Mission Report – Republic of Uganda

Technical Assistance for LLIN Mass Distribution Campaign

Dorothy E. ONYANGO - AMP Consultant

Mission Dates : August 6th to August 21st, 2012

Location : Kampala, Republic of Uganda

Report Date : August 28, 2012

Subject : Mass Distribution Campaign of LLINs in Uganda

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1. Mission Terms of Reference:

a) Work with the NMCP and partners to support the development of a revised distribution plan and strategy including a suitable urban distribution strategy to enable the country to achieve universal coverage. Ensure appropriate quantification for each district based on urban / rural context and strategy adopted.
b) Work with the NMCP and partners to finalise the LLIN gap analysis and PSM plan to indicate what the Global Fund supports and what gap should be supported by other partners.
c) Work with the NMCP and partners to revise the detailed work plan and budget to ensure that the country has sufficient operational costs for the LLIN distribution activities (including TA as required) in addition to procuring additional LLINs.
d) Work with the NMCP and partners to revise a timeline for all campaign activities, based on the implementation strategy and the procurement timelines.
e) Work with the NMCP and partners to revise the Performance Framework to accommodate additional LLINs.
f) Work with the NMCP and partners to update existing communication, training, supervision and evaluation tools and materials required for the implementation of the campaign. If this is not possible within the timeframe of the mission, to ensure that a list is developed of all required tools and documents, with an associated timeline for their development and finalization.
g) Work with NMCP and partners to develop a data management and monitoring plan for the campaign, identifying data to be collected, key periods when monitoring is crucial, the level from which monitoring should take place (central, regional, parish, etc.) and the tools that will be required for implementation of monitoring activities. Share monitoring tools from other countries with the Uganda team for adaptation to the local context.
h) Provide weekly updates to the AMP partnership on the progress of the TA mission, both via the weekly AMP conference call and via weekly sitreps to be shared with the EARN focal point and the Alliance for Malaria Prevention.

Deliverables:

1. End of mission report detailing:
    a. State of campaign planning on arrival and activities engaged in, including key partners met with and any travel undertaken.
    b. Campaign plan of action (or implementation guideline), timeline and budget. Consultant will identify potential constraints with the PoA and possible solutions that could be examined.
    c. Inputs and recommendations for the campaign planning and implementation. This will include support needed for local teams and recommendations to NMCP for next steps to ensure a successful campaign.
    d. Inputs and recommendations for roll out of future campaigns, including development of capacity (NMCP and partners) for roll out of the campaigns. The consultant will highlight any major issues that could constrain the efforts of NMCP and partners to scale up malaria prevention in the country.
    e. Gaps in human resources and periods for additional support from AMP or other partners.
    f. List of immediate next steps and recommendations for advancing campaign planning.
2. Detailed revised distribution plan and strategy
3. Updated gap analysis and revised PSM plan
4. Revised performance framework
5. Revised work plan and budget
6. Updated communication, training, monitoring and supervision tools
7. Detailed campaign chronogram and execution plan

2. General Observations

- This is AMP's third mission to Uganda; it follows a similar mission in May 2012. The original mission report is available on AMP's website.
- The current climate inside MOH is not conductive to the organization of a difficult nationwide LLIN mass distribution campaign. An investigation remains open from Phase I use of GF funds. In that regard, the previous campaign coordinator was almost entirely absent while the previous LLIN M&E officer had been rotated out of the Malaria office
- The AMP mission came during a busy time with NMCP and WHO busy with quarterly review meetings and other non-LLIN activities. In the absence of the LLIN campaign coordinator, the consultant found it challenging to obtain an orientation, assistance or information. Productive work began on both sides after the Program Manager took a direct role in working with the consultant. Given the short timeframe of the mission, the lack of a support taskforce contributed to some of the mission deliverables not being fully addressed.

3. Context:

- Uganda is planning to reach Universal Coverage with Long Lasting Insecticide Nets (LLIN) in 2012 – 2013.
- Various donors committed LLINs for the national campaign: 11,003,054 nets from GFATM Rd7 Phase II and 650,000 nets from USAID/PMI; (for a total of 11,653,054 LLINs). Savings were made to the amount of 17 million dollars attributed mainly to a drop in the unit price of LLINs. These savings activated the reprogramming process for which this TA was required. An agreement was already in place to procure 4 million more LLINs and provide the operational funding for the

same. The total number of nets expected at the beginning of the consultancy was therefore 15,653,054.

- The Phase II grant had been signed before the consultant's arrival. The exact timeframe for LLIN arrival was not yet known, but the first delivery in Uganda is expected around Sept 2012, with the order completed by February 2013, as per VPP tender terms.
- The Ministry of Health is the Principal Recipient for GFATM Rd7 (through the Ministry of Finance). The official evaluation and selection of sub-recipients (CSOs which were previously selected in Phase I distribution) has been completed and the report is pending.
- It is widely accepted that the campaigns will commence at the end of 2012 culminating in the first distribution in 2013. The coordinating structures have not started meeting to plan for the upcoming LLIN distribution campaign. A number of quality tools exist from the successful Phase I, and have been reviewed by PMI and the consultant for use in Phase 2. These tools are being piloted at the universal distribution campaign in four districts.

4. Mission rollout and main accomplishments

The Need

A revised LLIN quantification was drawn from 2012 and 2013 expected population data to provide a more accurate LLIN need for UC in Uganda. This was done because by the time the Phase II would be ready for distribution in 2013, almost the entire Phase I LLINs (7,289,921) distributed in 2010) would have reached the end of their valid life (estimated at 3 years). Furthermore there are no plans to account for existing nets within individual households. It was also widely accepted that all the GF campaigns would take place in 2013 and none at at the end of 2012 as first communicated. The total LLIN need for Uganda would therefore be slightly more than 19.6 million units.

The Gap

The current gap remains a sizeable 3,784,473 and mobilizing this number of nets in a timely fashion will be a daunting task. Though all partners should actively strategize to cover this gap, the lead times for the procurement of LLINs through other means could mean that some districts would be left out for another year. The partnership in Uganda consists mainly of USAID and PMI-funded projects that are undertaking continuous distribution. Only PMI and Global Fund support campaigns because UNICEF, which previously supported campaigns, is concentrating on iCCM. There is therefore an urgent need to develop a wider and more robust partnership in Uganda.

The Options

With regards to the existing LLIN gap, NMCP considered the five options.

i. Prioritization according to the time passed since the last campaign
ii. Prioritization according to the distance from the capital city
iii. Prioritization based on ongoing routine distribution and other current and planned interventions
iv. Prioritization according to the Malaria Risk Map
v. No prioritization. Equitable distribution to all districts.

Prioritization according to the time passed since the last campaign is a proxy for the age and integrity of the nets in existence in the households. The campaign would follow the same pattern as the

previous campaign replacing the older nets first, starting from the Eastern Wave, through Central, Western and then finally Northern Wave

Weakness: The weakness of this argument is that the country is already assuming that all the nets are no longer viable and this is the justification for a brand new mass campaign for universal coverage. Secondly, most districts in the Northern Region would be left out of the GF campaign because of lack of nets.

Prioritization according to distance from capital city would mean that the areas furthest from the capital city would be prioritized. These areas are presumably furthest away from the most highly regarded secondary and tertiary health centers and have lower access to health care providers from the private sector.

Weakness: The capital city and its environs, that is, the Central Region, would be left out of the GF campaign due to lack of nets. The influential people in the capital city can be a source of stress to the NMCP which is of course hosted in the capital city.

The Malaria Risk Mapping was done by PMI and the report dated July 2012 showed that the districts in the Western Region bordering the DRC and North bordering South Sudan were had a low risk ranking. Districts ranked as high risk tended to be grouped together in the NE and SW with other high risk districts scattered on the map.

This is an evidence-based decision making tool, the risk mapping was recently concluded and its data still valid.

Weakness: The partners expressed some disbelief in the results from some districts given the interventions that had been provided in those districts. However, they could have been biased if they were the ones that provided those interventions. Secondly, the districts ranked high risk are scattered and implementing in one while totally leaving out its neighbor or preferential allocations in which more nets would be provided in selected districts, would cause a backlash from politicians and further disrepute to a rather vulnerable NMCP

Close associated with this, the partners agree that there is no *current or planned intervention* that can be used to prioritize the districts for implementation because none of those other interventions are being provided at the same scale with the high vector control potential as the planned Universal Coverage and usage of LLINs. Additionally all recent interventions had already been incorporated into the modeling process for the development of the risk map.

Opportunities: Any kind of prioritization would have been desirable as it would give the NMCP and partners easily identifiable geographical regions to fill gaps in the future and could also allow the country to eliminate malaria in one half of the country starting from the low risk West, for example, and progressing Eastwards. (The country has a swamp and lake ecosystem in the center that effectively splits it into East and West)

Threats: There is an ongoing GF investigation, and the management at NMCP is not yet confirmed therefore all the actors would rather err on the side of caution because any new scandal would threaten the integrity of the program. Leaving out any region is not an option because it may be

misinterpreted as leaving out an ethnic group or communities of certain political affiliations and this is a threat to the national program.

Therefore, despite several sound methods of prioritizing districts, the potential for unpalatable political backlash for leaving out districts with no confirmed LLINs in the pipeline, brought about a compromise decision to equitably distribute available nets to reach UC in as high a percentage of households in every village as possible with the currently available stock of LLINs at 1 net for every two people in the household, rounding down for odd numbered households. Additionally it was decided that gains must be sustained and not punished. The specific case of Kampala and its urban distribution was debated and an option of the distribution of a set number of nets per household studied, but it resulted in an insignificant difference compared to the additional effort required to of develop and implement a whole different methodology for just one and a half districts out of 112.

Personnel quantification will be finalized following micro-planning, but already based on past and current strategy a few points can be noted:

- The number of volunteers at all levels planned for the upcoming Phase II distribution seems high but the methodology used will require them all.
- 4 members come from a single village (2 VHTs, 1 LC1 – local leader, 1 woman representative) though distribution sites are often combined with an average of 3 villages, making for an average of 12 volunteers per distribution site. This seems high, but the need for people who can identify the beneficiaries and the need for security at the DP and controls requires these people to all be present especially since distribution will take place on only one day.

The distribution strategy is based on reaching UC nationwide.

Key campaign numbers:

- ✓ Estimated population to be served: **35,350,214 persons** (2012 projections for 4 districts and 2013 for 108)
- ✓ Estimated number of HHs to be served: **7,505,074**
- ✓ The quantity of LLIN required to reach UC is: **19,639,008**
- ✓ Global Fund will provide: **15,204,535**
- ✓ PMI will provide: **650,000**
- ✓ The expected LLIN gap to reach UC is: **3,784,473**
- ✓ Number of Regions in Uganda: **4**
- ✓ Number of Health Districts: **112** *(all participating in the campaign)*
- ✓ Number of Sub counties (est.): **1600** (this figure is being used for the GF budget in order to err on the side of a slight overestimate. Savings, when discovered could cover other activities such as repositioning of nets to new sub-counties, coupons and more LLINs)
- ✓ Number of Parishes (est.): **8640**
- ✓ Number of Villages (est.): **65,664**
- ✓ Number of LLINs available: **15,204,535**
- ✓ Estimated number of VHTs (est.): **131,328**
- ✓ Estimated number of distribution sites (est): **21,888**
- ✓ LLIN specificity: **180x160x170 cm, White or Blue, 100 Deniers, 6 hooks & strings**

Timeline (*see document in Annex*):

The campaign timeline is based on current factors and will need to be revised should an important quantity of additional nets be committed to Uganda or should VPP communicate a different estimated time of arrival of LLINs. The household registration will happen in 2013 nationwide, in order to have valid data over a longer period. There will be a rotating distribution beginning in early 2013 and covering all 4 regions at least a month apart from one another, in order to fully finish all activities before moving on to the following region.

Budget (*see document in Annex*):

A new budget has been developed based on revised (but not final) distribution strategy. In response to a series of comments and notes that were given during this process, the consultant made further adjustments but left some issues for the National Program to make and own. The consultant made some changes and clarifications to key activities that were under (or over) budgeted in the following areas:

- Micro planning: This key activity was part of the Phase II budget but not stated as such. They call it the "pre-visit". The consultant recommends a different approach to this pre-visit.
- Training for HH registration: 1 day budgeted for all key activities to undertake
- Training for logistics: A separate day budgeted (unlike Phase 1)
- HH registration: all costs associated with new round of registration
- Supervision and TA: additional resources to coordinate and closely monitor planned activities

Training :

A second day of training was added to the logistics and registration training to ensure that the concepts are properly explained and the tools understood and used correctly.

The current training guide and associated tools are being piloted by PMI in the four campaigns that are currently taking place. Should some key decisions to change the methodology be adopted, the training guide and some tools would be revised.

Micro Planning:

Micro planning will take place beginning with a regional meeting/training for 4 participants per district, facilitated by a 10 person central team. After this meeting, the participants return to their Districts, while the facilitators split into three teams of three and a team leader and they mentor the district teams to develop verified micro plans and budgets. This whole activity would take 10 days and involves meeting district and sub-county personnel, communicating campaign strategy and keys points, sharing tools and most importantly adapting the national guideline to a locally specific reality. The outcome will be site-specific information about population, LLINs, volunteers, budget, warehousing and all necessary tools required to conduct the registration and distribution in the best possible manner.

A micro planning tool should be developed that will help gather all required data from the field and synthesize District and Sub county budgets. This information will ultimately inform the LLIN quantities being dispatched to individual distribution sites.

Human Resources and Supervision :

Comments were already made regarding the high number of volunteers being considered for Phase II activities. The consultant's recommendation is to continue working with the 2 malaria VHTs who are experienced in this work. Should the country choose to use coupons, the VHTs alone would suffice. If not then the current arrangement with the LC1 and Women's Rep will stand.

5. Recommendations

a) Coordination:
- The LLIN campaign coordinator is distracted and the previous malaria team rotated to other departments due to ongoing GF investigations. A counterpart for the LLIN campaign coordinator in the form of an international TA is recommended to support the program, and update stakeholders, meet regularly with NCC, all sub-committees and start planning for UC campaign, and ensure close & frequent coordination between MOH, VPP and LFA
- Consider delivering nets in districts as provided in the macro allocation and not as previously arranged
- Request additional TA from RBM, AMP, PMI and partners

b) Resource Mobilization:
- Efforts should be made to mobilize resources from partners within and out of the country. For example, a commitment of financial support for Operational Funding made in the near future, could free GF money to procure LLINs with minimal delay to the whole campaign. Try DFID and JICA. Commitments from other partners to produce BCC materials would have the same effect. Try Carter Centre.

c) Communication
- Recruit a local TA for Advocacy and Communication
- Start communicating at all levels around the LLIN campaign; new objectives
- Review mass & IPC communication resources / strategy and timing for maximum impact

d) Data Management:
- Review campaign database

e) Logistics:
- Confirm the need of additional warehousing
- Confirm with VPP the updated LLIN delivery schedule for the additional nets
- Recruit a local TA for Operations.

f) Micro Planning and Budget:
- Consider getting three experienced implementers from one country to provide short term TA to refine the micro planning tool from their own country and conduct the ToT for the 10-man team and oversee the first micro planning exercise (Zone 1).
- Finalize district and sub county budgets following micro-planning; ensure prompt transfer of funds
- There is the potential of obtaining some savings from the overestimation of administrative units.

The consultant recommends at least ten days micro planning for a region. Micro planning should take place beginning with a regional meeting/training for 4 participants per district, facilitated by a 10 person Regional Support Team/Cluster Supervision Team from the national level. After this meeting, the participants return to their Districts, while the facilitators split into three teams of three and a team leader and they mentor the district teams to develop verified micro plans and budgets. This whole activity would take 10 days and involves meeting district and sub-county personnel, communicating campaign strategy and keys points, sharing tools and most importantly adapting the national guideline to a locally specific reality. The outcome will be site-specific information about population, LLINs, volunteers, budget, warehousing and all necessary tools required to conduct the registration and distribution in the best possible manner.

A micro planning tool should be developed that will help gather all required data from the field and synthesize District and Sub county budgets. This information will ultimately inform the LLIN quantities being dispatched to individual distribution sites.

6. Next Steps

I. 5 key decisions need to be made by NMCP during final in-country review of the GF R7 P2 documents
   a) Change of objectives. The PMI concept note for the 4 districts has these same objectives but they are not in line with the country's definition of universal coverage. The country should make a decision to change the objectives and make the new objectives the national objectives.
   b) Consider using coupons or "net cards" for the whole country. The implementers the consultant spoke to say that since the VHTs and district people are extremely averse to this, the malaria program had written to Geneva explaining why they will not use coupons in the future. However, this would help to maintain a trail of documention to track the nets down to the end user. It would also eliminate the huge number of distribution staff at one distribution point because there would be no need for people to identify the beneficiaries, or call their names, or for beneficiaries to sign for nets (requiring literate VHTs and beneficiaries). It would be a simple exchange of net card for net. Right now - a DP serves 2 to 4 villages. The distribution personnel are 4 per village so there can be 16 people at one DP or even more. It is excessive. Six is adequate.
   c) Micro planning to take place as soon as possible because confirming the number of administrative structures and available storage facilities is critical. I made an assumption on number of sub counties and then used averages to calculated numbers of parishes and villages.
   d) Consistency of the naming of committees and subcommittees and for cadre of campaign staff. I would recommend the UG team to select and consistently use one naming system. The District Pre-visit should just be called "Micro planning" and finally put to rest the idea that Uganda does not conduct micro planning.
   e) End process Assessment. Again, the implementers were not interested in this. However, the teachers should be able to conduct a one-day end process assessment for the campaign. Why teachers? They are literate and neutral - were not involved in the distribution and are a great resource for health programs at the community level. Their capacity should be built.

End process can be as simple as sampling 10 households per village in four randomly selected villages per parish.

II. CSO selection has been completed. Release report and begin contractual negotiations for Phase II sub-recipient agreements.
III. Communicate with GF and other partners to close LLIN gap for Universal Coverage in Uganda. This is something which needs to be communicated at the weekly AMP call.
IV. Liaise with VPP for prompt delivery of additional LLINs to revised appropriate locations.
V. Obtain feedback from the 4 districts and revise the tools accordingly. Should the country agree to the use of coupons, the tools should be revised to capture that.
VI. Micro planning must be done at once

7. Conclusion

This country has a history of successful campaigns, and there is also a wealth of international experience and tools from previously successful LLIN distribution campaigns. A national level discussion needs to take place in the immediate future to ensure that all stakeholders are on the same page and planning for the 2012/2013 Universal Coverage campaign. Once key discussions have taken place, the tools can be quickly reviewed and then the normal production of tools and documents should promptly begin.

It is likely that Uganda will require additional technical assistance to organize this important campaign.

We would like to thank all of the colleagues who collaborated during this mission, especially NMCP, WHO and SMP and MC.

AMP remains available to provide additional technical assistance.

Documents attached in email :

1. Detailed revised distribution plan and strategy
2. Revised PSM plan
3. Revised performance framework
4. Revised work plan and budget
5. Updated communication, training, monitoring and supervision tools currently being piloted
6. Detailed campaign chronogram and execution plan

List of Acronyms :

AMP	Alliance for Malaria Prevention
BCC	Behavior Change Communication
CDC	Center for Disease Control and Prevention
CSO	Civil Society Organization
DS	Distribution Sites
EPI	Expanded Program on Immunization
GFATM/GF	Global Fund to fight AIDS, Tuberculosis and Malaria
HH	Households

HVT	Health Village Team
IEC	Information, Education and Communication
LC	Local Council
LFA	Local Fund Agent
LLIN	Long Lasting Insecticide Net
MOH	Ministry of Health
NCC	National Coordinating Committee
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
PMI	President's Malaria Initiative
PR	Principal Recipient
RBM	Roll Back Malaria
TA	Technical Assistance
UC	Universal Coverage
UNICEF	United Nations Children's Fund
USAID	Unites States Agency for International Development
VPP	Voluntary Pooled Procurement
WHO	World Health Organization

People the consultant met during this mission :

- Dr. Peter Okui, NMCP Programme Manager
- Dr. Jim Arinaitwe, MOH GF Coordinator
- Dr. Vincent Bagambe, MOH GF Quality Assurance Manager
- Connie Balayo, NMCP LLIN Coordinator
- Dr. Myers Lugemwa, Team Leader M&E and Research
- Dr. Ebony Quinto, M&E Specialist
- Medard Rukaari, Malaria TA UNICEF-funded
- Dr. Charles Katureebe, NPO Malaria WHO
- Agnes Suubi, MC Coordinator for ITNs
- Dr. Sam Siduda, Deputy COP Stop Malaria Project
- Dr. Anthony Esenu, Country Director Pilgrim
- Patrick Okwalinga, Administrative Secretary Pilgrim
- Dr. Henry Katamba
- Dr. Dennis Rubahika, Focal Person for Surveillance and Epidemics
- Mathias Kasuule, GF M&E