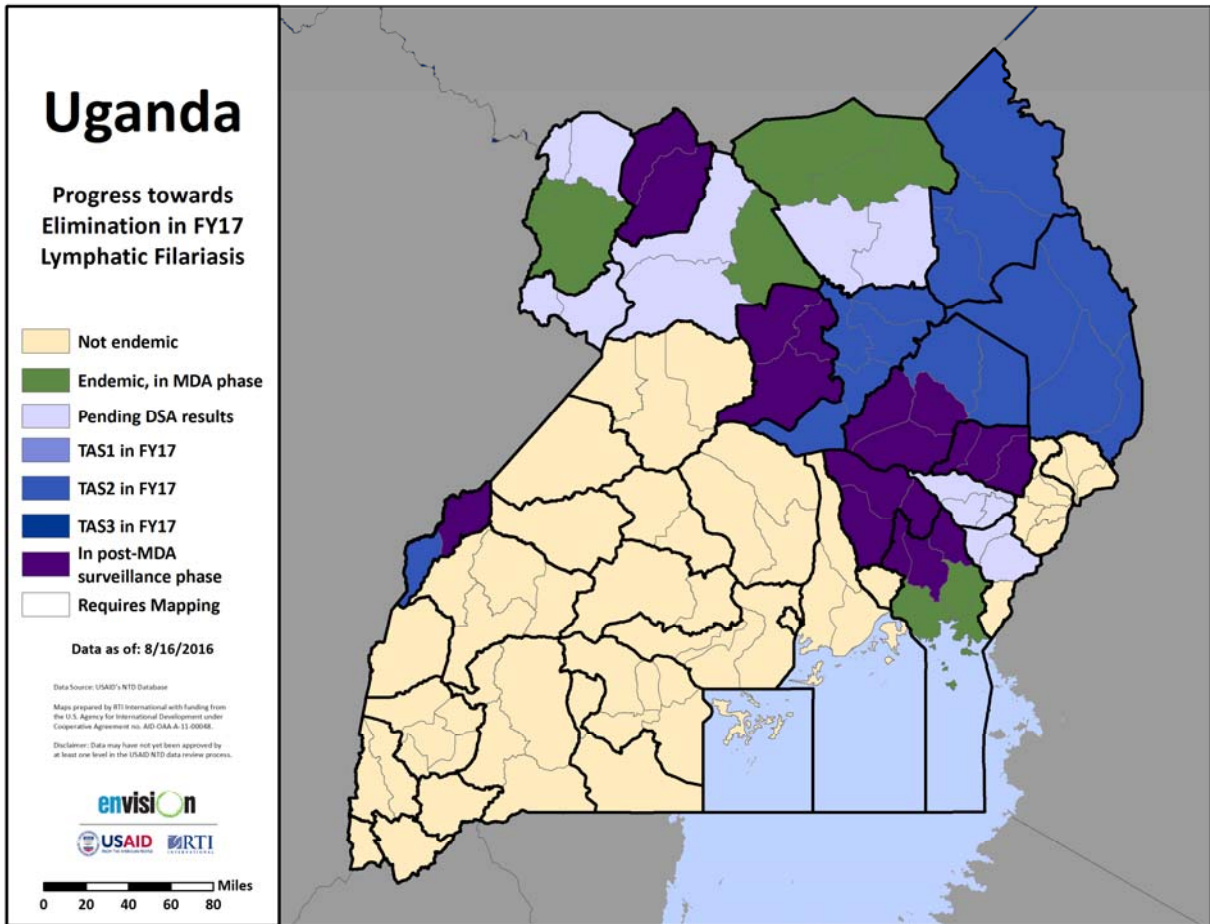




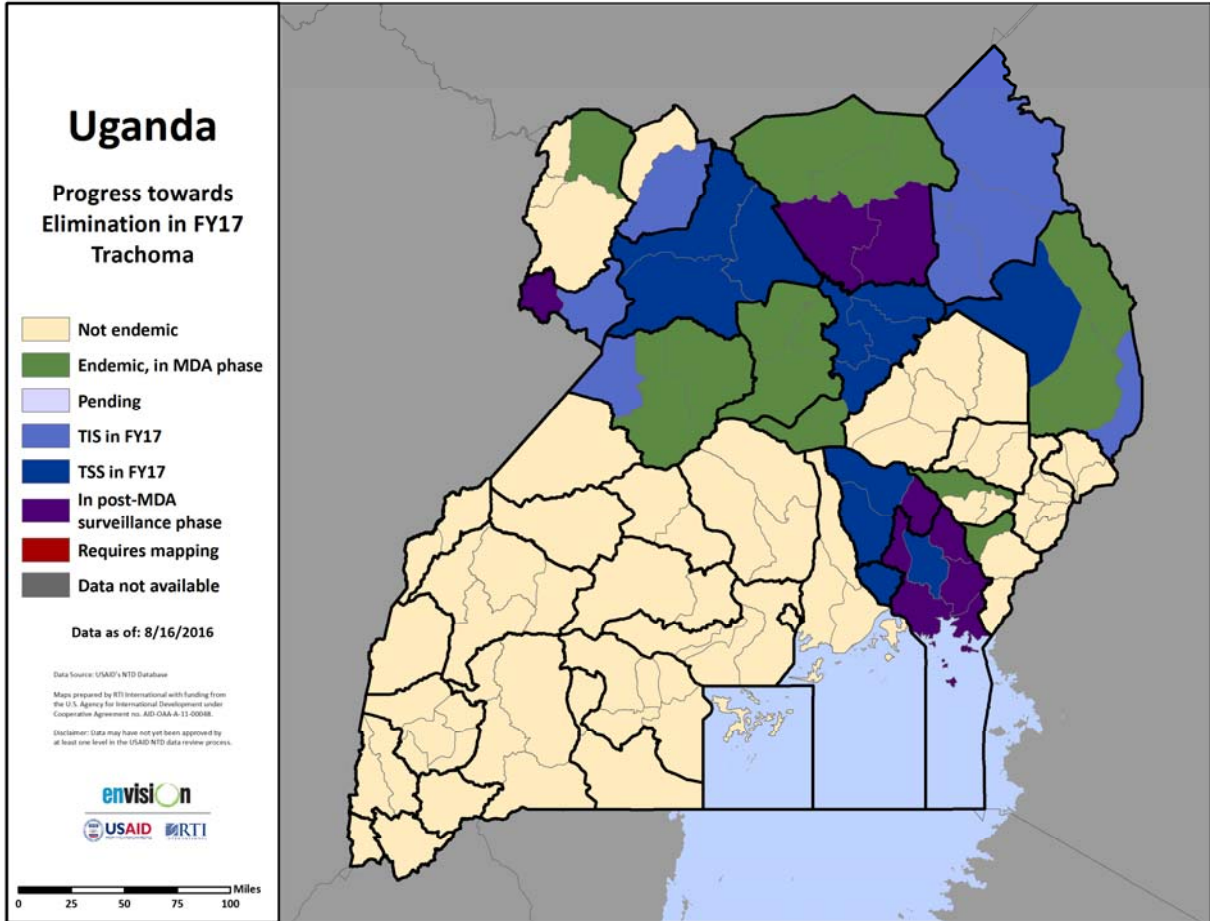
## Uganda: OV-endemic areas (foci)











## APPENDIX 1. WORK PLAN TIMELINE

FY17 Activities
Strategic Planning
NTD Technical Committee meetings
National planning and stakeholders' annual review meeting
National data review meeting
Regional planning and review workshops
Re-orient NTDCP staff in implementation, use of TIPAC
Review and update of the National NTD Master Plan
Cross-border meeting for Trachoma (Karamoja Region) and SCH (Albertine Region and Namayingo District)
Meeting to discuss plans for PC-NTD control after MDA for LF and/or OV is stopped
UOEEAC annual technical meeting
OV epidemiological & entomological coordination meetings
Bi-annual review meetings with OV/VCO NTD district focal persons
Micro planning for MDA and associated activities in 15 districts, involving the central-level MOH
Micro planning for MDA and associated activities in 40 districts, without the central-level MOH
NTD Secretariat
NTD Secretariat office operating costs
Program-specific supportive supervision
Building Advocacy for Sustainable National NTD Program
Use of the TIPAC for advocacy
High-level meeting with district leaders in three regions
District-level advocacy with local government and health officials
Advocacy Breakfast meeting with the Uganda Parliament's Social Services and Health Committees
News publications on NTDs
Ministerial statement on NTDs
OV sensitization workshops in four districts
Social Mobilization to Enable NTD Program Activities
Workshop to review IEC materials and social mobilization strategies
Production and delivery of IEC materials
Develop a documentary on SCH morbidity for Albertine sub region and on the Trachoma burden for Karamoja sub region
Radio talk shows, jingles, and announcements

<b>FY17 Activities</b>
Community dialogue in selected areas of three sub-regions
OV-related health education and sensitization by community supervisors
OV, LF, and trachoma post-treatment surveillance sensitization meetings
<b>Training</b>
Training of central trainers/supervisors in 55 districts
(Re)training of M&E assistants and program staff
Training of local government officials in FOG management in 55 districts
Train/reorient the MOH NTD Data Manager on General M&E Skills
Training of trachoma graders and recorders
Training of district NTD focal persons – 55 districts
Training of district trainers (TOTs) in 55 districts
Training of subcounty supervisors and health workers based at HSDs and lower health units
Training of parish supervisors
Training of CMDs/VHTs and teachers
Training in Program planning, management and evaluation (including financial management)
Training NTDCP Managers and senior staff on the Integrated NTD database
InsideNGO training for ENVISION staff
OV-specific training of parish and community supervisors
OV-specific re/training of health workers
OV-specific re/training of CDDs
<b>MDA</b>
Procure and position MDA supplies
Procure and position MDA supplies
MDA for LF-OV-SCH-STH and for Trachoma
MDA for OV
<b>Drug Supply Management and Procurement</b>
Emergency Drug Transport from national warehouse to Districts
Reverse supply chain of drug and diagnostic stocks (post MDA)
<b>Drug Storage</b>
<b>Drug Repackaging</b>
<b>Job Aid support</b>
Joint planning with NMS
Clearing and Handling of PC-NTD drugs
<b>Supervision</b>

<b>FY17 Activities</b>
Supportive supervision during training of subcounty supervisors & HWs in 55 districts
Supervision during training of parish supervisors
Supervision during training of CMDs, teachers and registration
Supervision during MDA and Data Collection
Supportive Supervision for Finance
Staff supervision
District leader supervision
STTA
Trachoma Surveys Quality Control specialist
M&E Specialist training visit
M&E Assistants
SAE Consultant
NTD Technical Committee Members
IEC Consultant
Independent Monitors of MDA
LF pre-dossier consultant
M&E
Workshop to use national PC-NTD data for programmatic decision-making
LF TAS 1 in five districts
LF TAS 2 in 16 districts
Trachoma impact survey in eight districts
Trachoma surveillance survey in 12 districts
SCH (and STH) re-assessments in nine districts
MDA coverage validation surveys in ten districts
OV MDA coverage surveys in three districts
OV impact surveys in six foci
OV monthly vector monitoring in six foci
Monthly entomological vector surveys in nine OV foci
OV quarterly entomological assessment in one focus
Cross-border epidemiological and entomological OV assessments in up to five foci, with DRC and South Sudan
Cross-border OV sensitization and planning meetings in seven districts
Harmonization of data in districts that have achieved stop-MDA criteria for LF and/or trachoma
Participatory evaluation meetings and face-to-face interviews to monitor CDTI in six foci

## APPENDIX 2. TABLE OF USAID-SUPPORTED DISTRICTS

	Region	Health Districts	TIS	TSS	LF TAS 1,2	Trachoma MDA	LF MDA	OV MDA	SCH MDA (XS = in schools only)	STH MDA	SCH-STH re-assessments
1	Northern Region	Adjumani	X					X	X		
2		Agago			X			X	X		X
3		Amuru		X	X			X	X		X
4		Apac						X	X		
5		Arua						X	X		
6		Alebtong			X	X		X	X		
7		Amolatar				X		X	X		
8		Gulu			X		X	X		X	X
9		Kitgum					X	X	X	X	
10		Lamwo					X	X		X	
11		Lira			X	X		X	X		
12		Moyo						X	X		
13		Nebbi	X					X	X		
14		Nwoya			X	X		X	X		
15		Omoro					X	X	X	X	X
16		Oyam						X	X		
17		Koboko						X	X		
18		Yumbe						X	X		
19		Zombo						X			
20		Dokolo			X	X				XS	
21	Maracha								XS		
55	Pader				X			X	XS		
22	Eastern Region	Budaka							XS		
23		Bugiri					X		X	X	
24		Buyende			X				X		X

	Region	Health Districts	TIS	TSS	LF TAS 1,2	Trachoma MDA	LF MDA	OV MDA	SCH MDA (XS = in schools only)	STH MDA	SCH-STH re-assessments
25		Butaleja							XS		
26		Iganga							XS		
27		Jinja							X		
28		Kaberamaido							X		
29		Kamuli							XS		
30		Kaliro							XS		
31		Katakwi				X			XS		
32		Kumi							XS		
33		Luuka							XS		
34		Mayuge						X	X	X	X
35		Moroto				X	X				
36		Namayingo						X	X	X	
37		Nakapiripirit				X	X				
38		Namutumba								XS	
39	Eastern Region	Ngora							XS		
40		Pallisa							XS		
41		Sererere							X		
42		Soroti							XS		
43		Tororo				X			XS		
44	Western Region	Buliisa	X					X	X		
45		Hoima						X	X		X
46		Kabale						X			
47		Kamwenge							X		X
48		Kanungu						X			
49		Kasese						X	X		
50		Kiryandongo							X		
51	Kisoro							X			

	Region	Health Districts	TIS	TSS	LF TAS 1,2	Trachoma MDA	LF MDA	OV MDA	SCH MDA (XS = in schools only)	STH MDA	SCH-STH re-assessments
52		Masindi						X			
53		Ntoroko			X				X		X
54		Rubirizi							X		
55		See Pader									
						<b>2</b>	<b>7</b>	<b>24</b>	<b>48</b>	<b>7</b>	