THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Sustainability Plan for Neglected Tropical Diseases Control Program

2020–2025

VECTOR BORNE AND NEGLECTED TROPICAL DISEASES DIVISION
MINISTRY OF HEALTH
P. O. BOX 7272
KAMPALA, UGANDA

Contents

Acronyms and Abbreviations

ASCEND	Accelerating Sustainable Control and Elimination of NTDs
BCC	Behaviour Change Communication
CAO	Chief Administrative Officer
CMD	Community Medicine Distributor
DFID	U.K. Department for International Development
DGHS	Director General of Health Services
DHIS2	District Health Information System 2
DHO	District Health Office (Officer)
DLG	District Local Government
EPI	Expanded Program for Immunization
FY	Fiscal Year
GESI	Gender Equity and Social Inclusion
HC2, 3, etc.	Health Centre Level 2, 3, etc.
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoGLSD	Ministry of Gender, Labour and Social Development
MoLG	Ministry of Local Government
MoWE	Ministry of Water and Environment
MP	Member of Parliament
NGO	Non-governmental Organisation
NMS	National Medical Stores
NNN	Neglected Tropical Diseases NGO Network

NTD	Neglected Tropical Disease
NTDCP	NTD Control Programme
OPM	Office of the Prime Minister
PC	Preventive Chemotherapy
R4D	Results for Development
RBF	Results-Based Financing
SCH	Schistosomiasis
SPC	Sustainability Planning Consultation
STH	Soil-Transmitted Helminths
TCC	The Carter Center
TEO	Tetracycline Eye Ointment
TOR	Terms of Reference
TT	Trachomatous Trichiasis
UGX	Uganda Shilling
USAID	U.S. Agency for International Development
VB & NTDs	Vector Borne and Neglected Tropical Diseases
VCD	Vector Control Division
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WI-HER	Women Influencing Health, Education, and Rule of Law

Foreword

Uganda still has a high burden of neglected tropical diseases (NTDs) that affects mainly the rural poor, resulting in low productivity and socioeconomic development of these populations. NTDs of public health importance include lymphatic filariasis (elephantiasis), schistosomiasis (Bilharzia), soil-transmitted helminths (intestinal worms), onchocerciasis (river blindness), trachoma, human African trypanosomiasis (sleeping sickness), visceral leishmaniasis (Kala-azar), plague, Buruli ulcer disease, rabies, tungiasis (jiggers), podoconiosis (non-filarial elephantiasis), echinococcosis, cysticercosis, brucellosis and leprosy. Currently, there are ongoing efforts to prevent, control and eliminate these NTDs with varying degrees of success. Control and elimination of NTDs is part of the Uganda National Minimum Health Care Package as highlighted in the Health Sector Development Plan II.

The overall goal of the Uganda NTD Control Program Sustainability Plan 2020-2025 is to bring together other sectors on board to strengthen mechanisms that will enable the Ministry of Health to sustain NTD efforts and strengthen the health system to provide sustainable, accessible, equitable and quality NTD services to the population. As we remain focused on advancing national progress towards achieving the World Health Organization's (WHO's) elimination and control goals for these NTDs, this sustainability plan focuses on supporting efforts to better mainstream NTD programmes into national governance, financing, planning and service delivery components of the health system. Incorporation of NTD priorities into routine government planning, implementation and monitoring will be essential to the sustainability of NTD programming in Uganda. However, this will require targeted advocacy, alignment with broader health and multi-sectoral policies and strategies as well as national domestic resource mobilisation. Therefore, to promote and achieve sustainability, the Ministry of Health is committed to investing in mainstreaming NTD control and elimination activities into the national health systems through other health programme areas, such as malaria control and other relevant sectors, including education, water, and sanitation.

The process of developing this sustainability plan was highly participatory, involving key stakeholders in a consultative manner at national and sub-national levels. It is centred on six health systems functional areas: Financing; Service delivery; Information systems; Operational capacity; Policy and planning; and Coordination; and a cross-cutting area of Gender equity and social inclusion (GESI). These functional areas have been adapted to be specifically relevant to NTD programmes and control and elimination goals as stipulated in the WHO guidelines.

To achieve the sustainability objectives, strong partnerships with other sectors – including Education, Water and Environment, Agriculture, development partners, civil society organisations, and the affected communities – are needed.

I wish to express my appreciation to all who participated in the development of this Uganda NTD Control Program Sustainability Plan 2020-2025, with special appreciation to the NTD Control Programme for taking the lead and USAID's Act to End NTDs | East Program for providing financial, logistical and technical support. I look forward to successful implementation of the plan.

Dr. Jane Ruth Aceng
MINISTER OF HEALTH

Acknowledgments

The Ministry of Health (MoH) would like to express its appreciation to all key stakeholders who supported the process of developing this sustainability plan 2020–2025 through technical and financial support. The development process was consultative and included a wide range of stakeholders from government ministries, agencies and departments; development partners, local governments and NTD implementing partners, at both national and sub-national levels. This participatory consultation cultivated an understanding of sustainability, defined and endorsed by stakeholders, and supported us in developing this Uganda NTD Control Program Sustainability Plan 2020-2025. Connecting with diverse stakeholders enabled us to unlock previously unidentified constraints, resources and factors that hinder NTD sustainability efforts.

Great thanks to all the stakeholders who were involved in the consultative process (see Annex 8) that included the Political Economy Assessment, Gender Equity and Social Inclusion Analysis and Sustainability Plan Consultation and Dissemination workshop. Your ideas enabled us to develop this sustainability plan.

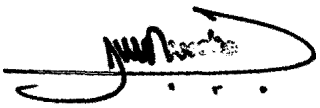
The development of this plan would not have been possible without the generous financial and technical support of USAID's Act to End NTDs | East (Act | East) Program.

On behalf of the Government of Uganda, I thank the U.S. Agency for International Development (USAID), Act | East consortium partners: RTI International; Women Influencing Health, Education, and Rule of Law (WI-HER); Results for Development (R4D); and the Carter Center, and the World Health Organization (WHO) Uganda Country Office for providing technical support during the consultation and sustainability development process.

Special thanks and recognition are made to the following National Taskforce under the guidance of the Acting Assistant Commissioner Health Services – Vector Borne and NTDs, who led the writing and review of this sustainability plan.

Name	**Designation**
Dr Alfred Mubangizi	Acting Assistant Commissioner, Vector Borne and NTDs/NTDCP Coordinator – MoH
Dr Francis Mugume	Programme Manager, Trachoma and Schistosomiasis – MoH
Gabriel Matwale	Programme Manager, Lymphatic Filariasis – MoH
Gilbert Baayenda	Trachoma Programme Officer – MoH,
Egitat Geoffrey	Vector Control Officer – MoH
Dr Narcis Kabatereine	Uganda Country Lead – ASCEND East
Dr Fatunmbi Bayo Segun	WHO, Uganda Country Office
Dr Wilberforce Owembabazi	USAID |Uganda
Joyce Kyalo	Regional HSS Lead – ASCEND Kenya
Dr Abbas Kakembo	Member – NTD Technical Advisory Committee/Chair NTD- Research Ethics Committee
Tom Lakwo	Member –NTD Technical Advisory Committee
Dr Peter Langi	Member – NTD Technical Advisory Committee
Dr Bhoka George	District Health Officer– Adjumani
Dr Oryema Jakor	District Health Officer– Nebbi
Muron Vincent	For NTD Focal Person – Moroto
Okumu Morris	NTD Focal Person – Buliisa
Taroub Faramand	Founder and President – WI-HER
Esther Karamagi Nkolo	Technical Director – WI-HER

Name	Designation
Jose Gonzalez	Program Officer R4D – Washington, DC
Maria Francisco	Program Director R4D – Washington, DC
Richard Killian	HSS Lead – Act | East, Washington, DC
Benjamin Binagwa	Chief of Party – Act | East, Uganda
Mike B. Mukirane	HSS Advisor – Act | East, Uganda
Martin Klaus Osilo	Senior Monitoring, Evaluation, Research, Learning, and Adaptation Specialist – Act | East, Uganda
Ms Stella Agunyo	Deputy Chief of Party – Act I East, Uganda



Dr. Henry G. Mwebesa
DIRECTOR GENERAL, HEALTH SERVICES

Executive Summary

As countries move towards global control and elimination goals for neglected tropical diseases (NTDs), national health systems must consider how they will ensure that achievements in controlling or eliminating these diseases are sustained over time. To achieve this, Uganda is among the countries that are focusing on health systems strengthening (HSS) as a key component to enable the country to meet and sustain these achievements. During the Sustainability Planning Consultation (SPC) and stakeholder engagement exercise, the diverse NTD stakeholders adopted the definition of sustainability of NTD programming as follows: "the national health system's capacity and commitment to maintain the provision of NTD interventions at levels that will continue progress towards control or elimination of diseases in accordance with national NTD goals."

This sustainability plan was developed based on the six core building blocks of the health system and one cross-cutting area of Gender Equity and Social Inclusion (GESI), with a focus on the gaps, root causes and solutions to these root causes. Other cross-cutting issues such as political will and community demand were also explored during the development of this plan. Closing these health system gaps will contribute to both sustaining the selected disease-specific goals and strengthen the core components of the health system, hence, benefiting the entire National NTD Programme and Ministry of Health (MoH) at large.

The following were identified as the sustainability priority gaps according to each health system functional or cross-cutting area.

- **Operational Capacity:** Lack of funding for and integration of the NTD medicines and supplies into the mainstream routine MoH supply chain processes at the national level (push versus pull)
- **Service Delivery:** Poor integration of NTD services into the existing health service delivery model (facility versus community based), health workers with low skill levels and who lack equipment to diagnose and manage NTDs in health facilities and gaps in mass drug administration (MDA), which leave some eligible people without prevention services
- **Financing:** Low levels of funding to the NTDCP because of limited use of data to inform planning and make a case for NTD programme budget support and evidence-informed advocacy.
- **Information Systems:** NTD data not fully incorporated into the health management information system (HMIS), weak surveillance system and inadequate utilisation of NTD data
- **Policy and Planning:** Limited reflection of NTD in the overall health policies and priorities at national and district levels
- **Coordination:** Inadequate multi-sectoral collaboration and weak coordination structures for all stakeholders, especially at the district level
- **Cross-cutting Area–GESI:** Inadequate integration of GESI considerations into NTD programming in Uganda.

To close the afore-mentioned gaps, the team identified the following objectives as essential to having sustainable NTD programming in Uganda.

- **Operational Capacity:** Integrate NTD MDA and case management medicines and supplies into the MoH's routine supply chain management practices by 2025
- **Service Delivery:** Fully integrate all NTD services into the existing healthcare system by the end of 2025, build the capacity of health workers to manage NTDs at different levels of the healthcare system and address GESI-related gaps affecting service delivery in health facilities of Uganda.

- **Financing:** Increase domestic financing for NTD programming from 12% to 30% by the end of 2025
- **Information Systems:** Integrate NTD data into the HMIS/District Health Information System 2 (DHIS2) to reduce data fragmentation and generate reports for strategic planning and decision making and strengthen the routine surveillance system for NTDs in Uganda
- **Policy and Planning:** Strengthen evidence-based advocacy and lobbying for NTD programming, targeting policy makers at national and district levels, and monitor and evaluate implementation of international, regional and national commitments on NTDs.
- **Coordination:** Strengthen NTD programming, multi-sectoral collaboration and coordination mechanism at national and district levels to enhance the efficiency and impact of the NTD programme
- **Cross-cutting Area–GESI:** Integrate GESI into NTD programme implementation in Uganda to achieve sustained elimination and control of NTDs by 2025.

Several strategies and activities to achieve the objectives have been suggested as detailed in this sustainability plan 2020–2025. It is envisaged that implementation of the planned activities will lead to several outcomes as outlined below:

- **Operational Capacity:** NTD drug donation, procurement and distribution systems are fully owned by the government and integrated, to the extent possible, into the mainstream MoH supply chain, including quantification, procurement, warehousing, distribution and utilisation to achieve control and/or elimination. Additionally, NTD medicines and supplies are included in the Essential Medicines and Supplies Kit for all levels of the healthcare delivery system so that NTD services can be accessed easily at all health facilities. Finally, people who need specific doses and formulations of drugs and supplies, such as pregnant and lactating women and some children, are catered for during procurement and distribution.
- **Service Delivery:** NTD services are provided through existing and emerging community and facility platforms as part of the basic services package. All campaigns are part of the comprehensive NTD package managed by the sub-national level with technical guidance from the MoH. Mechanisms to identify and reach individuals or groups who are missed by MDA are in place, and all the relevant health workers are in place to support implementation of the interventions through the existing platforms.
- **Financing:** Sufficient domestic funding (at least 50% of total NTD funding) to support NTD programming needs is available, both at national and sub-national levels, to sustain long-term NTD programme needs, including control and elimination targets. Programmatic data are used to advocate for government resources for NTDs and to demonstrate cost-effectiveness and health impact through periodic financial tracking at the national and sub-national levels. Interventions to reach individuals and groups facing exclusion and discrimination are included in NTD budgets.
- **Information Systems:** MoH DHIS2 includes all the relevant NTD data and indicators, ensuring that these data are collected, analysed and reported like other public health information, including gender-sensitive and sex- and age-disaggregated data. NTD data are reported from, and available at, both the facility and district levels to improve planning, resource allocation and responsiveness.
- **Policy and Planning:** An advocacy strategy is in place as are policies that promote NTD control and elimination interventions and address the unique needs and contributions of women and

men with emphasis on GESI while taking into consideration new epidemiological and demographic trends and control and elimination approaches.

- **Coordination:** Close coordination with other health or related programme areas, such as malaria and maternal and child health, and other sectors, including WASH and education is functional, and strengthened partnerships with other programme areas and sectors are developed. Expert committees and structures that formalise rules of engagement and working relationships among stakeholders are established and sustained. Coordination mechanisms that are representative of gender and other social considerations to promote health equity among all groups are in place.
- **Cross-cutting Area–GESI**: Existing social norms and behaviours that increase the risk of NTDs – such as poor health-seeking behaviour in men with NTDs and alcohol consumption by men and women – as well as considerations for risks many women with trichiasis face because of their frequent and recurrent infections – all of which affect NTD elimination/control efforts to achieve equity in access to NTD services, are mitigated. Additionally, sex disaggregated and gender-sensitive data availability and use are achieved at the national and sub-national levels.

1.0: NTD Control Programme Sustainability

1.1: Introduction

Uganda still has a high burden of neglected tropical diseases (NTDs) that affect mainly the rural poor, resulting in low productivity and affecting the development of these populations. NTDs of the highest public health importance in the country include lymphatic filariasis (elephantiasis), schistosomiasis (Bilharzia), soil-transmitted helminths (intestinal worms), onchocerciasis (river blindness), trachoma, human African trypanosomiasis (sleeping sickness), visceral leishmaniasis (Kala-azar), plague, Buruli ulcer disease, rabies, tungiasis (jiggers), podoconiosis (non-filarial elephantiasis), echinococcosis, cysticercosis, snake envenoming, scabies, brucellosis and leprosy. These NTDs in Uganda are managed by the NTD Control Programme (NTDCP), which is housed in the Vector Borne and Neglected Tropical Diseases Division of the Ministry of Health (VB & NTDs -MoH). The NTDCP is led by an Assistant Commissioner of Health Services (Vector Borne and Neglected Tropical Diseases [VB & NTDs]) who also serves as the National NTD Coordinator. He/she is assisted by disease-specific programme managers; senior technical and programme staff, including scientists, behaviour change communication (BCC) specialists, technologists, monitoring and evaluation specialists, entomologists and technicians; and support staff such as drivers, office attendants, etc. A number of these staff such as programme officers, entomologists and support staff are seconded to the VB & NTDs by various projects such as Schistosomiasis Control Initiative, The Carter Center (TCC) and now Accelerating Sustainable Control and Elimination of NTDs (ASCEND). The NTDCP coordinates activities against all preventive chemotherapy (PC) NTDs and the Innovative and Intensified Disease Management NTDs.

1.2: Heath systems and policy context

Uganda's health system operates under a decentralised framework, with the Ministry of Health (MoH) at the centre and the local governments at the sub-national level. The MoH is responsible for the overall stewardship of the health sector, including responsibility for policy formulation, strategic direction, setting of standards, disease surveillance, quality assurance and resource mobilisation. The MoH developed an NTD Master Plan 2017–2022 that follows the World Health Organization (WHO) guidelines for NTDs and describes in detail the setup of the country's health system and the NTDCP. The MoH, in collaboration with key stakeholders, sets the country's strategic direction for NTD efforts, incorporates NTDs in its

annual statement and budget to Parliament and provides an enabling environment for NTD-related programme implementation and research. With the assistance of the U.S. Agency for International Development (USAID), the disease specific NTD programmes were integrated and the NTD Secretariat was created in 2007 to provide technical oversight to the programme. The NTD Secretariat brings together all partners and the NTD programme team to assess progress with implementation of specific programme activities as articulated in the NTD master plan (2017–2022) and to ensure a well-coordinated effort.

The MoH established the NTD Technical Advisory Committee in 2013; this committee has been supporting the NTD Secretariat to ensure the NTD programme follows WHO's guidelines and standards in the implementation of the NTD Master Plan to meet disease-specific control and elimination goals. There is also a NTD Secretariat that is tasked with providing supportive supervision to sub-national level entities to ensure that the Master Plan, national policies and guidelines are followed. However, this supervision has been limited because of staff shortages and insufficient financial resources. This has negatively affected capacity strengthening at the district and sub-district levels as well as evidence-informed planning due to data not being shared in a timely manner.

The 2017–2022 National NTD Master Plan in Uganda is estimated to cost US$ 39,232,478 in fully implement, excluding the government's contribution (salaries) and support from partners (donations of funds and medicines). However, the government's commitment to NTD activity costs is estimated at US$ 474,000 over the 5-year period; and by 2018, partners had committed annual support of US$ 3,528,621, leaving an overall NTD implementation gap of US$ 35,229,857. This shows a substantial funding gap over the plan's 5-year implementation period, and without additional budget tracking information on NTD spending by government and development partners, the annual NTDCP funding gap cannot be easily estimated, particularly because a large share of NTD spending comes from off-budget donor contributions. An August 2019 desk review, conducted by MoH – NTDCP with financial and technical support from Act I East, did not find more-recent estimates of resource needs or completed NTD financing planning tools, such as the Tool for Integrated Planning and Costing (TIPAC), nor is there any indication that government spending on NTDs is routinely tracked. However, numerous assessments of Uganda's health system have been conducted by several partners, including RTI with support from USAID; all of these assessments at national, district and community levels indicate that Uganda is ready and willing to conduct health system strengthening (HSS) efforts targeting its NTDCP.

1.3: Donor/implementing partners landscapes and trends

The major donors supporting Uganda's NTDCP are USAID, WHO, the Korea International Cooperation Agency and the U.K. Department for International Development (DFID). Other NTD implementing partners currently operating in Uganda that provide support through other donor agencies include TCC, Sightsavers, the Schistosomiasis Control Initiative and World Vision. RTI with financial support from USAID, is currently implementing the Act to End NTDs | East Program and Crown Agents, with financial support from DFID, is implementing the ASCEND East grant that will continue through 2022.

1.4: Sustainability efforts and success

Uganda has made significant achievements related to NTDs, such as being certified free of Guinea worm in 2009 and having achieved interruption of onchocerciasis transmission in 28 out of 40 districts. Impact assessments for the rest of the preventive chemotherapy (PC)-NTDs[1] is ongoing, and findings indicate a positive trend towards interruption of transmission. For lymphatic filariasis (LF), mass drug administration

[1] The five PC-NTDs are LF (which causes elephantiasis and hydrocele), trachoma, onchocerciasis (river blindness), SCH (bilharzia) and STH (which includes roundworm, hookworm and whipworm).

(MDA) has been stopped in all endemic districts, with assessments being carried out to confirm transmission interruption. Out of the 51 trachoma-endemic districts, only 3 are still undergoing MDA. Not much progress has been achieved with Kala-azar, schistosomiasis (SCH) and soil transmitted helminths (STH).

Therefore, as Uganda moves towards its NTD control and elimination goals, the MoH, in collaboration with relevant ministries such as Ministry of Education and Sports (MoES); Ministry of Water and Environment (MoWE); Ministry of Gender, Labour and Social Development (MoGLSD); Ministry of Finance, Planning and Economic Development (MoFPED); and Ministry of Local Government (MoLG), is assessing and putting in place mechanisms through which coordinated efforts for control and elimination of NTDs can be sustained. Such mechanisms include, among others, a focus on HSS and strengthened multi-sectoral collaboration through coordination committees such as the Uganda Onchocerciasis Elimination Expert Advisory Committee and the upcoming SCH/STH expert committee that will further expand and add value the sustainability efforts. The mission and four strategic priorities of the NTD Master Plan 2017–2022 focus on sustainability through several key strategies, including government ownership, advocacy, coordination and partnerships; resource mobilisation; financial sustainability of national NTD programming; scale-up of system capacity; access to interventions; and enhancement of NTD monitoring and evaluation as well as surveillance and operations research.

The Government of Uganda, alongside its partners, has already invested in HSS activities, indicating its commitment to building a sustainable and equitable health system that will be supportive of the NTD control and elimination goals. These efforts include development of the national NTD Master Plan 2017–2022 that clearly articulates control and elimination strategies, including those for NTDs, in the overall health policies, in the national health sector investment and development plan and in the national health budget. The Master Plan also includes NTD medicines on the essential medicines and health supplies list. There are also clear opportunities for further activities across all the health system functional areas and contextual factors, and the MoH, with support from partners such as USAID's Act | East Program, the DFID-supported ASCEND programme and the recently awarded USAID-supported Health Systems Strengthening Activity that is led by Palladium, is poised to support NTD sustainability efforts through a strengthened healthcare delivery system. This support is well aligned with the USAID Country Development Cooperation Strategy, which focuses on strengthening health financing, human resources for health (HRH), health information systems and the health products supply chain.

2.0: Sustainability Planning

2.1: Defining a sustainable NTD programme

The following definition of sustainability is adopted from the NTD Non-governmental Organisation (NGO) Network [NNN] statement endorsed by its Executive on 18 September 2019:

> *"Sustainability, for NTD programming, is realized when the intended result is achieved for as long as required. Sustainability is not a binary achievement that either exists or does not; rather, it is a spectrum comprised of multiple context-specific factors.*
>
> *A central theme of sustainability is a national government's long-term commitment to a goal or result with multi-level, local ownership. Sustainability and ownership are further characterized by the three components of domestic commitment, resource mobilization,*

and accountability. The three components are closely linked and may not always be completely independent of one another."[2]

Based on the above statement and the Sustainability Planning Consultation (SPC) and stakeholder engagement exercise in September–October 2019 as well as the SPC Results Dissemination and Prioritisation workshops in February 2020, the diverse NTD stakeholder group and smaller task force therefore adopted the following definition of *sustainability of NTD programming*:[3]

> *"The national health system **capacity** and **commitment** to maintain the provision of NTD interventions at levels that will continue progress toward control or elimination of diseases in accordance with national and global NTD goals."*

2.2: Sustainability planning and writing process

The MoH – NTDCP, with support from USAID's Act | East Program, conducted an SPC in September and October 2019, which engaged key stakeholders on issues of programme sustainability in the context of NTDs in Uganda. The consultation process generated an understanding of sustainability in the context of NTD programming. This consultation process, which was defined and endorsed by the MoH and its stakeholders, supported the NTDCP in developing this current Sustainability Plan, which identifies priority gaps and root causes of and solutions for the gaps, and which outlines short-, medium- and long-term actions. The consultation was a step in the process of analysing sustainability considerations and informing critical decision-making processes that would put Uganda on a path to operationally, technically and financially sustain its NTD programming.

In a January 2020 sustainability planning workshop, national and local-level experts from the public, private and NGO sectors convened by MoH voted to prioritise 8 key gaps out of 29 stakeholder-identified priorities. After prioritisation, these experts used root cause analysis to identify underlying causes and solutions for each of the prioritised gaps across the six functional areas as outlined in the sustainability framework. The team then formulated objectives and activities based on the gaps, root causes and solutions.

2.3: Country NTD sustainability priority gaps

The following were identified as the sustainability priority gaps according to each functional or cross-cutting area.

Operational Capacity

- Lack of integration of the NTD medicines and supplies into the mainstream routine MoH supply chain processes at the national level (push versus pull)

Service Delivery

- Poor integration of NTD services into the existing health service delivery model (facility versus community based)
- Health workers lacking skills and equipment to diagnose and manage NTDs in health facilities
- Gaps in MDA that leave some eligible people without prevention services

[2] This statement is adopted from the September 2019 NNN paper *Sustainability: A statement from the NNN*.
[3] The definition is adopted from USAID's 2019 working paper entitled *USAID NTD Program: Framework and Strategy for the Promotion of Sustainability*.

Financing

- Low levels of funding to NTDCP because of limited use of data to inform planning, budget allocation, evidence-informed advocacy and resource tracking.

Information Systems

- NTD data that are not fully incorporated into the health management information system (HMIS), weak surveillance system and inadequate utilisation of NTD data

Policy and Planning

- Limited reflection of NTD in the overall health policies and priorities at national and district levels

Coordination

- Inadequate multi-sectoral collaboration and weak coordination structures for all stakeholders, especially at the district level

Cross-cutting Area—Gender Equity and Social Inclusion (GESI)

- Inadequate integration of GESI considerations into NTD programming in Uganda

3.0: NTD Sustainability Gaps, Context, Objectives and Strategies

3.1: Functional area – Operational Capacity

Gap

The major gap within Operational Capacity is that NTD supplies and medicines are not integrated into the MoH's routine supply chain for NTD treatment at the facility level and MDA.

The assessment report identified multiple key causes of this gap. First, NTD medicines and related supplies are not part of the National Medical Stores (NMS)/MoH Essential Medicines and Supplies Kit for lower level health facilities. As a result, these health facilities cannot requisition NTD medicines and supplies for morbidity management. Second, NMS has not received rotating funds, i.e. a credit line, to purchase these medicines for morbidity management and MDA at all levels of the health system, limiting their availability for distribution. Although the NTDCP budgeted for including NTD medicines and supplies in the credit line, the MoH budget committee has not approved this funding, citing insufficient budget allocation to the MoH. Third, stakeholders noted that funding for medicines is dependent on high-quality data. The NTDCP presented limited morbidity and mortality data to MoH senior management during the budgeting process, weakening the argument for Parliament to appropriate resources for NTD medicines and supplies. Finally, government reliance on existing support from development partners for NTD medicines and supplies has contributed to poor integration of NTD medicines and supplies into the routine supply chain. Donors only provide funding for NTD medicines that are used during MDA, not for facilities conducting morbidity management, which creates a significant service gap.

Context

The country has relied mainly on donated NTD medicines because of the global understanding of the impact of these diseases on rural communities and the poor. Given the availability of these donated NTD medicines and supplies, the Government of Uganda uses available domestic resources for other social service priorities. As targets for stopping LF and trachoma MDA are being reached (both diseases are targeted for elimination), the option of combining MDA for SCH and/or STH (both diseases are targeted for control) with that of the elimination diseases will become less available, and ongoing control efforts

for SCH/STH will require the identification of other options. Therefore, integrating NTD medicines and supplies into the Essential Medicine and Supplies Kit and the routine supply chain is paramount. This possibility relies on several factors ranging from timely reports on morbidities and mortality that stimulate national concern by leaders at all levels to budgetary constraints in an economic environment where national budgets hinge on priorities as determined by community feedback on particular services. For Uganda, the lack of NTD medicines and supplies in the Essential Medicines and Supplies Kit brings to light the need for a strong monitoring, evaluation, research and reporting mechanism. Such a mechanism will make available programmatic data that is timely and of very good quality to raise the required consciousness about the negative impact of NTDs on the socio-economic and geopolitical development aspects of the country. For the country to have a sustainable NTD programme, integrating NTD medicines into the supply chain is required.

Objective

Integrate NTD MDA and case management medicines and supplies into MoH routine supply chain management practices by 2025.

Strategy

To integrate NTD medicines and supplies into the routine supply chain, the NTDCP will carry out several sequenced actions. First, NTDCP will collect, analyse and package NTD morbidity and mortality data and make a case for the inclusion of NTD medicines into the routine essential medicines supply chain of the country.

This data will be shared with all levels of decision making, including Parliament's budget committee. In addition to this data, the NTDCP will provide quantified medicine requirements for the next 5 years, presented in annual budgetary figures for ease of understanding and budgetary allocation on an annual basis.

Using this data, NTDCP shall conduct targeted advocacy to MoH Senior Management, MoFPED, parliamentarians and district decision makers on reviewing and changing medicines quantification and procurement policies – such as the National Medicines Policy and National Pharmaceutical Sector Strategic Plan – to include NTD-related medicines and supplies as essential medicines at all levels of the healthcare system and allocation of funds for NTD medicines and supplies.

Once the supply chain incorporates NTD medicines and supplies, it is important to ensure that these medicines are available at the different levels of the healthcare delivery system. To do this, NTDCP shall work with the MoH Pharmacy Department, National Drug Authority and NMS to review and define the package of NTD medicines and supplies that will be needed at each level of the healthcare delivery system. With this background, the review shall be presented to the Director General of Health Services (DGHS) for review and approval. NMS staff will be oriented on using the WHO Joint Application Package, ensuring warehousing capacity and determining how drugs for MDA will be distributed to endemic districts. Health staff will also be trained on the use of these drugs through on-the-job training and through dedicated support supervision by trained central supervisors.

Recognising that GESI is a major consideration for drug availability, any new policy or procurement plan should ensure that rural and hard-to-reach communities access these medicines. These communities include people with disabilities, migrants, young people and others with physiological conditions such as pregnant women, children under 5 and lactating women.[4] Guidance on how to administer the correct

[4]Currently, WHO does not provide praziquantel to Uganda to cater for the age group of 15+years or albendazole for the age group of < 5 years and 15+ years.

formulations of these medications to each category of people is also a critical consideration because providers may be unfamiliar treating people outside of the 'norm'.

Indicators

- Number and type of NTD medicines and supplies included on the Essential Medicines and Supplies Kit for Uganda
- Proportion of districts ordering medicines and supplies recommended for NTDs through the MoH Supply Chain Management System
- The number (proportion) of individuals who report receiving the prescribed NTD medicine, both at the health facility and during outreaches (noting that leaving medicines behind at empty houses will not be counted as being reached).

3.2: Functional area – Service Delivery

Gap

Findings from the SPC revealed that partial integration of NTD services (lab diagnosis, clinical diagnosis, treatment and availability of NTD drugs) into the existing health service delivery system coupled with inadequate health worker skills and equipment to diagnose and treat NTDs in health facilities has led to shortcomings in the types of NTD services delivered. Stakeholders identified the major cause of partial integration as being healthcare managers' and frontline staff's limited knowledge about integrated NTD programming. Most NTD activities are implemented as nationally determined and donor-funded campaigns like MDA, trachomatous trichiasis (TT) surgeries, disease-specific assessments (DSA), hence making delivery of NTD services and reporting on NTDs through the health facilities difficult. This has been exacerbated by inadequate numbers of skilled health workers and high turnover in rural and hard-to-reach endemic areas where most NTD-affected populations and marginalised groups are based. Furthermore, because of underreporting and low mortality, NTDs have not been prioritised compared to other diseases, such as malaria, HIV and TB.

Context

The SPC process found a major gap in provision of NTD services in primary healthcare facilities. The overarching issue is that PC-NTD and case management activities have remained siloed. Hydrocelectomies can only be performed at level 4 health centres (HC4s) or district hospitals; however, at HC4s, most of the theatres are not operational due to reasons such as high turnover of doctors and stock out of needed supplies and equipment. Ideally, lymphedema management services should be available at HC3s, but due to lack of required supplies and inadequate health worker skills, this is not always possible. For TT, referral is made to centres providing TT surgery (not a health centre, but a district hospital) or TT surgery camp. This and other factors mentioned above have widened the gap of addressing GESI issues into NTD service delivery. NTDs should be managed within the healthcare system, but the poor or incomplete referral systems hinder efforts to effectively manage NTD morbidity and the opportunities to integrate NTD-related services more fully into other health delivery platforms. Another challenge is an inadequate capacity for NTD case identification and management among the general health staff in health facilities especially at the community level and lack of community awareness about the existing NTD services at their health facilities.

Objectives

1) Fully integrate all NTD services into the existing healthcare system by the end of 2025
2) Build the capacity of health workers to manage NTDs at different levels of the healthcare system

3) Address GESI-related gaps affecting service delivery in health facilities of Uganda.

Strategy

As a policy issue, integration of management of NTDs into the healthcare delivery system requires strong human resource capacity to manage the interventions at the national and district levels. Therefore, the NTDCP will conduct a mapping exercise to identify the human resource needs at the national level and district levels; specifically the goal is to establish the number and category of the staff at the different levels of the healthcare delivery system, especially in the NTD endemic areas. Working in collaboration with the Health Service Commission and the Human Resources Department, where need be, new staff will be recruited to fill in existing gaps, based on the staffing norms and the HRH budgets of the ministry.

The NTDCP will engage the Human Resources Department to develop a training plan for the new staff and integrated into the HRH capacity development strategy. This will be shared with key partners for logistical, financial and technical support. Training will be carried out in line with the MoH's Human Resources Development Plan with priority given to health workers in NTD endemic districts. The NTDCP will work with the Pharmacy Department to quantify the required logistics to support diagnostics for NTDs and the logistics data will be included in the National Pharmaceutical Sector Strategic Plan to guide the procurement and distribution process to health facilities with laboratory capabilities. To create greater impact, the MoH will aim at integrating NTD interventions with other BCC/water, sanitation and hygiene (WASH) activities at national and district level and conduct continuous sensitisation, health promotion and other BCC activities through leveraging onto the other partners' programming and increase utilisation of NTD services.

The NTD Secretariat will then engage the MoH senior management committee through the relevant TWG on integration of NTDs into the mainstream national healthcare delivery system. An NTD stakeholders' meetings will be organised for briefing and sensitisation on delivery of NTD interventions through the national primary healthcare delivery system so as to reach the last mile.

Integration of NTD interventions into the mainstream healthcare system will be implemented in a phased manner with preparation, training and supporting healthcare managers and frontline health workers on integration of NTD data into health facility primary data collection and reporting tools and processes. A series of activities such as introduction of quantification and ordering of NTD medicines and supplies through the MoH supply chain system based on health facility NTD data, reflection of NTD services in the sub-national workplans, , developing training guidelines on management of NTDs and using these guidelines to conduct targeted on the job training of health workers in districts on management of NTDs.

In collaboration with the MoH Human Resource Department, refresher training will be structured and cascaded to the lower levels by the NTDCP management as well as conducting various consultations with different health worker councils on the institutionalisation of NTDs training in all health workers training institutions' curriculum.

The NTDCP will scale-up district supervision through conducting periodic support supervision and monitoring visits to the districts and lower level health facilities as a way of tracking quality of services and performance of the health workers. Incentives in the form of training opportunities and recognition of health workers in hard-to-reach and marginalised areas will be created within the district for those who excel in service provision. This will be aimed at retaining health workers in these hard to reach areas.

To mainstream GESI, high-risk individuals and groups including women and children will be targeted with NTD prevention and treatment messaging ; and NTD outreach schedules will be reviewed to ensure that excluded groups such as migrants and people with disabilities are covered.

Indicators

The following indicators will be tracked during implementation:

- Percentage of health facilities providing all the NTD services assigned in the minimum service package, according to level
- Proportion of selected health training institutions that have included minimum NTDs and GESI content in their training curriculum
- Proportion of health workers in selected health facilities in NTD endemic districts sensitised and oriented on NTDs and GESI
- Proportion of clinicians from selected health facilities in NTD endemic districts trained on the management of NTDs (content appropriate to their cadre and level of facility)
- Proportion of health worker turnover in rural and hard-to-reach NTD endemic areas (disaggregated by sex)
- Number of people in NTD endemic districts seeking NTD management at health facilities.

3.3: Functional area – Financing

Gap

The major gap identified in financing was the low levels of funding to the NTDCP. This is partly a result of inadequate data to inform planning and make a case for NTD programme budget support and evidence-informed advocacy. The government's contribution to NTD financing is spread across many budget holders — District Health Offices (DHOs), individual facilities [infrastructure and operations], National Medical Stores (NMS). Since little is exclusively for NTD service inputs, basic financial reporting does not provide a complete picture of government spending on NTDs. The only documented estimates of NTD spending appear in Uganda's health accounts for FYs 2014/15 and 2015/16, though the latter lacks data for development partners (Uganda National Health Accounts 2014/15 & 2015/16).

The Vector Borne and Neglected Tropical Diseases Division (VB & NTDs) and some districts do track on-budget donor funding, which sits in separate accounts and requires detailed reporting. However, much of donor funding flows are off budget; therefore, there has not been a systematic effort to track or estimate donor expenditure on NTDs. Finally, due to this lack of financial data to demonstrate cost-effectiveness and existing funding gaps, previous efforts by the NTDCP and others to advocate for more government funding for NTDs have been ad hoc and ineffective.

Context

Uganda's health accounts show that in FY 2014/15, public sources accounted for 20 per cent of NTD spending, while development partners contributed the other 80 per cent. The MoH pays salaries of disease-specific programme staff, provides office and laboratory space, pays ground rates, and contributes to the procurement of laboratory equipment. At other levels of the health system, the MoH and district-level governments recruit and provide salaries for NTD staff.

In 2017, the MoH updated its 5-year plan to provide NTD interventions in Uganda with an estimated budget of US$ 39,232,478 (this excludes government contributions to salaries and infrastructure) and an estimated government commitment of US$ 474,000 (1.2% of the total 5-year budget), - leaving an implementation gap of US$ 38,758,478 (98.8%) that is either unsupported or supported by donors and implementing partners. According to the sustainability planning consultation report, "both needed and available resources were imprecisely estimated in 2016, distorting the calculated funding gaps".

Therefore, the MoH will need to more precisely estimate accurate financial gaps and needs. More recent analyses of the government's NTD financing share are not available, though stakeholders offered estimates ranging from 10 per cent to 30 per cent. Despite expectations that donor funds for NTDs will decline, there are few signs that government funding for NTDs will increase soon.

To date, there is inadequate financial commitment as reflected from PHC allocations from health or finance at the central or district level. For the sustainability plan to be operational, MoH and other relevant government sectors need to scale up funding for NTD programming. In fact, at the central level, NTD budgets have declined in recent years: the most recent NTD Master Plan (2017–2022) shows slightly more than US$ 4 million committed to NTD activities in 2016/2017, with only 12% expected to be sourced domestically and the remainder coming from development partners. Whereas MoH made sizable programme-specific allocations in 2015 and 2016, in FY 2019/20, UGX 60 million was allocated by the MoH for NTDs which is 0.005 per cent of the government's health budget, much lower than expected.

Objective: Increase domestic financing for NTD programming from 12% to 30% by the end of 2025.

Strategy

To increase domestic financing for NTD programming from 12% to 30% by the end of 2025, the government of Uganda will follow a comprehensive list of health financing activities to reach progressive milestones towards a more domestically funded NTD response. *Sustainability milestones and timelines are shown in Annex 3.*

First, the MoH will conduct customised workshops and on-the-job training sessions on how to process, analyse and package NTD data to inform financial decision making, targeting NTDCP and district staff. In so doing, the MoH will enhance its technical capacity to manage financial data and produce compelling reports for different audiences. At the same time, the NTDCP will assess NTD financial data availability, quality and completeness and will put in place tracking and reporting mechanisms. Also, the NTDCP will examine detailed financial and programmatic records of major donor funded NTD initiatives and will identify ways to integrate NTD financial data into the Integrated Financial Management System. Finally, the NTDCP will access NTD off-budget financial data and will integrate this information into existing budgeting and planning processes. In this way, the MoH will routinely collect financial data and will have clear information about current NTD revenues and expenditures from all sources.

The MoH, as part of routine planning and budgeting, will estimate NTD-related resource needs and funding gaps. To do this, the NTDCP will analyse financial and epidemiological data on NTDs and will perform financial analysis and forecast to identify financial gaps and needs to support the phase of transition from external donor funding as well as NTD programmatic transitions in terms of disease mix and the status of control or elimination. If considered necessary, the MoH will develop an investment case for NTDs which will provide evidence on the cost-effectiveness and the expected return on investment of NTD interventions. Also, the NTDCP will work on strengthening accountability mechanisms for results and resources and ensuring that domestically raised public funds for NTD programming are spent efficiently and effectively. To achieve this milestone, the NTDCP will identify, prioritise and address key inefficiencies in resource use and will address weak budget performance at national and local levels by focusing on public finance bottlenecks and constraints. In addition, the MoH will conduct a desk review on existing policy guidelines on results-based financing (RBF) programmes in Uganda and will initiate the implementation of a pilot project on RBF for NTD services.

The MoH will use the information collected and processed by the NTDCP to conduct evidence-based advocacy to progressively increase the proportion of domestic financing for NTDs. To do this, the NTDCP will map out key actors and decision-making spaces for NTD budget allocation and define criteria/guidelines for funding prioritisation of NTD services and activities at national and decentralised

levels, considering the disease elimination trajectory. Thereafter, the NTDCP will develop an advocacy strategy for domestic resources mobilisation and conduct high-level advocacy and engagement activities with the MoH, the MoFPED, the Parliament, and partners to put NTDs in their agenda. Moreover, the NTDCP will engage the Health Sector Partners and Multi-Sectoral Coordination Department of MoH to convene a committee within MoH with multi-stakeholder engagement to support coordination of health financing decisions and donor resources. Once established, the capacity of this committee will be built to strategically coordinate NTD donor funding. Finally, the MoH will explore alternative in-country financing mechanisms to mobilise domestic resources, diversify sources of funding and increase resources for NTDs, -including innovative financing mechanisms and partnerships with the private sector and philanthropy.

In the development of the Uganda NTD finance strategy, the NTDCP will take several GESI considerations into account, such as the disaggregation of financial indicators by sex and age group, the prioritisation of resources to identify and address GESI issues and the inclusion of accountability measures for monitoring progress in addressing GESI issues in NTD results-based management and RBF models.

Indicators

- Proportion of targeted staff at both national and district levels trained on financial data packaging for advocacy
- Proportion of districts that periodically track and report on NTD allocations and spending
- Proportion of districts that have GESI-responsive budgets
- Number of selected relevant government sectors that include NTD-related activities in their routine programmes
- Annual proportion of budget allocation to NTDs by central and local governments from domestic resources.

3.4: Functional area – Information Systems

Gap

Stakeholder identified fragmented NTD data, weak surveillance systems and inadequate utilisation of NTD data as the main information system gaps. Little information on cases and preventive treatment for PC-NTDs was previously included on the monthly HMIS forms, and few NTD coverage indicators have been added to the forthcoming DHIS2 update. However, NTD data are in a transitional phase, and historical data are stored in a parallel system. NTD case detection in health facilities and communities is weak. Other than the surveys conducted by the NTDCP, there is no routine NTDs surveillance conducted by the districts as is done for other diseases like malaria. NTD data are not regularly discussed in health sector coordination meetings, which could improve awareness and use of NTDs data. Opportunities exist to improve data sharing for cross-sectoral planning and decision making (e.g. targeting water, sanitation, and hygiene [WASH] efforts) but these have not been fully explored. There is a great need for more and better WASH data to be used to improve on NTD programming and for NTD data to inform WASH programming in Uganda.

Context

The MoH is currently and progressively improving its HMIS. As part of this process, some NTD programming indicators have been incorporated into the DHIS2. The indicators currently included in the DHIS2 may not be sufficient to effectively monitor NTDCP performance, hence the need to include a few more. There has been limited flexibility by the MoH Resource Centre to add more NTD indicators in the DHIS2. For instance, there was no provision for data from surveys or MDA. This and other gaps have

resulted in limited data on NTDs included the HMIS/DHIS2 because the parallel NTD programme reporting channel for such data does not feed into the MoH mainstream reporting system, hence having inadequate data on NTDs to inform policy, planning, budget allocation and review processes (magnitude/burden of disease is unknown to decision makers). Making more NTD data available will help improve the awareness of programme performance as well as its use for strategic planning and resource allocation. The current update included some information on PC-NTDs on the monthly HMIS forms and MDA coverage indicators to DHIS2. District health data teams have not been trained on the updated DHIS2 section on NTDs and limited funds have been allocated to the MoH Resource Centre to produce and distribute the updated NTD data tools (forms for data collection, registers, MDA reporting forms). Despite the data integration gaps, some NTD data are available at the national level and are being used within the NTDCP and the MoH to guide planning though with gaps and limitations such as completeness

Also, the NTD surveillance system in Uganda is still weak, including case detection surveillance in health facilities and communities, and this is bound to limit the capacity to detect recrudescence of some NTDs. Post-MDA surveillance that includes impact surveys takes longer. For example, LF programme pre-validation surveillance is 4–6 years after MDA cessation and trachoma pre-validation surveillance is 2 years after MDA cessation. Therefore, a need exists for programmes and districts to conduct surveillance to detect any possibilities of recrudescence.

There is an existing committee, the Uganda Onchocerciasis Elimination Expert Advisory Committee, that guides the country on river blindness elimination. However, with a general concern that once a disease is eliminated, partners may withdraw suddenly, and districts expected to come in to fill the gap quickly; therefore, there is also a need for clear plans for post-MDA surveillance especially for LF, trachoma and onchocerciasis as Uganda progresses toward elimination targets. Post-validation surveillance guidelines for LF or trachoma and inclusion of PC-NTDs on the weekly expanded program for immunization (EPI) surveillance form used for routine surveillance will play a big role in improving surveillance both at national and district level.

Objective

1) Integrate NTD data into the HMIS/DHIS2 system to reduce data fragmentation and generate reports for strategic planning and decision making and strengthen the routine surveillance system for NTDs in Uganda

Strategy

To have most key NTD indicators integrated into the mainstream MoH system, discussions will be held with the MoH Resource Centre Management to present and agree on the important indicators to be included in DHIS2. An NTD data Focal Person will be identified in the resource centre and assigned duties of handling NTD data at the centre. A deliberate plan to expand the HMIS to capture all data from NTD implementation activities e.g. MDAs on specific NTDs, data on morbidity management, specific survey data will be developed and hence an update of the NTD database to include the missing indicators will be made.

The integrated NTD database will be upgraded to a web-based platform to be remotely accessed at all MoH approved levels. NTDCP will follow up with the MoH Resource Centre to ensure that NTD data reporting is fully integrated into the HMIS. To strengthen NTD case detection at health facilities, the NTDCP will advocate for inclusion of PC-NTDs on the weekly EPI surveillance form used for routine surveillance since this will play a big role in improving surveillance and response both at the national and district levels.

After the upgrade, all tools will be reviewed by the NTD Secretariat in collaboration with the MoH Resource Centre and with technical guidance of the NTD Technical Advisory Committee to ensure that they capture adequate and complete data for NTDs, and this will be followed by training of the national and district health data teams and health workers on NTD data reporting using the revised HMIS tools. This training will be rolled out to lower health facilities and post training follow up at the lower health facilities will be conducted. Districts will be mandated to include NTD data updates as a standard agenda in the quarterly meetings and consequently utilising this NTD data for planning, programme implementation and evaluation in NTD endemic districts. Likewise, at the national level, NTD data will be presented to sectoral platforms in and outside the MoH for advocacy, planning and decision making.

Adequate revised tools will be printed and distributed to the health facilities, and health facilities will be encouraged to take stock of NTD data tools periodically and submit requests for replenishment.

All NTD data tools and platforms will include analysed sex and age disaggregated data, and gender-sensitive indicators will be included in DHIS2. All NTD data tools will be equitably distributed. The importance of GESI consideration in reporting and health services delivery will be emphasised during all training.

Indicators

- Proportion of district health data staff trained on the updated DHIS2 section on NTDs and how to generate reports for NTD budget advocacy
- Proportion of health facilities in the endemic districts that have included NTDs on their weekly EPI surveillance forms
- Proportion of selected health facilities with values for NTDs indicators in expected monthly reports.
- Proportion of NTD endemic districts with evidence of use of NTD data from DHIS2 to inform policy, planning, budgeting, and implementation
- Proportion of districts reporting sex disaggregated NTD data through DHIS2
- Proportion of identified NTD indicators/data elements integrated into the HMIS.

3.5: Functional area – Policy and Planning

Gap

The low NTD case fatality in Uganda coupled with inadequate knowledge among decision/policy makers has contributed to limited reflection of NTDs in the overall health priorities at national and district level. NTD data have not been optimally used to make decisions such as budget allocation and staffing for both the national and district levels. There has not been any evaluation about the progress of the NTD Master Plan for 2017–2022. Much as Uganda is party to several global and regional NTD commitments, there has been limited follow-up and tracking of these international and national commitments at the country level.

Context

At the highest level, political commitment for NTDs is strong; policy makers at both the national and district levels, regularly make supportive public statements about NTD programming. For example, the MoH has made a step in following all WHO dossier guidelines for NTDs, including LF and trachoma. However, the Health Ministerial Policy Statement and the Health Budget Framework Paper 2019/20 do not prioritise NTDs, whereas other health needs, such as HIV and malaria, are featured prominently. This

prioritisation gap also happens at the lower level, where community demand for NTD services is weak and citizens prioritise other development needs over NTDs.

As part of policy development and implementation, to the government should ensure that NTD programming is sufficiently accounted for in the policies and action plans for health, education and other relevant sectors. For example, national NTD master plans should inform broader health sector strategic plans and financing decisions, which should also reflect and mutually reinforce communities' priorities. The SPCs and sustainability planning process to some extent assessed progress and challenges; however, a mid-term evaluation of the Master Plan would still be useful and contribute to the body of knowledge. Therefore, conducting a midterm review of the National NTD Master Plan 2017–2022 is essential so that issues affecting the achieving of its objectives are identified and mechanisms to overcome can be identified. Pro-sustainability policies and plans will also promote and address unique needs and contributions of women and men and promote GESI.

Objectives

1. Strengthen evidence-based advocacy and lobbying for NTD programming targeting policy makers at national and district levels
2. Monitor and evaluate implementation of international, regional and national commitments on NTDs.

Strategy

To address the issue of political prioritisation of NTDs through advocacy for NTD programming in Uganda, the NTDCP will increase and strengthen engagement with policy makers at national and district levels through dissemination of well-packaged data on NTDs and their impact on the affected people to influence their decisions on allocation of both financial and human resources for NTD programming in Uganda. The NTDCP will set up a lobby and advocacy team for NTDs comprising champions and other influential people at the national and district levels.

The National NTD Master Plan 2017–2022 will be reviewed to identify issues affecting the achievement of its objectives and integrate new developments that have been cited in the sustainability plan. This will be followed by development of an advocacy and resource mobilisation strategy to guide the NTD advocacy interventions. Targeted advocacy messages with clear analysis of the NTD burden, socio-economic costs and return on investment will be developed for use during advocacy sessions with policy makers and representatives of the communities in Parliament and District Councils.

International, regional and national commitments related to NTDs will be mapped and their implementation tracked on a regular basis to determine how the country is performing. The NTDCP could partner with the Samasha Medical Foundation, which is based in Uganda, to leverage their Family Planning tracking methodology and tool to conduct national, regional, international commitment tracking. The NTDCP will identify local and international champions to conduct intensive targeted advocacy on these national and global NTD commitments based on the reports from the tracking exercise.

GESI gaps in the different commitments and programming related to NTDs will be identified and brought to the attention of stakeholders. Advocacy messages for GESI will highlight GESI issues in NTD programming, and recommended actions to address these issues will be brought to the attention of decision makers by NTD advocates to bring awareness on GESI in relation to NTDs. Policy and media briefs will highlight GESI issues, their solutions and the role of policy makers and planners in respect to GESI.

Indicators

- Number of targeted evidence-based advocacy sessions conducted for policy makers

- Proportion of recommendations implemented out of the advocacy campaigns
- Proportion of districts, including NTD-related activities, in their work plans and budgets
- Proportion of national, regional and international NTD commitments achieved/complied with beyond 80%.
- Number of local and international champions identified for each commitment.
- Number of Domestic Resource Mobilisation statements made by senior political offices during national and district level NTD events.

3.6: Functional area – Coordination

Gap

Inadequate multi-sectoral collaboration and weak coordination structures for all stakeholders especially at the district level were identified by the stakeholders as a hindering block to sustainability of NTD programming in Uganda. This was attributed to inconsistency of the formal and unified fora at national and sub-national levels with clearly defined terms of reference where NTDs issues are discussed.

The multi-sectoral fora that include the MoFPED, MoWE, MoES and the Ministry of Agriculture, Animal Industry and Fisheries have not been consistently participating in these meetings. Moreover, these other ministries have not prioritised NTDs as a major concern in their programming. At the district level, other government sectors, private sector and civil society organisations that target the underserved and marginalised groups such as people with disabilities have not been brought on board to participate in NTD interventions. Given that the affected people are poor with limited knowledge, they have no voice to influence the government to prioritise NTDs. There has been limited funding for multi-sectoral collaboration.

Context

The NTD control programme has formalised coordination and collaboration mechanisms with other sectors at the national level, but discussions from these fora have not led to specific integration actions across the range of potential collaboration opportunities. Although disease-specific coordination structures exist in Uganda, these structures still need strengthening. Cross-sectoral coordination does occur in the existing NTD-specific structures; yet, this collaboration could be strengthened by improved formal collaboration, especially at the service level. For instance, resources existing in the MoES and MoWE could benefit NTD programming. A few districts have promising models for coordinating implementing partners, including consolidating partner work plans, establishing memoranda of understanding and including them in district planning meetings, but most districts are still lagging. By strengthening partnerships with other programme areas and sectors, national NTD programmes can integrate NTD activities into existing service delivery platforms, supply chain, HRH infrastructure; and they can identify private sector and multi-sector resources to increase synergy, efficiency and accountability to achieve NTD control and elimination goals.

SCH and STHs remain endemic throughout Uganda and among the challenges cited by stakeholders was a lack of clear guidance on strengthening collaboration between sectors at the national and district levels. There is no separate SCH/STH Expert Committee, and matters related to these diseases and cross-sector coordination are addressed through the national NTD Technical Advisory Committee at the national level and the District Health Team and others at the district level. With SCH/STH still struggling to achieve tangible results, the need for a specific expert committee to offer technical guidance still exists.

Objective

Strengthen NTD programming multi-sectoral collaboration and coordination mechanisms at national and district levels to enhance the efficiency and impact of NTD programming.

Strategy

The NTDCP will identify key sectors and stakeholders at the national and sub-national levels to strengthen, multi-sectoral collaboration and coordination mechanisms. The profiles of these key sectors and stakeholders will be updated in the NTDCP database and their different sector coordination mechanisms explored and leveraged to drive the NTD agenda forward. The government will also prioritise integration using the existing coordination mechanisms, especially in terms of forming other taskforces. To define the terms of reference for the coordination mechanisms, the NTDCP will review any existing terms of reference and update/tailor them to reflect Uganda's current NTD programming. Also, MoH's NTDCP will work with relevant ministries such as the MoES, MoWE, MoGLSD , MoFPED and MoLG to include NTDs on their agenda and plans through sharing of key NTD data and information and participating in their different relevant coordination mechanisms in an effort to control and eliminate NTDs. This will be cascaded to the district level through inclusion of NTDs in the agenda of the above sectors' taskforces and meetings with decision makers in their respective districts.

Sensitisation of leaders at all levels on NTDs will be conducted with an aim of engaging the district and community leadership to link NTD affected communities to NTD services in their communities.

Standard operating procedures and good practices for different government sectors and partners joint activity implementation arrangements focusing on sharing of data, jointly funding activities, and coordinating actions will be developed under the leadership of NTDCP and disseminated through the coordination meetings.,

To improve SCH/STH interventions, an SCH/STH Expert Committee will be established to provide technical and strategic guidance and oversight of Uganda's SCH/STH implementation.

While programming for NTD interventions at national and district levels, the NTDCP will consider GESI at individual, group, and village levels, as provided for in the National Equal Opportunities Policy (2006) and the Equal Opportunities Commission Act (2007). Deliberately targeting the underserved and high burden communities through outreach health services and campaigns will be prioritised. Data, funds, activities and donor contributions to identify and address GESI issues across the many NTD funders will be identified by NTDCP and catered for during the planning and budgeting process. GESI stakeholders, including the MoGLSD, the Equal Opportunities Commission and gender-focused civil society organisations will be part of SCH/STH Expert Committee, at least one third of whom will be women.

Indicators

- Proportion of NTD endemic districts with functional multi-sectoral NTD coordination committees
- Proportion of NTD coordination/expert committees with recommended representation of GESI stakeholders
- Proportion of recommendations of multi-sectoral national and district coordination committees that are implemented
- Number of NTD interventions jointly implemented by multi-sectoral stakeholders
- Proportion of recommendations of the SCH/STH Expert Committee that are implemented

3.7: Cross-cutting area – GESI

Gap

The main gap is inadequate integration of GESI into NTD programming in Uganda especially during mass drug administration (MDA) campaigns. As a result, there are categories of people directly or indirectly excluded from the current NTD programming, with gender, disabilities, and other social norms and physical traits affecting exposure to NTDs, varied impacts experienced as a result of NTDs, access to services for individuals suffering from NTDs and disparities in male and female human resources providing NTD services. To ensure that GESI is prioritised and implemented in NTD programming, aspects of GESI have also been integrated into the 6 HSS functional areas of this plan.

Context

GESI combines the concepts of gender equity and social inclusion. Gender equitable NTD programming is achieved when girls, boys, women and men have the same rights to NTD services and opportunities. Social inclusion is achieved when disadvantaged individuals and groups are identified and covered in NTD prevention, control, and elimination efforts. In 2015, the Government of Uganda introduced new sections into the Public Finance Management Act that required a gender lens in all planning processes. Consequently, government ministries present a Certificate of Gender Equity Compliance from the Equal Opportunities Commission within the MoGLSD before their budget, policy or plan is approved by Parliament. Local governments are also encouraged to use gender-aware budget statements and conduct sex-disaggregated beneficiary assessments. In line with this, Uganda's NTD Master Plan 2017–2022 is gender-sensitive, identifying the equal access to health services, with due attention to gender and equity issues, as a guiding principle. However, identification and addressing GESI issues is not yet integrated in the NTD prevention, control, and elimination efforts at implementation level. Through this sustainability and gender action plan, MoH intends to operationalise and implement GESI in the NTD programme at the national and sub-national levels. Considering GESI in NTD sustainability efforts reaches the last mile and ensures that no-one is left behind. This will result in stronger systems and sustained control and elimination outcomes.

Objective

Integrate GESI into NTD programme implementation in Uganda to achieve sustained elimination and control of NTDs by 2025.

Strategy

NTDCP will identify and address GESI issues into all the activities to prevent, eliminate, and control NTDs. GESI issues were identified through a gender analysis conducted by the NTDCP in Uganda. These issues include migration affecting MDA, people out of school who are not targeted for SCH, poor health-seeking behaviour of men with hydrocele, women with TT not accessing surgery, women exposed to trachoma because of frequent and recurrent exposure as caregivers of children, unclear dosing of tetracycline eye ointment (TEO) for children and pregnant and lactating women during trachoma MDA, working men and women missing directly observed treatment during door-to-door MDA and disparities in recruitment and availability of male and female community medicine distributors (CMDs). Solutions proposed to address each of these issues in Annex 7 will be implemented and adapted based on data on success of prevention, elimination and control efforts. In addition, to create an NTD health system supportive of GESI, each functional area in this sustainability and gender action plan considers and addresses relevant GESI issues.

Indicators

In addition to GESI mainstreaming indicators added to each functional area, the following gender-sensitive indicators are included to measure progress in addressing GESI issues

- Proportion of people (men, women, boys and girls) who are migrants who access MDA.
- Proportion of out-of-school boys and girls who access MDA
- Number of men with hydrocele who underwent a hydrocelectomy
- Number of women and men with TT who benefited from TT surgery
- Proportion of households practicing desired behaviours relating to facial hygiene and sanitation
- Proportion of children and pregnant and lactating women who receive and adhere to correct dose of TEO during MDA
- Number of working men and women eligible for MDA who receive it
- Proportion of villages with equal numbers of male and female CMDs

Annexes

- Detailed tables for each functional area
- List of stakeholders consulted
- References

Annex 1: Functional Area – Operational Capacity

Gap: Lack of integration of NTD medicines and supplies into the mainstream routine MoH supply chain processes at the national level (push versus pull) for both NTD treatment at facility level and MDA

Objective: Integrate NTD MDA and case management medicines and supplies into the MoH routine supply chain management practices by 2025.

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: NTD medicines and related supplies not part of NMS/MoH credit line and Essential Medicines and Supplies Kit for lower level health facilities **Solution:** Include NTD medicines and related supplies in the Essential Medicines and Supplies Kit for lower level health facilities	1.1.1 Organise, analyse and package available data on all NTDs (morbidity, MDA, clinical) to provide information for evidence-based advocacy 1.1.2a Carry out targeted evidence-based advocacy with DHOs to facilitate change in current drug procurement policy to include NTD medicines 1.1.2b Review and document the forecasting and quantification reports of the NTD medicines 1.1.2c Conduct a technical review of NTD medicines to be	Consider suitable alternative medicines for the following group of people not eligible for NTD medicines: 1. Ivermectin contraindicated for pregnant women 2.Ivermectin and praziquantel contraindicated for children < 5 years, pregnant and lactating women 3. Azithromycin contraindicated for children < 6 months. 4. Currently, WHO does not	Data sets from the WHO Integrated NTD Database and MoH Resource Centre Workshop materials (stationery, LCD projector, MoH conference hall, refreshments, meals) Resource persons, time, NTD data Allowances, vehicles, fuel Technical assistance on how to manage populations facing contraindications	1.1.1.1 Data for all NTDs compiled, analysed and used for advocacy. 1.1.2.1 Technical review of NTD medicines for inclusion in the MoH Essential Medicines and Supplies Kit carried out 1.1.2.2 Desk review report on forecasting and quantification 1.1.2.3 List of NTD medicines for inclusion in the Essential Medicines and Supplies Kit for lower level health facilities	**Timeline:** 2020–2021 **Responsible person:** Assistant Commissioner of Health Services (ACHS) – VB & NTDs	1.1.1.1.1 Information on approved NTD indicators available for use by stakeholders. 1.1.2.1.1 List of NTD medicines for inclusion in the Essential Medicines and Supplies Kit for lower level health facilities available for submission to DGHS 1.1.2.2.1 Communicated list of NTD medicines for inclusion in the Essential Medicines and Supplies Kit for lower level health facilities received and approved by the DGHS 1.1.2.3.1 Number and type of NTD

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	included in the MoH Essential Medicines and Supplies Kit for lower level health facilities through workshop/retreat 1.1.2d Communicate and follow up with the DGHS on inclusion of NTD medicines in the Essential Medicines and Supplies Kit for lower level health facilities	provide praziquantel to Uganda to cater for the age group of 15+ years or albendazole for the age group of < 5 years and 15+ years.	**Anticipated sources of support:** MoH, Act | East	communicated to DGHS		medicines included in the Essential Medicines and Supplies Kit for Uganda 1.1.2.3.2 Proportion of districts ordering Medicines and supplies recommended for NTDs through the MoH Supply Chain Management System 1.1.2.3.3 Number (proportion) of individuals who report receiving the prescribed NTD medicine, both at the health facility and during outreaches (noting that leaving medicines behind at empty houses will not be counted as being reached)

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 2: Existing support towards NTD medicines from development partners without a sustainability/ transition plan **Solution:** Ensure that donor transition plans for NTD programme medicines and memoranda of understanding are developed and disseminated from inception, and updated regularly	1.2.1 Develop donor transition plans for NTD programme medicines 1.2.2 Disseminate donor transition plans for NTD programme medicines to relevant stakeholders 1.2.3 Integrate all the donor transition plans for NTD programme medicines into the NTD Sustainability Plan	Ensure availability of logistics support for delivering medicines and supplies in the correct quantities to excluded communities such as migrants and pregnant and lactating women, as well as formulations for children with guidance on how to successfully administer the medication	Resource persons, meals, refreshments, time, allowances, MoH & district conference halls, LCD projector, stationery, fuel refund, airtime. **Anticipated sources of support:** MoH, Act | East, ASCEND East	1.2.1.1 Donor transition plans for NTD programme medicines 1.2.2.1 Donor transition plans for NTD programme medicines disseminated to all MoH departments and NTD-affected districts of Uganda 1.2.3.1 Donor transition plans for NTD programme medicines integrated into the Uganda NTD Sustainability Plan	**Timeline:** 2020–2024 **Responsible person:** ACHS – VB & NTDs	1.2.1.1.1 Donor transition plans for NTD programme medicines developed and in place 1.2.3.1.1 NTD programme sustained by the Government of Uganda

Annex 2: Functional Area – Service Delivery

Gaps: Poor integration of NTD services into the existing health service delivery model (facility versus community-based); Health workers lacking skills and equipment to diagnose and manage NTDs in health facilities; and Gaps in MDA that leave some eligible people without prevention services.

Objectives:

1) Fully integrate all NTD services into the existing healthcare system by the end of 2025
2) Build the capacity of health workers to manage NTDs at different levels of the healthcare system.
3) Address GESI-related gaps affecting service delivery in health facilities of Uganda

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: NTD interventions have not been fully integrated into the national healthcare delivery system, making reporting through the health facilities difficult **Solution:** Integration of all NTD interventions into the national healthcare delivery system	2.1.1 The national NTD Technical Advisory Committee engages MoH Senior Management on integration of NTDs into the mainstream national healthcare delivery system 2.1.2 Conduct NTD stakeholder meetings to sensitise on service delivery through the national primary healthcare delivery system		Funds to facilitate the NTD Technical Advisory Committee meetings and stakeholder meetings Technical assistance for development of the implementation guidelines **Anticipated sources of support:** MoH and partners	2.1.1.1 Integrated NTD services 2.1.1.2 Joint work plans	**Timeline:** 2020–2021 **Responsible person:** ACHS – VB & NTDs	2.1.1.1.1 Percentage of health facilities providing all the NTD services assigned in the minimum service package, according to level

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 2: Healthcare managers and frontline staff not conversant with integrated NTD programming as part of the health systems processes in operation **Solution:** Promote management and implementation of NTD services as part of broader health system processes	2.2.1 Train and support healthcare managers and frontline health workers to integrate NTD data into facility-level primary data collection and reporting tools and processes 2.2.2 Districts undertake ordering of NTD medicines and supplies through the Government of Uganda procurement and supply chain system based on health facility NTD data 2.2.3 Develop training guidelines and conduct targeted training of health facility workers in districts on diagnosis and treatment of NTDs	Ensure gender equity in access to trainings Consider GESI factors when selecting trainers and trainees	Technical assistance Other resource persons Allowances Conference hall Computer (projector) Time Stationery Refreshments Meals Funds for printing NTD training manuals Funds for NTD supportive supervision **Anticipated sources of support:** MoH and partners	2.2.1.1 Integrated data tools 2.2.2.1 District quantification procurement forms 2.2.3.1 Training manuals on NTDs diagnosis and treatment developed Health facility workers trained on diagnosis and treatment of NTDs 2.2.3.2 A pool of health workers trained on diagnosis and treatment of NTDs available 2.2.3.3 Health facility workers supervised and supported post-training	**Timeline:** 2020–2022 **Responsible person:** NTD Programme Managers For high-level advocacy: ACHS – VB & NTDs and Hon. Member of Parliament (MP) Nakapiripirit	2.2.1.1.1 Proportion of health workers trained on NTD integration into the broader healthcare system 2.2.2.1.1 District quantification order form includes NTD medicines 2.2.3.2.1 Proportion of health workers in selected health facilities in NTD-endemic districts sensitised and oriented on NTDs and GESI 2.2.3.2.2 Proportion of clinicians from selected health facilities in NTD-endemic districts trained on the management of NTDs (content appropriate to their cadre and level of facility)

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	2.2.4 Support supervision to health facility workers trained on diagnosis and treatment of NTDs					
Root Cause 3: Inadequate numbers of male and female skilled health workers to manage NTDs in endemic areas **Solution:** Capacity building in key skill areas at all levels by NTDCP	2.3.1 Programme Managers map their NTD HR capacity and training needs 2.3.2 Conduct advocacy sessions with MoH Senior Management and stakeholders to mobilise required staffing and training resources 2.3.3 Recruit and train new male and female staff on NTDs and their management 2.3.4 Sensitize and orient health workers in selected health facilities in NTD endemic	Disaggregate workforce data by sex	Funds Skilled trainers Recruitment guidelines Technical assistance from curriculum development committee of respective health worker associations/councils **Anticipated sources of support:** MoH and partners for capacity building	2.3.1.1 Report on mapping of training and resource requirements 2.3.3.1 Additional staff – both women and men –-to handle NTDs recruited at national and district levels and posted to NTDCP and districts 2.3.4.1 GESI aware health workers in NTD endemic districts 2.3.5.1 NTD training content gaps identified, and content developed and integrated into	**Timelines:** 2021 (mapping and advocacy) 2021–2024 (recruitment and training) 2025 (institutionalisation of NTDs in health institutions' training curricula) **Responsible person:** ACHS – VB & NTDs	2.3.1.1.1 NTDCP staffing gap analysed 2.3.2.1.1 Proportion of health workers seconded/recruited to handle NTD programming 2.3.2.1.2 Gap in balance between male and female health workers decreased 2.3.3.1.1 Proportion of recruited health workers in frontline health facilities trained in NTD management 2.3.4.1.1 Proportion of health workers in selected health facilities in NTD

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	districts on NTDs and GESI 2.3.5 Hold various consultations on the institutionalisation of NTDs in all health worker training institutions' curricula			curricula for health training institutions		endemic districts sensitised and oriented on NTDs and GESI 2.3.5.1.1 Proportion of selected health training institutions that have included minimum NTDs and GESI content in their training curricula
Root Cause 4: High staff turnover in rural and hard-to-reach endemic areas **Solution:** Motivation of health workers in hard-to-reach and rural NTD endemic areas	2.4.1 Provide incentives to improve retention in hard-to-reach endemic areas: 2.4.2 Conduct refresher trainings 2.4.3 Conduct continuous supportive supervision and monitoring to improve performance	Include targets and outcomes for these hard-to-reach areas	Funds for incentives, refresher training and supportive supervision **Anticipated sources of support:** MoH and partners	2.4.1.1 Incentives mobilised and provided 2.4.2.1 Refresher trainings conducted and completed	**Timeline** 2021–2025 **Responsible person:** ACHS – VB & NTDs	2.4.1.1.1 Proportion of health worker turnover in rural and hard-to-reach NTD-endemic areas (disaggregated by sex and age)
Root Cause 5: NTD-affected populations are poor	2.5.1 Conduct continuous and regular	Engage local civil society groups and	Funds for BCC activities	2.5.1.1 IEC materials and messages	**Timeline:**	2.5.1.1.1 Number of eligible people in NTD endemic

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
and marginalised rural populations **Solution:** Empower NTD-affected / at-risk communities to demand services (NTD case management, prevention and control services)	sensitisation, health promotion and other BCC activities 2.5.2 Integrate NTD interventions with other BCC/WASH activities at national and district level	special interest groups such as women and youth groups, fishermen and women, lumber workers Identify and mitigate cultural norms; power dynamics; legislation; and knowledge, beliefs, and perceptions within affected populations that propagate the disease(s) Target high-risk individuals and groups, including women and children	Packaging and printing of NTD information, education and communication (IEC) materials Funds for NTD/WASH/BCC stakeholders' meetings **Anticipated source of support:** MoH, Act | East, ASCEND	developed; BCC sessions conducted 2.5.2.1 Integrated NTD/WASH/BCC interventions conducted	Ongoing (2021 – 2025 **Responsible person:** ACHS – VB & NTDs, DHOs District NTD Focal Persons	districts seeking NTD management at health facilities
Root Cause 6: NTD not a priority area because rate of mortality	2.6.1 Integrate NTDs management into routine health facility services and	Review NTD outreach schedules to ensure excluded groups such as	Funds for conducting regular integrated outreaches (including NTDs)	2.6.1.1 NTD data captured at health facility level	**Timeline:** July 2021–June 2025	2.6.1.1.1 Reduced morbidity, mortality, and disabilities from NTDs resulting in a

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
and morbidity from NTDs is small **Solution:** Integrate NTDs into routine health programmes so that data are captured immediately from lower level health facilities	integrated outreaches 2.6.2 Capture NTD data at lower health facilities for reporting into DHIS2	migrants and people with NTD disabilities are covered.	**Anticipated Source of Support:** MoH, ACT | East, ASCEND	2.6.2.1 NTDs included in integrated outreach reports	**Responsible person:** ACHS – VB & NTDs, DHOs District NTD Focal Persons	healthy and productive community

Annex 3: Functional Area—Financing

Gap: Low levels of funding to the NTD programme because of limited use of data to inform planning, NTD programme budget support, and evidence informed advocacy.

Objective: Increase domestic financing for NTD programming from 12% to 30% by the end of 2025.

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: Inadequate capacity to process and analyse data and produce clear reports to policy makers for financial decision making **Solution:** Strengthen capacity of MoH and district staff to manage NTD data at different levels of government and produce data-driven reports for different audiences	3.1.1 Conduct customised training for planners, managers, data administrators, statisticians, service providers and policy analysts on how to process, analyse and package NTD data for use in financial decision making	Include sex-disaggregated and gender-sensitive data	Funds Trainers Training materials **Anticipated sources of support:** MoH, district local governments (DLGs) and partners	3.1.1.1 Fit-for-purpose financial information available for decision making 3.1.1.2 Informational material targeting different audiences that showcases return on investment for investing in NTDs	**Timeline:** Activity 3.1.1 by September 2021 **Responsible person:** ACHS – VB & NTDs	**Sustainability milestone:** 1. The MoH has the technical capacity to manage financial data and produce data-driven reports for different audiences **Indicators:** 3.1.1.1.1 Proportion of targeted staff at both national and district levels trained in financial data packaging for advocacy
Root Cause 2: There is no clear information about how much is	3.2.1. Conduct an assessment for financial data availability, quality, completeness and	Track data on how much is budgeted for and spent to identify and	Funds Technical assistance for	3.2.1.1 Assessment reports	**Timeline:** Activity 3.2.1 Ongoing	**Sustainability milestones**: 2. The central government and

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
received and spent on NTDs at the national and district levels, and the existing tools for capturing off-budget financial data are not integrated into existing MoH systems **Solutions:** Assess data gaps and needs, and create a dissemination strategy for data and results (increase demand for NTD financial data) Create dashboards, tools and protocols to collect and consolidate financial data (routine data collection mechanism)	potential users, as well as existing tracking and reporting mechanisms with a focus on budget allocation, budget releases, district contributions, MoH contributions and donor contributions – national and district levels. 3.2.2 Review and update existing budget tracking tools 3.2.3 Integrate NTD financial data into the Integrated Financial Management System 3.2.4 Examine detailed financial and programmatic records of major donor funded NTD initiatives. 3.2.5 Prepare analysed communication	address GESI issues in NTD prevention and control efforts	conducting assessments **Anticipated source of support:** MoH, DLGs and partners	3.2.1.2 Quarterly bulletins and policy briefs 3.2.2.1 Updated budget tracking tools 3.2.3.1 NTD off-budget support captured in MoH and district plans and budgets 3.2.3.2 NTD off-budget support captured in the Integrated Financial Management System	(Annually, 2021–2023) **Responsible person:** ACHS – VB & NTDs Chief Administrative Officers (CAOs), DHOs, Chief Financial Officers **Timeline:** Activities 3.2.2–3.2.5 By September 2022 **Responsible person:** ACHS – VB & NTDs ACHS - Budget and Finance	districts have clear information about current NTD revenues and expenditures (from all sources) 3. The MoH routinely collects and analyses financial data using a resource tracking tool 4. NTD off-budget financial data are accessed and integrated into existing budgeting and planning processes **Indicators:** 3.2.3.1.1 Proportion of districts that periodically track and report on NTD allocations and spending 3.2.3.1.2 Proportion of districts that have GESI-responsive budgets

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Integrate NTD off-budget financial data into MoH and district work plans and budgets	pieces such as quarterly bulletins and policy briefs for dissemination at MoFPED and Parliament of Uganda					
Root Cause 3: There are no periodic estimations of resource needs, funding gaps and the cost and benefits of NTD elimination and control efforts **Solutions:** Establish a mechanism to estimate resource needs and funding gaps periodically Estimate the cost of NTD elimination and calculate its return on investment (cost-benefit analysis)	3.3.1 Collect and analyse financial and epidemiological data on NTDs 3.3.2 Perform financial analysis and forecast to identify financial gaps and needs to support the transition phase 3.3.3 Develop an investment case for NTDs 3.3.4 Create dashboards to display financial data on NTDs and return on investment in NTDs	Disaggregate financial data and results by sex and age group Estimate cost of continuously identifying and addressing GESI issues in NTD elimination efforts Advocate for resources to identify and address GESI issues in NTD elimination efforts Include GESI considerations in investment case report	Consultancy fee Health and NTD financial data (including NTD revenues and expenditures from all sources) Funds for developing and printing data collection tools Budget line to facilitate the exercise **Anticipated source of support:**	3.3.1.1 Financial and epidemiological reports 3.3.2.1 Financial analysis report 3.3.3.1 Investment case report 3.3.4.1 Advocacy strategy for resource mobilisation 3.3.4.2 Policy briefs on NTD domestic financing	**Timeline:** Activities 3.3.1, 3.3.2 & 3.3.4 Ongoing (Annually, 2021–2023) Activity 3.3.3 September 2022 **Responsible person:** ACHS – VB & NTDs	**Sustainability milestone:** 5. The MoH, as part of routine planning and budgeting, estimates NTD-related resource needs and funding gaps **Indicators:** 3.3.2.1.1 Annual funding gap estimated by the MoH 3.3.3.1.1 Investment case is being used for high-level advocacy for resource allocation from the government and partners

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Establish a mechanism for displaying data for decision makers			MoH, MoFPED, MoLG, DLGs and partners			
Root Cause 4: Weak accountability mechanism for results and resources **Solution:** Introduce/integrate results-based management and innovative financing models for NTD programme such as the Uganda Maternal and Child Health Improvement programme and USAID reproductive health voucher	3.4.1 Conduct desk review on existing policy guidelines on RBF programmes in Uganda. 3.4.2 Identify and prioritise key inefficiencies in resource use 3.4.3 Develop and implement an action plan to address inefficiencies with continuous monitoring of progress made in terms of efficiency gains 3.4.4 Identify the drivers of both strong and weak budget performance at national and local levels with special attention to public	Include accountability measures for monitoring progress in identifying and addressing GESI issues in NTD RBF	Consultancy fee Funds for training the service providers **Anticipated sources of support:** MoH, DLGs and partners	3.4.1.1 Desk review report 3.4.2.1 Report on financial inefficiencies 3.4.3.1 Action plan to address inefficiencies 3.4.4.1 Report on financial bottlenecks and constraints 3.4.5.1 RBF model for NTDs	**Timeline:** Activities 3.4.1–3.4.5 by September 2022 **Responsible person:** ACHS – VB & NTDs ACHS – Budget and Financing	**Sustainability milestone:** 6. Domestically raised public funds for NTD programming are spent efficiently and effectively **Indicators:** 3.4.3.1.1 Key sources of inefficiency in resource use addressed 3.4.4.1.1 Improved NTD programme performance 3.4.5.1 Annual proportion of budget allocation to NTDs by central and local governments from domestic resources

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	finance bottlenecks and constraints 3.4.5 Initiate and implement a pilot NTD RBF project.					
Root Cause 5: Low advocacy and lobbying with policy and decision makers **Solution:** Strengthened/ increased advocacy/ lobbying for NTD prioritisation with decision makers	3.5.1 Map out key actors and decision-making spaces for NTD budget allocation and define criteria/guidelines for funding prioritisation of NTD services and activities (domestic public resources), considering the disease elimination trajectory 3.5.2 Develop an advocacy strategy for domestic resource mobilisation and conduct high-level advocacy and engagement activities with the MoH, MoFPED, Parliament and partners to put	Advocacy for NTD services for excluded groups of men, women, boys and girls	Funds to facilitate meetings Transport, fuel, logistics and facilitation of champions Advocacy briefs, memos, fact sheets **Anticipated source of support:** MoH, DLGs and partners	3.5.1.1 Mapping report on key actors and decision-making spaces 3.5.2.1 Advocacy and resource mobilisation strategy 3.5.3.1 Advocacy/lobby briefs, memos, fact sheets, press releases 3.5.3.2 Annual NTD status reports, scorecards 3.5.3.3 Advocacy/lobby meetings held with policy and decision makers	**Timeline:** Activities 3.5.1–3.5.2 by September 2021 **Responsible person:** NTD Programme Managers ACHS – VB & NTDs and Hon. MP Nakapiripirit **Timelines:** Activities 3.5.3–3.5.4 by September 2022 **Responsible person:**	**Sustainability milestone:** 7. The MoH conducts evidence-based advocacy to increase domestic financing for NTD efforts **Indicators:** 3.5.1.1.1 Increased prioritisation and support for NTD efforts among stakeholders 3.5.2.1.1 Proportion of other government sectors actively supporting and including NTD-related activities in their routine programmes 3.5.3.1.1 Advocacy strategy is being used

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	NTD efforts in their agendas 3.5.3 Develop targeted NTD advocacy messages (analyse burden, return on investment, high socio-economic costs associated with NTDs, low fatality rate and morbidity) 3.5.4 Disseminate targeted NTD advocacy messages through briefs, memos and fact sheets to policy and decision makers to ensure prioritisation				NTD Programme Managers. ACHS – VB & NTDs and Hon. MP Nakapiripirit	to mobilise domestic resources
Root Cause 6: Inadequate Government of Uganda budget allocations to NTDCP **Solution:** Improve prioritisation and visibility of NTD	3.6.1 Engage the Health Sector Partners and Multi-Sectoral Coordination Department of MoH on the establishment of a committee within MoH with multi-stakeholder engagement to support coordination	Resources for addressing gender issues need to be identified and availed e.g. positioning experts with skills to do a gender analysis within the NTD	Health and NTD financial data (including NTD revenues and expenditures from all sources) Funds to facilitate	3.6.1.1 Meeting reports 3.6.2.1 Quarterly allocation summaries	**Timeline:** Ongoing 2021–2025 **Responsible person:** Permanent Secretary to MoH	**Sustainability milestone:** 8. NTD financing is predominantly sourced from domestically raised public funds 9. Donor support is strategically coordinated by the

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
efforts in annual budgets and work plans at the local and central government levels	of health financing decisions and donor resources 3.6.2 Build the capacity of government at all levels to strategically coordinate donor funding 3.6.3 Conduct meetings with parliamentarians and district political leadership to lobby for increased resource allocation by local and central government to NTD activities 3.6.4 Explore alternative in-country financing mechanisms to mobilise domestic resources, diversify sources of funding and increase resources for NTD efforts, including innovative financing	health workforce and funds to pay for the interventions to mitigate gaps identified in the gender analyses	meetings and conduct gender analyses **Anticipated source of support:** MoH, MoFPED and National Planning Authority		ACHS – VB & NTDs CAOs, DHOs, Chief Financial Officers	government to supplement domestic contributions **Indicator:** 3.6.1.1.1 Increased proportion of budget allocation to NTDs by central and local governments

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
	mechanisms and partnerships with the private sector and philanthropy					

Annex 4: Functional Area—Information Systems

Gap: NTD data that are not fully incorporated into the HMIS, weak surveillance system and inadequate utilisation of NTD data

Objectives:

1) Integrate NTD data into the HMIS/DHIS2 system to generate reports for strategic planning and decision making.
2) Strengthen the routine surveillance system for NTDs in Uganda

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: District health data teams have not been trained on the updated DHIS2 section on NTDs **Solution:** Train all district data health teams (biostatisticians, NTD focal persons, health information assistants) on the updated DHIS2 section on NTDs and how to generate data-driven reports to improve advocacy for increased NTD budget allocations	4.1.1 Identify the district health data teams 4.1.2 Train the district health data teams 4.1.3 Roll out trainings to lower level health facilities 4.1.4 Conduct post-training follow up at the lower level health facilities	Include sex disaggregated data in the DHIS2 and make it part of the training Capture data on the sex of the trainees Include training on gender-sensitive indicators	Funds to facilitate training and trainers Training Materials **Anticipated source of support:** MoH and partners (Act | East, ASCEND, others)	4.1.1.1 A database of district health data teams 4.1.2.1 A pool of trained health workers 4.1.2.2 Quarterly DHIS2 reports with NTD data	**Timeline:** Short term (July/August 2020) **Responsible person:** ACHS – VB & NTDs, DHOs	4.1.2.1.1 Proportion of district health data staff trained on the updated DHIS2 section on NTDs and how to generate reports for NTD budget advocacy 4.1.2.1.2 Proportion of districts reporting sex disaggregated NTD data through DHIS2

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 2: Limited funds to produce and distribute the updated NTD data tools (forms for data collection, registers, MDA reporting forms) **Solution:** Increase the budget allocation for printing and distributing the updated NTD data tools by the Resource Centre	4.2.1 Print adequate HMIS tools and distribute to the health facilities 4.2.2 Health facilities to take stock of NTD data tools periodically and submit requests for replenishment	NTD data tools should be disaggregated by age and sex Distribute printed tools equitably	Funds for printing and distribution of the tools to districts and health facilities **Anticipated source of support:** MoH and partners (Act | East, ASCEND East and other implementing partners)	4.2.1.1 HMIS forms, MDA reporting tools and registers	**Timeline:** Ongoing (2020–2025) **Responsible person:** ACHS – VB & NTDs ACHS – Resource Centre DHOs Biostatisticians	4.2.1.1.1 Proportion of selected health facilities with non-missing values for NTD indicators in expected monthly reports
Root Cause 3: Limited flexibility by the Resource Centre to add more NTD indicators in the DHIS2 **Solutions:** Create fields in the Integrated NTD Database to capture	4.3.1 Hold a meeting with the MoH Resource Centre management staff to discuss and agree on the important indicators to be included in DHIS2 4.3.2 Re-programme the NTD database to include the missing indicators	Include gender-sensitive indicators in the Integrated NTD Database	Funds to aid re-programming and designing and launching a web-based platform Team to review and update the Integrated NTD Database	4.3.1.1 Meeting report 4.3.2.1 HMIS with new NTD indicators	**Timeline:** By September 2021 **Responsible person:** ACHS – VB & NTDs ACHS – Resource Centre	4.3.1.1.1 Number of NTD indicators added to the HMIS 4.3.2.1.1 Number of NTD data elements fully integrated into the HMIS and all targeted Districts have access to the revised HMIS tools

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
the missing NTD indicators Lobby to add more NTD indicators into the DHIS2	4.3.3 Train the data team at MoH on the added indicators 4.3.4 Upgrade the Integrated NTD Database to a web-based platform to support remote access		**Anticipated source of support:** MoH and partners (Act | East, ASCEND, others)			
Root Cause 4: Inadequate data on NTDs to inform policy, planning, budget allocation and review processes (magnitude/burden of disease is unknown to decision makers) **Solution:** Strengthen data/information sharing with stakeholders through different channels and make existing forums functional	4.4.1 Districts to include NTD data updates as a standard agenda item in quarterly meetings 4.4.2 Include NTD data on the weekly EPI surveillance forms 4.4.3 Utilise NTD data for planning, programme implementation and evaluation in NTD-endemic districts	Data platforms should include analysed sex- and age-disaggregated data and GESI-sensitive indicators	Software for data capturing Funds to facilitate orientations on expanded HMIS **Anticipated source of support:** MoH; MoFPED, MoES; Ministry of Agriculture, Animal Industry and Fisheries; MoWE; DLGs WHO, UNICEF, USAID, DFID, TCC, RTI, ASCEND	4.4.1.1 District quarterly NTD data review meetings and reports 4.4.2.1 NTD data weekly and monthly reports from DHIS2 4.4.3.1 Reports on specific NTD survey data	**Timeline:** By September 2022 **Responsible person:** ACHS – VB & NTDs, DHOs, District NTD Focal Persons	4.4.1.1.1 Proportion of NTD endemic districts with evidence of use of NTD data from DHIS2 in policy, planning, budgeting and implementation 4.4.2.1.1 Proportion of health facilities in the endemic districts that have included NTD data on their weekly EPI surveillance forms

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 5: There are limited data on NTDs in the HMIS/DHIS2 due to a previous parallel NTD programme reporting channel that does not feed into the MoH's main reporting system **Solution:** Advocate for full integration of required NTD data elements into the HMIS and dissemination to all districts	4.5.1 Expand HMIS to capture all data from NTD implementation activities, e.g. MDA rounds for specific NTDs, data on morbidity management, special survey data 4.5.2 Follow up with the MoH Resource Centre to ensure that NTD data reporting is fully integrated into the HMIS	Ensure that the reporting system captures NTD data according to age group and sex During the training, emphasise the importance of GESI considerations in reporting and health service delivery	Funds for staff training, printing new tools for NTD data and HMIS procedure manuals **Anticipated source of support:** MoH, Act | East, ASCEND East and other partners	4.5.1.1 An integrated HMIS/DHIS2 system at MoH Resource Centre	**Timeline:** By September 2022 **Responsible person:** ACHS – VB & NTDs ACHS – Resource Centre DHOs Biostatisticians	4.5.1.1.1 Proportion of identified NTD indicator data elements fully integrated into the HMIS

Annex 5: Functional Area—Policy and Planning

Gap: Limited reflection of NTD in the overall health priorities at national and district level

Objectives:

1) Strengthen evidence-based advocacy and lobbying for NTD programming targeting policy makers at the national and district levels
2) Monitor and evaluate implementation of international, regional and national commitments on NTDs.

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: NTDs have low case fatality, though high socio-economic impact (chronic disease) **Solution:** Prioritise NTDs in national and district intervention plans as well as national policies and harmonise with plans, budgets and performance reviews	5.1.1 Engage national and district policy and decision makers with evidence on NTD morbidity and mortality data 5.1.2 Conduct midterm review of the national NTD Master Plan 5.1.3 Conduct midterm review of the Uganda NTD Control Program Sustainability Plan 2020-2025	Advocacy messages for GESI will highlight GESI issues in NTD efforts and recommended actions to address these issues	Resources for meetings, meeting venues, transport, advocacy briefs, memos, fact sheets **Anticipated source of support:** MoH, WHO, Act | East, ASCEND East and other partners	5.1.1.1 Reports from advocacy/ lobby meetings held with policy and decision makers 5.1.1.2 Policy briefs, memos, fact sheets, annual NTD status reports, scorecards 5.1.2.1 Updated national NTD Master Plan 5.1.3.1 Updated Uganda NTD Sustainability Plan	**Timeline:** Activity 5.1.1 By September 2021 **Responsible person:** ACHS – VB & NTDs, DHOs, District NTD Focal Persons **Timeline:** Activity 5.1.2 By September 2021 **Responsible person:** ACHS – VB & NTDs **Timeline:** Activity 5.1.3 By September 2023	5.1.1.1.1 Number of targeted evidence-based advocacy sessions conducted for policy and decision makers 5.1.1.1.2 Proportion of NTD endemic districts including NTD-related activities in their work plans and budgets

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
					Responsible person: ACHS – VB & NTDs, DHOs, District NTD Focal Persons	
Root Cause 2: No follow-up and tracking of international and political commitments at the country level **Solution:** Identify global, regional and national champions to follow up on international commitments on NTD elimination, control and eradication	5.2.1 Conduct an inventory of all commitments related to NTDs 5.2.2 Identify and engage local and international champions for intensive advocacy on national/ regional/global NTD commitments 5.2.3 Track implementation of all national, regional and global NTD commitments	Identify GESI gaps in the different commitments related to NTDs	Staff time, logistics, facilitation, funds for meetings and publicity/media **Anticipated source of support:** MoH, WHO, RTI Act | East, ASCEND East, TCC and other partners	5.2.1.1 Database of all national, regional, and global NTD commitments 5.2.2.1 Database of identified NTD champions 5.2.3.1 Progress reports on implementation of national, regional, and global NTD commitments 5.2.3.2 Reports on awareness sessions with decision makers on national, regional, and global NTD commitments	**Timeline:** Activities 5.2.1–5.2.2 by September 2021 **Responsible person:** DGHS ACHS – VB & NTDs **Timeline:** Activity 5.2.3 Ongoing 2021–2025 **Responsible person:** ACHS – VB & NTDs	5.2.2.1.1 Number of national and international NTD champions identified and actively engaged 5.2.3.1.1 Proportion of national, regional, and global NTD commitments achieved/complied with beyond 80%

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 3: Policy and decision makers are not directly affected by NTDs and have inadequate knowledge about the magnitude and impact of NTDs **Solution:** Increased engagement between policy makers on NTDs and people affected by NTDs to prioritise NTD interventions	5.3.1 Select an advocacy and lobby team from among the NTD stakeholders 5.3.2 Develop an advocacy strategy and plan (to be combined with financing) 5.3.3 Develop NTD advocacy messages (analyse burden, return on investment, high socio-economic costs associated with NTDs, low fatality rate) 5.3.4 Conduct advocacy and dialogue sessions on NTDs with policy makers and representatives of the communities in Parliament and district councils	Decision makers should understand GESI issues in relation to NTDs Policy and media briefs should always highlight GESI issues and their solutions	Consultant Funds for consultation meetings and printing of the advocacy strategy Funds for developing and printing of materials for dialogue meetings BCC and media technical assistance Advocacy technical assistance **Anticipated source of support:** MoH and NTD partners	5.3.1.1 NTD advocacy and lobby team in place and facilitated to engage policy law makers at national and district levels 5.3.2.1 Advocacy strategy in place 5.3.3.1 Clear advocacy messages and targeted data 5.3.4.1 Advocacy meeting reports and recommendations	**Timeline:** Activities 5.3.1 & 5.3.2 by September 2021 **Responsible person:** ACHS – VB & NTDs, NTD Programme Managers, NTD champions **Timeline:** Activities 5.3.3 & 5.3.4 Ongoing 2021–2021 **Responsible person:** ACHS – VB & NTDs, NTD Programme Managers, NTD champions	5.3.1.1.1 Proportion of recommendations implemented from the advocacy campaigns 5.3.2.1.1 Number of domestic resource mobilisation statements made by high-level political offices during national and district-level NTD events

Annex 6: Functional Area—Coordination

Gap: Inadequate multi-sectoral collaboration and weak coordination structures for all stakeholders especially, at the district level

Objective: Strengthen multi-sectoral collaboration and coordination mechanisms at national and district levels to enhance the efficiency and impact of NTD programming

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: Lack of formal unified fora at the district level with clearly defined terms of reference (TORs) where NTD issues are discussed (multi-sectoral – education, water and environment, agriculture; private sector; and district civil society/disability groups) **Solution:** Establish multi-sectoral coordination framework for NTDs at national,	6.1.1 Map NTD stakeholders at the national and district levels 6.1.2 Define/ review the TORs for the multi-sectoral national and district coordination mechanisms 6.1.3 Establish or strengthen multi-sectoral national and district coordination mechanisms 6.1.4 Hold multi-sectoral coordination meetings at the national and district levels defined by the TORs	Membership to the coordination mechanisms should consider the accepted current membership norms (1/3 membership for women) GESI stakeholders should be part of coordination structures	Resources to support coordination meetings, transport, fuel, staff time **Anticipated source of support:** MoH, WHO, RTI Act | East, ASCEND East, TCC and other partners	6.1.1.1 Database for national and district multi-sectoral stakeholders 6.1.2.1. Clearly outlined TORs in place 6.1.3.1 Functional national and district multi-sectoral NTD coordination mechanisms/ structures formed 6.1.4.1 Regular meetings held 6.1.4.2 Joint multi-sectoral committee recommendations on NTD activities	**Timeline:** Activities 6.1.1–6.1.3 By September 2021 **Responsible person:** DGHS ACHS – VB & NTDs **Timeline:** Activity 6.1.4 Ongoing 2021–2025	6.1.1.1.1 Map of NTD stakeholders is completed 6.1.2.1.1 TORs for the multi-sectoral national and district coordination mechanisms are updated and adopted 6.1.3.1.1 Proportion of NTD-endemic districts with functional multi-sectoral NTD coordination committees 6.1.3.1.2 Proportion of NTD coordination/ expert structures or committees with recommended representation of GESI stakeholders 6.1.4.2.1 Proportion of recommendations from

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
district and community levels						multi-sectoral national and district coordination committees that are implemented
Root Cause 2: Weak collaboration between relevant government sectors and NTD stakeholders to leverage joint NTD activities **Solution:** Strengthen coordination of NTD stakeholders on joint interventions and financing	6.2.1 Develop standard operating procedures for relevant government sectors and stakeholders focusing on sharing data, funding, joint activities and coordinating actions for joint interventions 6.2.2 Develop joint annual work plans for joint NTD activities at national and district levels and conduct joint activity implementation	Identify and address GESI issues across the multiple NTD joint interventions	Funds for standard operating procedure development meetings **Anticipated source of support:** MoH, DLGs and partners	6.2.1.1 Standard operating procedures developed 6.2.2.1 Joint work plans with NTD activities integrated	**Timeline:** Activity 6.2.1 by September 2022 Activity 6.2.2 Annually, 2022–2025 **Responsible person:** ACHS – VB & NTDs	6.2.1.1.1 Improved joint NTD intervention coordination, data sharing and funding 6.2.2.1.1 Number of NTD interventions jointly implemented by multi-sectoral stakeholders
Root Cause 3: Inadequate guidance on SCH/STH collaboration between sectors at	6.3.1 Develop the SCH/STH Expert Committee terms of reference and submit for approval	Membership to the SCH/STH Expert Committee should consider the accepted current	Resources to support the Expert Committee meetings,	6.3.1.1 Approved SCH/STH Expert Committee terms of reference	**Timeline:** Activities 6.3.1 and 6.3.2 By April 2021	6.3.1.1.1 SCH/STH Expert Committee proceedings guided by the approved TORs.

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
both national and district levels **Solution:** Establish an SCH/STH Expert Committee to provide expert and strategic guidance and oversight of Uganda's SCH/STH implementation	6.3.2 Follow up on the appointment of the SCH/STH Expert Committee members by the Minister of Health 6.3.3 Conduct regular SCH/STH Expert Committee meetings 6.3.4 Implement the SCH/STH Expert Committee's resolutions	membership norms (1/3 membership for women) GESI stakeholders should be part of the SCH/STH Expert Committee	transport, fuel, staff time **Anticipated source of support:** MoH, WHO, RTI Act | East, ASCEND East, TCC and other partners	6.3.2.1 SCH/STH Expert Committee in place 6.3.4.1 Decisions made by the Expert Committee	Activities 6.3.3 and 6.3.4 Ongoing 2021–2025 **Responsible person:** ACHS – VB & NTDs Programme Manager SCH	6.3.4.1.1 Proportion of recommendations from the SCH/STH Expert Committee that are implemented
Root Cause 4: The affected people are the rural poor with no voice **Solution:** Districts with NTDs are given special consideration in budget allocation	6.4.1 Sensitise leaders at all levels on NTDs 6.4.2 Include NTD information and efforts in agenda for meetings with decision makers	Engage both men and women during village planning consultations	Funds for developing and printing of advocacy briefs **Anticipated source of support:** MoH, DLGs and partners	6.4.1.1 Meeting reports 6.4.2.1 Recommendations on NTDs from meetings held	**Timeline:** Activities 6.4.1 and 6.4.2 Ongoing 2021–2025 **Responsible person:** ACHS – VB & NTDs, CAOs, DHOs, District Executive Committees	6.4.2.1.1 Increased budget allocation to NTD affected sub counties based on vulnerability and NTD data

Root cause and solution	Key actions	GESI consideration	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 5: Epidemiological coverage of NTDs is low compared with other diseases **Solution:** Practice equity in resource allocation to provide for communities affected by NTDs	6.5.1 Map NTD-affected communities for refinement of information on NTD-endemic zones 6.5.2 Engage affected community leaders/ communities during planning	Consider equity at individual, group and village levels when programming for NTDs	Funds for facilitating community meetings **Anticipated source of support:** MoH, DLGs and partners	6.5.1.1 Updated maps of affected communities 6.5.2.1 Community meeting reports and recommendations	**Timeline:** Activity 6.5.1 By September 2021 Activity 6.5.2 Ongoing 2021–2025 **Responsible person:** ACHS – VB & NTDs, DHOs and District NTD Focal Persons	6.5.1.1.1 Proportion of districts with updated NTD prevalence maps 6.5.2.1.1 Proportion of districts consulting the community leaders of NTD affected communities during district planning and budgeting

Annex 7: Cross-cutting Area—GESI

Gap: Inadequate integration of GESI considerations into NTD programming in Uganda

Objective: Integrate GESI into NTD programme implementation in Uganda to achieve sustained elimination and control of NTDs by 2025

Root cause and solution	Key actions	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 1: Migration affecting MDA **Solution:** Mitigate the effect of migration on NTD control and elimination efforts	7.1.1 Map migratory populations 7.1.2 MoH issues a directive on CMD selection for migratory populations 7.1.3 Identify and train CMDs within these migratory populations 7.1.4 Hold cross-border coordination meetings with South Sudan, Kenya, Democratic Republic of the Congo and Uganda 7.1.5 Add cross-border NTD concerns to the agenda of the East African Community sectoral committee on health	Staff Tools Funds Training material IEC Material **Anticipated source of support:** MoH, RTI Act | East and ASCEND	7.1.1.1 Database for migratory communities in NTD districts in Uganda 7.1.2.1 MoH circular on CMDs from migratory populations in place 7.1.3.1 Trained CMDs representing migratory populations in place 7.1.4.1 Cross-border coordination meetings held 7.1.5.1 Recommendations on NTD cross-border issues	**Timeline:** Ongoing **Responsible person:** Programme Manager – Trachoma and SCH	7.1.1.1.1 Proportion of people (men, women, boys and girls) who are migrants, who access MDA

Root cause and solution	Key actions	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
			from the East African Community sectoral committee on health		
Root Cause 2: People out of school not targeted for SCH control efforts **Solution:** Extend SCH programme to school-age boys and girls, whether or not they are in school.	7.2.1 Introduce SCH MDA distribution points within the community to reach out-of-school youth	Funds, human resources, tools, IEC materials in local languages **Anticipated source of support:** MoH, RTI Act | East and ASCEND	7.2.1.1 MDA distribution points for out-of-school youth introduced	**Timeline**: By the end of September 2021 **Responsible person:** Programme Manager – Trachoma and SCH	7.2.1.1.1 Proportion of out-of-school boys and girls who access MDA
Root Cause 3: Poor health-seeking behaviour of men with hydrocele **Solution:** Understand and mitigate the reasons behind	7.3.1 Sensitise men and women in communities with high prevalence of hydrocele	Funds, IEC materials, technical support **Anticipated source of support:** MoH, RTI Act | East and ASCEND	7.3.1.1 IEC materials produced	**Timeline:** Ongoing 2021–2025 **Responsible person:** Programme Manager – LF	7.3.1.1.1 Number of men with hydrocele seeking hydrocelectomy

Root cause and solution	Key actions	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
poor health-seeking behaviour by men on access to treatment for hydrocele					
Root Cause 4: Women with TT not accessing surgery **Solution:** Understand and mitigate the reasons behind women with TT not accessing surgery	7.4.1 Develop, print and implement a surgery preparation plan for men and women with TT, including information on the benefits of surgery; develop a list of steps to take before and after surgery, items needed for surgery, and proposed solutions for families to consider	Funds, technical support **Anticipated source of support:** MoH, RTI Act | East and ASCEND	7.4.1.1.A surgery preparation plan template for men and women with TT developed, printed and disseminated	Developed by September 2021 Dissemination and printing ongoing **Responsible person:** Programme Manager – LF	7.4.1.1.1 Number of women and men with TT accessing surgery
Root Cause 5: Women exposed to trachoma because of frequent and recurrent exposure during childcare **Solution:**	7.5.1 Add communication on facial hygiene and sanitation to NTD IEC materials and communication programmes.	Technical and financial support to develop correct messaging **Anticipated source of support:** MoH, RTI Act | East and other Partners	7.5.1.1 IEC materials produced and disseminated	**Timeline:** Ongoing 2021–2025 **Responsible person:** Programme Manager – Trachoma and SCH	7.5.1.1.1 Proportion of households practicing desired behaviours relating to facial hygiene and sanitation

Root cause and solution	Key actions	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Mitigate norms that lead to women being over-exposed to trachoma					
Root Cause 6: Unclear dosing of TEO for children and pregnant and lactating women during trachoma MDA **Solution:** Mitigate the effect of unclear dosing of TEO for pregnant and lactating women and children during trachoma elimination efforts	7.6.1 Standardise the TEO dose for MDA and disseminate the standard	Technical support on dosing Additional TEO **Anticipated source of support:** MoH and RTI Act | East	7.6.1.1 TEO dosing standardised in MDA materials	**Timeline:** By September 2021 **Responsible person:** Programme Manager – Trachoma and SCH	7.6.1.1.1 Proportion of children and pregnant and lactating women who receive and adhere to correct dose of TEO during MDA

Root cause and solution	Key actions	Inputs	Deliverable	Timeline/ responsible person	Milestone/outcome indicator
Root Cause 7: Working men and women miss directly observed treatment during door-to-door MDA **Solution:** Reach all working men and women	7.7.1 Implement MDA outside working hours through CMDs selected amongst the targeted group	Funds and human resources **Anticipated source of support:** MoH, RTI Act | East and other Partners	7.7.1.1 Strategies for reaching working men and women added to MDA training materials	**Timeline:** By September 2021, and ongoing **Responsible person:** Programme Manager – Trachoma and SCH	7.7.1.1.1 Proportion of working men and women eligible for MDA who receive it
Root Cause 8: Disparities in recruitment and availability of male and female CMDs **Solution:** Correct disparities when recruiting new CMDs	7.8.1 Create and manage a database of CMDs for MDA 7.8.2 Replacement of CMDs should follow the guideline of one man, one woman (do not dismiss existing CMDs)	Technical support Updated information from districts Funds from community meetings **Anticipated source of support:** **MoH, DLGs, RTI Act | East and other Partners**	7.8.1.1 Database created 7.8.2.1 CMD selection criteria included in the MDA training materials	**Timeline:** By April 2021, ongoing **Responsible person:** DHOs and District NTD Focal Persons	7.8.2.1.1 Proportion of villages with equal numbers of male and female CMDs (target is 50% of each)

Annex 8: Stakeholders who participated in the development of the Uganda NTD Control Program Sustainability Plan 2020-2025

Participants - Sustainability Plan Consultations

National Level

Name	Designation	Department/Station
Moses Adriko	Programme Manager, Bilharzia	VB&NTDs Division MoH
Dr Alfred Mubangizi	Programme Manager, Uganda Guinea Worm Eradication Programme & Jiggers	VB&NTDs Division MoH
Moses Wakaisuka	Senior Programme Officer	Sightsavers
Polly Kariman Nayarugaki	Lions of Uganda	Lions Club
Christopher Katongole	Programme Officer, Onchocerciasis	VB&NTDs Division MoH
Bob Onada Amodan	Environmental Health Officer	Environmental Health Department MoH
Rogers Batesaki	Senior Environmental Health Officer	Environmental Health Department MoH
Nathan Nasarin	Data Manager	WHO
Musa Birungi	MoES representative on the NTD Secretariat	MoES
Gabriel Matwale	NTD Programme Coordinator	VB&NTDs Division MoH
Annet Khainza	TCC Programme Manager	TCC
Edson Byamukama	TCC Data Manager	TCC
Dr Bayo S. Fatunmbi	DPC	WHO, Uganda Country Office
Dr Francis Mugume	Programme Manager, Trachoma and SCH	VB&NTDs Division MoH
Dalson Kusaasira	Office of the Prime Minister (OPM) Refugee Department	OPM
Dr Abbas Kakembo	Former Sleeping Sickness Programme Manager; NTD Secretariat Member; Chair of the VCD REC	

Tom Lakwo	Former Programme Manager, Onchocerciasis; NTD Secretariat Member	NTD Secretariat (retired from MoH)
Dr Narcis Kabatereine	Country Representative, ASCEND	ASCEND
Dr Charles Wamboga	Senior Medical Officer, HAT PM	VB&NTDs Division MoH
Dr Owembabazi Wilberforce	Project Management Specialist, Office of Health and HIV, USAID Uganda	USAID
Muhumuza Charles	Human Resources Officer	MoH
Benjamin Tinkitina	Data Manager	VB&NTDs Division MoH
Dr Onapa Ambrose	Former Chief Technical Advisor	ENVISION
Andrew Musoke	Principal Economist, Policy and Planning	MoLG
Samuel Babiito	Senior Economist, Policy and Planning	MoLG
Garona Kena	HSS Advisor	USAID/Uganda

Sub-national Level

Name	Designation	District
Manaseh Anziku	Assistant DHO Environmental Health/NTD Focal Person – Arua	Arua DLG
Kafa Adule	District Planner	Arua DLG
Margaret Bayoru	Inventory Management Officer	Arua DLG
Ben Angumaniyo	Biostatistician	Arua DLG
Jimmy Asiku	District Inspector of Schools	Arua DLG
Paul Bishop Drileba	Acting DHO	Arua DLG
Simon Abebi	Assistant CAO	Arua DLG
Puja Mayor	Secretary for Health	Arua DLG
Solomon Osakan	Refugee Desk Officer	Arua OPM Office
Dr Fred Chandi Opeli	Health Centre In-Charge	Arua DLG

Jackline Onzia	Records Assistant	Arua DLG
Gideon Dukua	Health Inspector	Arua DLG
Dr Pontius Apangu	Health Sub-District In-Charge (Principal Medical Officer)	Arua DLG
Stephen Obitre	Water Officer	Arua DLG
Elvis Robinson Okello	Biostatistician	Gulu DLG
David Maxwell Lyclon	HMIS Focal Person	Gulu DLG
William Onyayi	District Health Educator	Gulu DLG
Rose Jenny Okilangole	Acting DHO	Gulu DLG
Michael Chankara	District Surveillance Officer	Gulu DLG
Martin Ojara Mapenduzi	Lower Council 5 Chairperson	Gulu DLG
Dennis Olobo	NTD Focal Person	Gulu DLG
Patricia Aciro	Health Assistant/NTD Sub-County Supervisor	Gulu DLG
Robinson Obot	Senior Inspector of Schools	Gulu DLG
Vincent Muron	Health Sub-District In-Charge; former NTD Focal Person; Former Acting DHO	Moroto DLG
Joseph Aleper	District Inspector of Schools	Moroto DLG
Andrew Napalia	Lower Council 5 Chairperson	Moroto DLG
Cosmas Ayepa	Secretary for Health	Moroto DLG
Michael Lokawa Lotem	Adviser (former Lower Council 5 Chairperson)	Moroto DLG
Ben Loupa	District Biostatistician	Moroto DLG
Walter Owiny	District Surveillance Focal Person	Moroto DLG
Jeftar Onyamasie Waikesa	Senior Clinical Officer/District Medicines Management Supervisor	Moroto DLG
Lorna Lopuwa	District Medical Stores Assistant	Moroto DLG
Patrick Bongomin	Assistant District Water Engineer in Charge of Sanitation	Moroto DLG
Stephen Otim	Acting Assistant DHO Environmental Health/NTD Focal Person	Moroto DLG

Betty Aya	Senior Clinical Officer/Facility In-Charge	Moroto DLG
Sarah Adiakah	Midwife professional	Moroto DLG
Ben Richard Alinga	Chief Finance Officer	Moroto DLG
Charles Onyang	DHO	Moroto DLG
Edward Eko	Principal Assistant Secretary, Office of the CAO	Moroto DLG
Caroline Agaro	Assistant DHO for Environmental Health	Oyam DLG
David Okello	NTD Focal Person	Oyam DLG
Joseph Owani	Assistant In-Charge, Anyeke HC4	Oyam DLG
Onyang Geoffrey	Sub-County Supervisor, Anyeke HC4	Oyam DLG
Dan Odongo	Medicine Stores Focal Person	Oyam DLG
Godfrey Largo Oringa	Lower Council 5 Chairperson	Pader DLG
Anna Apio	DHO	Pader DLG
William Oyet	NTD Focal Person	Pader DLG
Constantine Ojara	Biostatistician	Pader DLG
Francis Olwoch	District Education Officer	Pader DLG
Catherine Amony	District Planner	Pader DLG
Roseline Atim Apila	Medical Stores Focal Person	Pader DLG
Moses Ogwang	Sub-County Supervisor	Pader DLG
Paul Komakech	District Health Educator	Pader DLG
Kizito Omonya	District Surveillance Officer	Pader DLG
Brian Wilfred Adong	Chief Finance Officer	Pader DLG

Participants – Sustainability Plan Consultation Report Dissemination Meeting, 10–11 February 2020

Name	Position	Email Address
Dr Alfred Mubangizi	Acting Assistant Commissioner, VB & NTDs/NTDCP Coordinator	alfmbagz@yahoo.com
Ben Binagwa	Chief of Party – Act | East	bbinagwa@rti.org
Stella Agunyo	Deputy Chief of Party - Act | East	sagunyo@rti.org
Dr Wilberforce Owembabazi	Project Management Specialist – Global Health Security Agenda, Office of Health and HIV – USAID Uganda	wowembabazi@usaid.gov
Dr Bayo Fatunmbi	Disease Prevention and Control - WHO Uganda Country Office	fatunmbib@who.int
Dr Francis Mugume	Programme Manager, Trachoma and SCH	fmugumek@gmail.com
David Ogutu	Programme Manager, Onchocerciasis	dogutu@gmail.com
Gabriel Matwale	Programme Manager, Lymphatic Filariasis	gkmatwale@gmail.com
Fred Muwanguzi	Executive Director – Alliance Water Solutions	alliancewatersolutions@gmail.com
Dr Charles Wamboga	Programme Manager, Trypanosomiasis	cwamboga@gmail.com
Dr Narcis Kabatereine	Country Representative – ASCEND East	N.Kabatereine@ascend.crownagents.com
Philip Davies	HSS Lead – ASCEND London	philipdavies@abtbstain.co.uk
Joyce Kyalo	Regional HSS Lead – ASCEND Kenya	Jkyalo24@gmail.com
Christine Kabarangira	Programme Officer – World Vision	christineoseku@gmail.com
Arthur Freeman Kato	Senior Probation and Social Welfare Officer – MoGLSD	kattobushrah@gmail.com
Swaleh Sebina	Economist – MoH	swalehsebina@gmail.com
Kenneth Lujja	Research Officer – MoLG	kennethlujja@gmail.com
Dr Abbas Kakembo	Member of the NTD Technical Advisory Committee/Chair NTD-Research Ethics Committee	kakemboabbas@gmail.com
Tom Lakwo	Member – NTD Technical Advisory Committee	tlakwo@gmail.com
Dr Peter Langi	Member – NTD Technical Advisory Committee	peterlangi42@gmail.com
Janet Namukwaya	Senior Program Assistant – MoH	sendjanette@gmail.com
Dr George Bhoka	DHO, Adjumani	gdbhoka@gmail.com
Dr Jakor Oryema	DHO, Nebbi	jakororyema410@gmail.com
Paul Bishop Drileba	Acting DHO, Arua	pdrileba@yahoo.co.uk
Mannasseh Anziku	NTD Focal Person, Arua	manasehanziku@gmail.com

Name	Position	Email Address
Vincent Muron	For NTD Focal Person, Moroto	vmuron002@yahoo.com
Donath Eswili	CAO, Arua	eswiludonath@gmail.com
Morris Okumu	NTD Focal Person, Buliisa	okumumorris@yahoo.com
Esther Karamagi Nkolo	Technical Director – WI-HER	enkolo@wi-her.org
Maria Francisco	Programme Director – R4D	mfrancisco@usaid.gov
Jose Gonzalez	Programme Officer – R4D	jgonzalez@r4d.org
Richard Killian	HSS Lead – Act | East, Washington, DC	rkillian@rti.org
Betty Nabatte	Programme Officer Field Operations – Act | East	bnabatte@rti.org
Agnes Atim	Human Resources and Administrative Manager – Act | East	aatim@rti.org
Peter Rubangakene	Senior Procurement and Logistics Specialist – Act | East	prubangakene@rti.org
Mike B. Mukirane	HSS Advisor – Act | East	mmukirane@rti.org
Martin Klaus Osilo	Senior Monitoring, Evaluation, Research, Learning, and Adaptation (MERLA) Specialist – RTI	kosilo@rti.org
Michael Tabuzibwa	Senior Health Educationist – MoH	tabuzibwam@gmail.com
Geoffrey Egitat	Vector Control Officer – MoH	gegitat@gmail.com
Musa Birungi	Senior Education Officer – MoES	birungi.musa@yahoo.com

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